

Chairperson's Message

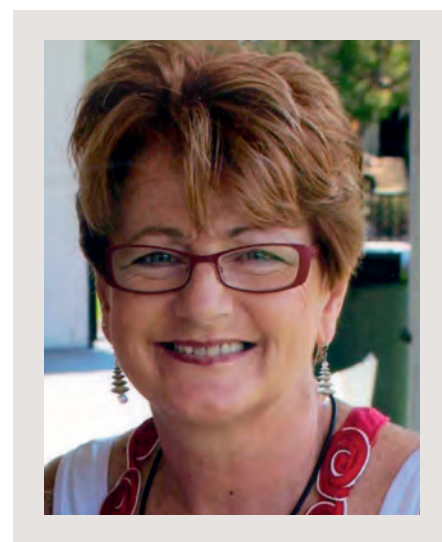
by Annette Cassar

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What a wonderful year of celebration it has been for AMT's golden anniversary. The recent 50th Anniversary Conference was the icing on the cake. To commemorate, this edition of the journal is packed with articles and images from the conference and a wander down memory lane, revisiting many fabulous clinical articles from previous editions of *In Good Hands*.

I'd like to focus on an important event that occurred at the conference; the presentation of life membership to two valued members of AMT. Life membership is a significant achievement. This award isn't given lightly—it recognises the exceptional contribution of individuals to the massage therapy profession and, in particular, their contributions to AMT. Life membership is intended to recognise a substantial legacy of contribution—it is more than simply being a long-term member of AMT.

It was with great pleasure that Derek Zorzit presented Alan Ford with his AMT Life membership. Alan and Derek have been friends and colleagues for over two decades. After spending 20 years in the navy, Alan started massaging in the early 1990s. He studied massage at both Canberra College of Advanced Education (CCAEE) and Om Shanti College before further study under Rich Phaigh, learning the art of muscle energy treatment. He then opened his own practice in Kingston, Canberra. In addition to presenting at previous AMT conferences, events and workshops, passing on his vast knowledge and experience, Alan has numerous achievements to his credit, including:



- paid Olympic Therapist from 1993 to 2000
- Massage Therapist of the Year in 2005
- nominated Australian of the Year in 2012
- AMT president from 2006 to 2009
- AMT president 2012-13.

Leonie Dale was another worthy recipient of AMT Life membership. Tamsin Rossiter had the pleasure of presenting her colleague and partner in crime with the award. Tamsin's speech stated that during her long impressive career Leonie has many achievements to be proud of. Over her working life Leonie has traversed across health paradigms from nursing in the biomedical model to massage therapy, aromatherapy and working with people living with cancer within a complementary healthcare paradigm. She is a passionate educator and has taught in TAFE colleges, university and has given countless community talks and conference presentations.

Leonie's commitment to health and education and the AMT was very evident. She has taught pathophysiology and symptomatology at TAFE and completed comprehensive study into psychoneuroimmunology as part of her Masters of Nursing in humanities and healing. Leonie has an extraordinary capacity for empathy and support for her clients. In Tamsin's words she "works from the heart".

Leonie's support for her students is indicative of her approach to learner-centred teaching, once again teaching from the heart.

Leonie and Tamsin assisted in the founding of the massage therapy qualification at Blue Mountains TAFE designing curriculum and practising massage therapy technique and sequences. It was at this time that Leonie challenged the notion of massage being contraindicated for people living with cancer, leading her into extensive study in both Australia and the UK.

This is when Leonie became quite well known as a presenter and educator and massage therapist for people with cancer.

In closing, I would like to congratulate the conference committee, AMT Board and staff for all their hard work over the past year. On behalf of AMT I would like to wish all members a Merry Christmas and Happy New Year. ■amt

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DEADLINE

**Deadline for the
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Congratulations to:

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Secretary's Report

by Rebecca Barnett

It was a genuine thrill to be able to present preliminary data from AMT's research study partnership with the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM), at the 50th anniversary conference and celebration in September. There was much to celebrate in the results so far collected from the patient arm of the study, which examines the expectations and experiences of patients using massage therapy.

For those of you who may feel that massage therapists are not valued health service providers, the survey data tells a surprising and hopefully uplifting story. Of the group of patients who were exit interviewed by a research assistant after attending a treatment at one of the clinics recruited for the study, 82% said they used massage therapy regularly or often, pointing to a stable pattern of demand for services and a strong sense of value from treatment. But this is just the tip of the iceberg in terms of the good news story embedded in the data ...

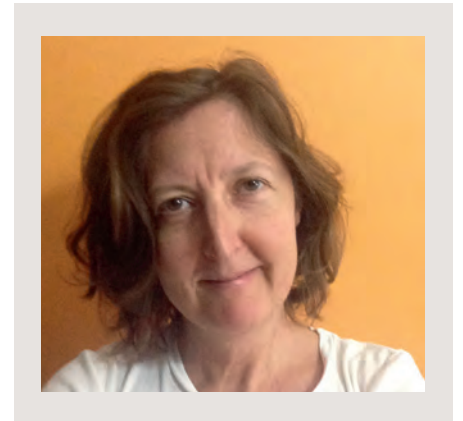
In the exit survey, patients were asked about what conditions they sought treatment for on that particular day; what conditions they had used massage therapy for in the past; what other kinds of health practitioners they were consulting concurrently; what factors were important in deciding to see the practitioner that day; how many years of training they thought their massage therapist had and a range of other questions relating to advice and recommendations and what health and lifestyle issues they would be comfortable discussing with their massage therapist.

For me, though, the single most stunning piece of data to emerge from the survey was the responses regarding perceived years of training of the treating therapists.

A spectacular 65% of surveyed patients thought their therapist had received more than three years of training in massage therapy. A further 12% thought their therapist had three years training. Just pause for a minute to think about that statistic and what it means: a whopping 77% of patients thought their massage therapist had **at least** three years training. Do you still feel like your skills, knowledge and expertise are not recognised or valued? Is it possible there is a disconnect between our image of ourselves and the esteem in which our patients view and hold us?

Survey data also explicitly shows that massage therapists are providing a significant level of service related to one of the nine National Health Priority Areas (NHPAs) identified by the Australian Government, namely arthritis and musculoskeletal conditions. It's literally *painfully* clear from the data that we're not all about the bliss – far from it, in fact. We are treating a tonne of pain!

According to Global Burden of Disease estimates, low back pain is ranked first in Australasia (Including Australian and New Zealand) compared to sixth in the world and neck pain is rated 10th in Australasia compared to 21st in the world (<http://www.aihw.gov.au/arthritis-and-musculoskeletal-conditions/> accessed 31 October 2016). These data are clearly reflected in the patterns of consultation evident from the survey responses. Half (50%) of the patients surveyed were seeking treatment for low back pain on the day they were surveyed. When you expand the parameters to include use of massage therapy for low back pain at any time, that percentage grows to 70. In relation to neck pain, the figures are 40% on that day and 65% at **any** time (note that patients were allowed to select multiple presenting conditions from a list.).



Thirty percent of clients attending on the day were also seeking treatment for chronic pain. Again, this reflects the bigger picture - according to Neura Australia, one in five Australians experience chronic pain that is serious enough to disable them, costing the country approximately \$35 billion a year. (<https://www.neura.edu.au/health/chronic-pain/> accessed 31 October 2016).

The message is clear and unequivocal - whether the government formally recognises massage therapy as a health service or not, massage therapists are at the front line of treating Australians with musculoskeletal conditions and chronic pain. Again, I believe we are more valued and recognised than perhaps we have come to believe, by the very people who matter the most: the clients we treat.

But there's also another story the patient survey tells us we need to pay due attention to. Only 5% of respondents said they had used massage therapy to help manage anxiety and depression at any time. Given that some of the strongest evidence we have is for the efficacy of massage therapy in alleviating both state and trait anxiety, are we starting to miss the mark in how we promote our services and communicate with our clients?

Even more alarmingly, not a single respondent said they had used massage therapy at any time to help manage insomnia. Given the intimate connection between poor sleep and pain - particularly chronic pain - that the research clearly shows this result seems a little eccentric to put it mildly. Have we started to assess and treat too mechanistically? Are we biomedicalising at such a frantic pace that we're completely neglecting our holistic roots? Have we forgotten that our clients are complex, messy, wonderful and irreducible, not just a set of shifts, tilts, upslips and fascial slings? Are we treating people or presenting conditions?

The plot thickens if we then consider the responses to this survey question: "Which of the following were important in deciding to see your practitioner today?". A whopping 62% of respondents said they preferred a natural approach to treatment and 40% said that conventional medical treatment had not worked for them. Is our march to align our treatment paradigms with the biomedical hegemony imperiling the foundations, relationships and trust we have built over many decades with the public? Is our perception of the benefits we offer clients at odds with our clients' motivation for seeking massage therapy? Have external influences conspired to make us too disease and condition-focused, and forget that there's not only a market but also a significant need for wellness and relaxation-focused work?

These questions are important for us to engage with because they speak to the heart of the issue of professional identity and how we see ourselves operating within the health care system in Australia. They're also important because they show we are leaving a massive gap in the health marketplace that is currently being flooded by a tidal wave of Uber-style on-demand massage platforms with attractive and inviting names like "Soothe", "Blys" and "ZenNow".

Are we ready to cede the relaxation and wellness marketplace over to a group of tech-savvy outsiders who are seemingly eager to take control of our destiny and possibly even exploit the services of qualified massage therapists in exchange for substantial booking commissions? Carving up people into Cartesian dualisms of mind/body inevitably means we're also carving up our own market as well, and giving over some significant terrain that we are best trained to service. But that's an entire conversation in itself to be developed at a later time ...

One last statistic before I sign off though. Only 34% of respondents said that being able to claim through a private health fund was an important factor in seeking treatment. This begs two final questions - are we placing too much emphasis on being health fund providers? And, if we are, what are the risks and costs of this overemphasis?

I have asked a whole lot of questions in this report. I don't pretend to have the answers to all of them but I will be bold and say one definite thing - each of the questions relates in some way to empowerment. The patient survey tells a success story. We are far more empowered and valued than many of us have come to believe and there are manifold opportunities to consolidate even further. Let's not allow private health insurance companies and opportunistic app developers to take the initiative away from us by capitalising on the good will that we have spent so many years creating.

■ amt

Call for nominations for appointment to the AMT Board of Directors

I strongly encourage AMT members to consider nominating for our Board. We are looking for passionate members with vision, a strong sense of accountability to fellow members and the ability to approach emergent issues both critically and strategically on behalf of AMT. The strength and effectiveness of AMT relies on the involvement of our members in the governance of our organisation. Board members are involved in strategic planning, high level oversight of our organisation's key directions and activities and ensuring compliance with all legislative requirements. A nomination form can be found in this edition of the journal.



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About the founder of the Myofascial Cupping Technique™

David Sheehan has a Bachelor of Applied Science (Human Movement), Diploma of Health Science (Remedial Massage) and Diploma of Education. His career highlights include working as a lead sports trainer with various football clubs, which included the use of vacuum cupping for both prevention of and treatment for injuries.

Over time, David has developed these skills and now teaches his own energy efficient and effective cupping techniques to massage therapists and physiotherapists in Australia, New Zealand, Canada and the United States, including physiotherapists and remedial therapists at the Australian Institute of Sport (AIS).

WORKSHOP DATES

Melbourne – Saturday 25 & Sunday 26 March 2017

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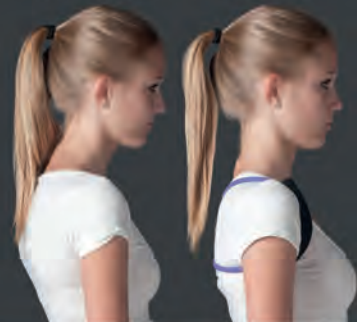
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Being a health fund provider: your responsibilities and obligations

A reminder from the AMT Board

The AMT Board and past executives have worked hard to establish and maintain provider agreements with the various private health funds on behalf of AMT members. These agreements between AMT and the funds involve a mutual undertaking to honour the spirit and letter of the conditions as they are laid down.

A high percentage of AMT's members maintain provider status with the health funds. Health fund recognition has helped to raise the profile of massage therapy in the community, moving massage from the margins into mainstream healthcare.

However, it is worth remembering that the privilege of achieving provider status and working as a healthcare professional also comes with a set of professional and ethical responsibilities. These responsibilities are comprehensively encapsulated in the AMT Code of Practice.

Standards of Care: Maintaining Clinical Records

If you are complying with the standards laid down in the AMT Code of Practice then you can be confident that you also meet the provider terms and conditions set by individual health funds. As a service provider for a specific fund, you should be aware that you are bound by the provider terms and conditions of that fund. It is crucial to keep abreast of your obligations. The AMT Board strongly recommends that you review both the AMT Code of Practice and the various health fund provider terms and conditions to ensure that you are operating in accord with expected standards.

The AMT Code of Practice can be accessed online at: <http://www.amt.org.au/amt/code-of-practice.html>

The various health fund provider terms and conditions are available for download here: <http://www.amt.org.au/members/health-fund-info.html>

Maintenance of appropriate clinical records is particularly crucial for manifold reasons. Be aware that the health funds have the right to audit your practice at any time and may request copies of client files and treatment plans. Health funds can and do take action to recover funds from providers if the records they keep do not clearly show that rebatable, remedial massage has taken place. Sometimes this recovery of funds can amount to thousands of dollars' worth of claims. The AMT Board has also commenced a program of audits of members to ensure that record keeping is in line with the standards in the Code of Practice.

Aside from the Code of Practice, AMT has made available useful resources to help you maintain appropriate treatment records. These include case history / intake forms and informed consent templates. These practice resources can be downloaded here:

<http://www.amt.org.au/members/practice-templates.html>

Say no to fraud

The exponential growth in health insurance fraud over the past five years represents one of the biggest threats to the advancement of our industry. The AMT Board takes an extremely dim view of members who compromise the provider agreements we have worked so hard to initiate and uphold by being slack or dishonest in receipting treatments.

Over the past year, the AMT Board has taken action to remove members who have committed insurance fraud.

The provider numbers issued to you by AMT and the individual funds are yours and yours alone. They are issued on the understanding that you will continue to honour your basic obligation to be ethical and honest in your dealings with your clients and the third party insurers that subsidise the cost of client treatments with rebates.

The following are all examples of insurance fraud and will not be tolerated by the AMT Board:

- Allowing another therapist to use your provider number(s)
- Pre-signing receipts for use by other therapists
- Using another therapist's provider number for a treatment performed by you (for example, when you are not registered as a provider with a particular fund but a colleague is)
- Issuing receipts for a service and/or treatment you did not provide.
- Backdating receipts
- Falsifying any information on a receipt (for example, issuing a receipt in the name of another family member when a client has reached the limit of their own claims)
- Splitting receipts - writing receipts for two half-hour treatments when the treatment was for one hour.

The dishonest practices of a single member or group of members deeply compromise the good relationships AMT has built with the private health funds. AMT's credibility as a professional, representative body is on the line every time a member (or members) fiddle the system.

Sophisticated fraud detection software now gives the funds an unprecedented capacity to crosscheck and spot inconsistencies in receipting.

If a client is pressuring you to do the wrong thing and falsify receipts, say no.

If a colleague is pressuring you to do the wrong thing and falsify receipts, say no.

If an employer is pressuring you to do the wrong thing and falsify receipts, say no.

We have published AMT's receipting standard in full in this journal (opposite) so you are aware of your professional and ethical responsibilities as a member of AMT and a health fund provider.

AMT's goal is to strive for recognition and acknowledgement of our professional expertise. However, if we are to be taken seriously as professionals, we must be serious about our professionalism.

Health insurance fraud is dishonest and damaging behaviour that threatens to drag the entire industry back twenty years.

Please do the right thing by AMT, by the private health insurers, by your colleagues, by the industry at large and by your clients. ■ **amt**

MEMBERSHIP FEES	
FOR 2017	
GENERAL LEVEL	\$190.00
SENIOR LEVEL 1	\$235.00
SENIOR LEVEL 2	\$265.00
AUXILIARY	\$55.00

AMT STANDARD - Issuing Receipts

PURPOSE

Massage therapists are aware of their legal and ethical responsibilities in relation to receipting treatments, and can apply this understanding in accordance with the policy.

BACKGROUND

Receipts are a record of a financial transaction. In the massage therapy clinical setting, a receipt is a written acknowledgement of receiving payment for treatment on a specific day for a specific fee. Similarly, an invoice/tax invoice is a written record of a treatment being provided on a specific day for a specific fee. An invoice and receipt can be incorporated into a single document.

A receipt should be issued as soon as payment for a treatment has been tendered. When payment is not tendered immediately after a treatment, an invoice/tax invoice may be issued to the client or, where applicable, to a third party payer such as a workers' compensation authority.

Massage therapists have a professional duty of care to ensure that details included on receipts are accurate and truthful. Modifying receipts to enable false claims on insurance is fraud and punishable by law.

POLICY

Message therapists are required to:

- issue a receipt after each payment transaction
- issue an invoice for treatment if payment has not been tendered
- issue a tax invoice if registered for and charging GST. The tax invoice must include an ABN and be titled "Tax Invoice".
- retain copies of receipts, invoices and tax invoices, either on paper or electronically
- ensure that the details on the receipt/invoice/tax invoice (date, nature of treatment, client's details) coincide with the client's clinical record
- mark duplicate receipts, invoices and tax invoices with 'copy' or 'duplicate'.

Message therapists do not:

- falsify details on the receipt, such as the client's name or the duration/frequency of treatment, to enable a client to make a false claim with a third party
- change the date or nature of treatment to enable a client to make a false claim with a third party
- use another practitioner's details or provider number(s) to enable a client to make a false claim with a third party
- use correction fluid or tape to make corrections
- charge GST unless registered to charge GST.

INFORMATION REQUIRED ON RECEIPTS

The following details must be clearly printed on receipts, invoices and tax invoices (i.e. it cannot be handwritten):

- Name of the therapist who gave the treatment
- Business name if applicable
- Practice address. This must be a street address not a PO Box.
- AMT member number
- ABN if applicable.

The following details must also be included but may be handwritten:

- Client's name and address
- Date of treatment
- Nature of treatment
- Health Fund provider number(s)
- Fee
- Date of payment.

TAX EVASION AND FRAUD

Failing to declare assessable income, not wanting to issue a receipt or providing a false invoice are all considered to be forms of tax evasion.

Health insurance fraud and inappropriate claiming is where someone receives a benefit payment using false or misleading information. If massage therapists issue receipts with incorrect or falsified details, such as the date of the treatment, treatment description, name of the treating therapist or name of the client, then they are committing fraud. Health insurance fraud is a criminal offence and is punishable by law.

CHARGING GST

Massage therapists must register for GST if their gross income exceeds \$75000 per annum. If massage therapists are registered for GST, then they must issue tax invoices for their treatments, quoting their ABN.

REFERENCES

ATO website record keeping and Tax invasion - www.ato.gov.au

The Australian Consumer Law - A guide to provisions 2010

The Australian Consumer Law - An introduction November 2010

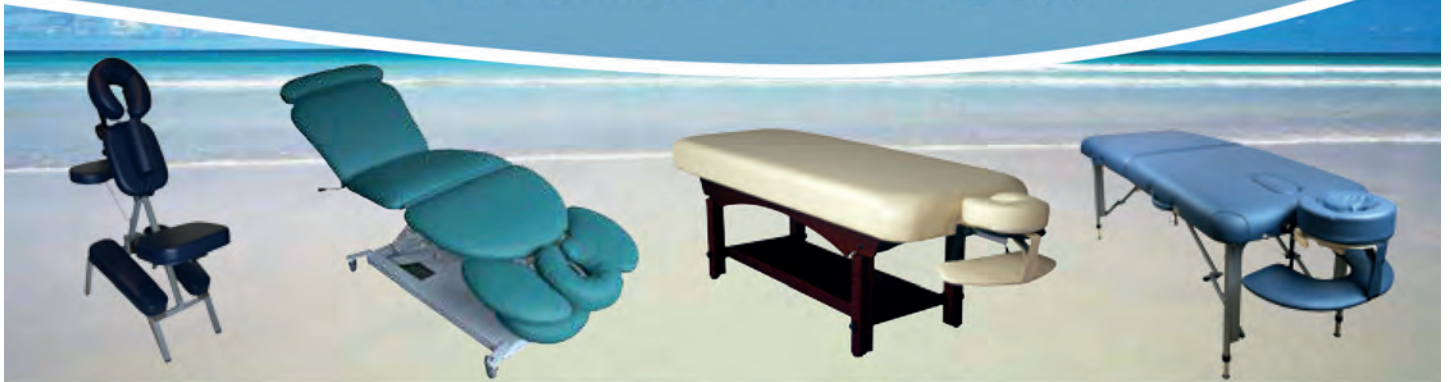
Fair Trading Act NSW (1987)

ATO fact sheet - How to set out tax invoices and invoices - www.ato.gov.au

Excerpts from CCH Australian Master GST Guide July 2000

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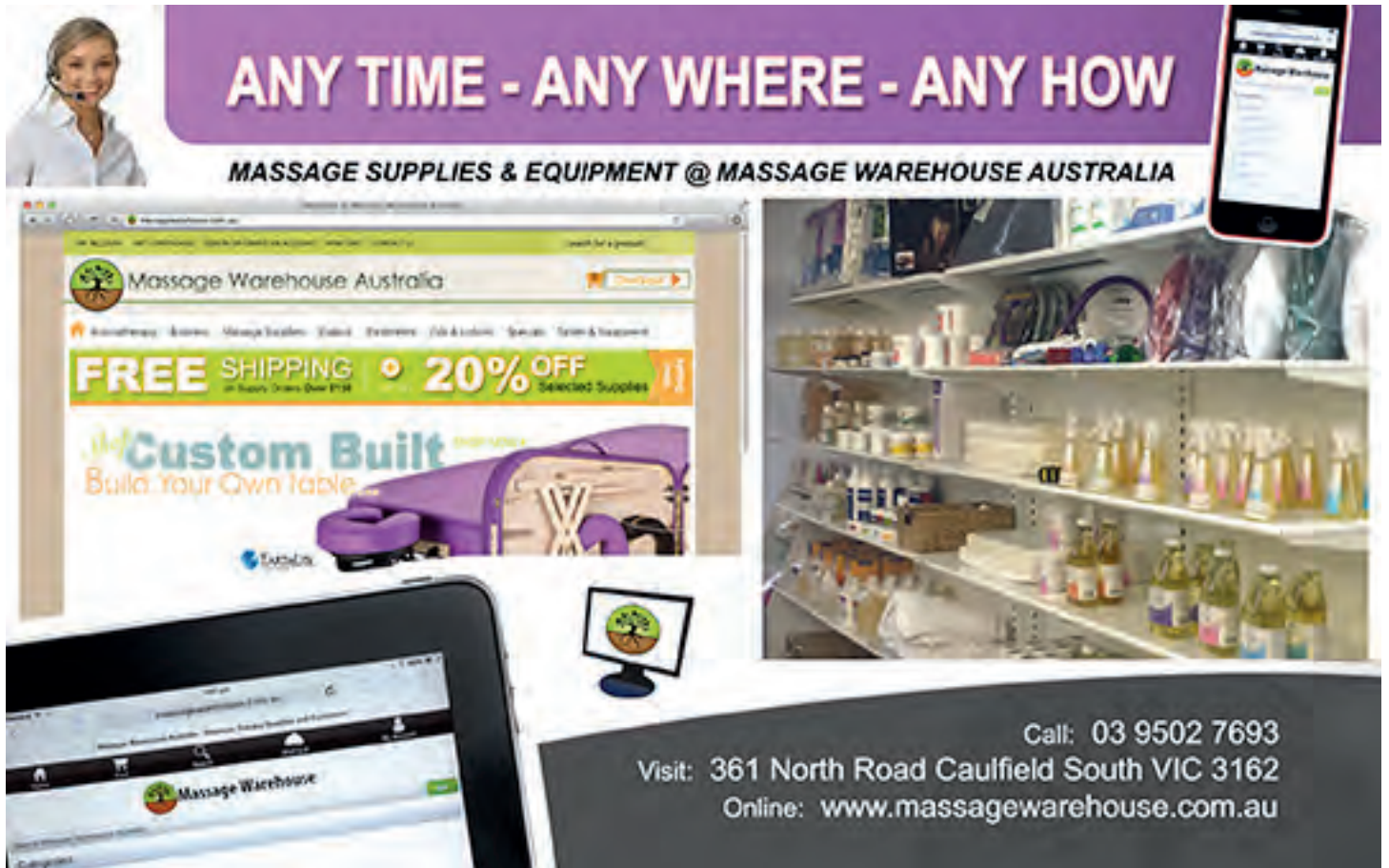
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Clinical Perspectives: Carpal Tunnel Syndrome

Ed's note: Originally published p.20 December 2009, in *Good Hands*.

We carry on our regular series about how different therapists view and treat a particular musculoskeletal problem with a look at carpal tunnel syndrome. Three therapists, Kerry Hage, Alan Ford and Colin Rossie generously share their approach and treatment protocols for this prevalent condition.

A Myotherapist's Approach By Kerry Hage

Carpal Tunnel Syndrome (CTS) is a condition that most people have heard of but don't actually understand. It is a term often used to describe any wrist or hand pain. However, true CTS is caused by increased pressure on the median nerve through the carpal tunnel which is made up of the carpal (wrist) bones and the flexor retinaculum. Symptoms include sensory disturbances distal to the wrist in the areas of the hand innervated by the median nerve, namely the thumb, first, second and half of the third fingers. Pain may be felt in the hand, wrist, up to the elbow and as far as the shoulder.

Diagnosis for CTS is confirmed following a positive nerve conduction test. Nevertheless, clinical testing can help the manual therapist to assess and identify the probability that their client is suffering from the condition. The most commonly used tests for assessing CTS are Tinel's Sign and Phelan's Manoeuvre.

Tinel's Sign is conducted by tapping over the median nerve which, if positive, will reproduce tingling and paraesthesia into the hand along the distribution of the median nerve. Phelan's Manoeuvre is conducted by asking the client to place the dorsal aspect of both hands together with the wrist at a 90 degree angle. It is deemed positive if symptoms are reproduced within 60 seconds. The quicker the symptoms appear, the more severe the case.

My Experience with a case of CTS

Forty-seven year old female career receptionist suffering with CTS.

Both of this client's arms were strongly affected but symptoms were more severe in the right hand, arm, shoulder and into her neck. Aggravating factors were knitting, working with her arms up and at night time. She experienced numbness at the wrist and hands which could sometimes affect the whole arm and could be quite painful. She woke up every night with pain, burning and numbness. She also experienced a burning sensation at the shoulders, once again mainly on the right side.

The client had a nerve conduction test which was positive. She also tested positive to Tinel's Sign and Phalen's Manoeuvre. She had been putting off having surgery for two years, but was seriously considering it due to pain levels. She booked a myotherapy session with me as one last resort before taking the surgery option.

Treatment

First session:

Taking into account the client's occupation, my treatment involved the neck, shoulders, arms and hands. As a starting point, I identified that the pain patterns experienced by the client were also consistent with many of the referral pain zones for trigger points in muscles of the rotator cuff, triceps, wrist flexors and wrist extensors. Therefore I used myofascial dry needling at the trapezius, rhomboids, levator scapulae, infraspinatus and supraspinatus. Once the needles had been removed, deep tissue massage and trigger point therapy was used through the triceps, wrist flexors and hands. I advised the client to have another treatment in one week to compound the effects of her initial treatment.

Second session: three weeks later

The client reported that she felt like she was back at square one—her arms were sore and burning etc. These symptoms had only been reoccurring in the previous two days which was why she had not come back one week after her last treatment. She had experienced nearly two weeks of relief from pain in her arms, hands and shoulders with only mild 'true' CTS symptoms consisting of tingling in her hands still present.

Once again the treatment focus was on using myofascial dry needling at the trapezius, rhomboids, and levator scapulae; with deep tissue massage and trigger point therapy through the triceps, wrist flexors and hands. I advised the client to have another follow-up treatment in two weeks, but due to great results, the client did not rebook.

To date: six months later

The client has still not experienced a reoccurrence of symptoms other than mild tingling in her hands which she is quite happy to put up with. She feels no need to go through with surgery. She is now able to sleep normally without having her arms or hands in odd positions and can do all the activities she enjoys like knitting. She is able to continue at work as a receptionist without aggravating symptoms.

Reference

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Kerry Hage has been a myotherapist for 12 years. She treats at two prominent multidisciplinary clinics in Victoria's south-east. Kerry believes that client education is as important as a comprehensive, multifaceted treatment.

An Onsen Therapist's Perspective By Alan Ford

As an Onsen-trained sports and remedial massage therapist, I look for the cause of CTS coming from other areas of the body, not just in the vicinity of the symptoms. As with all neural symptomatic pain, CTS pain can vary from a dull ache radiating from the hand and wrist up into the arm and shoulder, to acute discomfort which may render the client incapable of any movement in the hand and wrist. All of this pain, numbness and weakness is associated with compression of the median nerve against the inelastic transverse carpal ligament. Often, this is caused by pressure from swollen synovium in the flexor tendons.

The first requirement for an Onsen therapist in relation to this condition is to take a thorough case history to find out if this is the client's first occasion of these symptoms, and whether he or she has undertaken any recent repetitive hand movement activities.

The sliding movements of the flexor tendons within the carpal tunnel change the viscosity of the synovial fluid—not unlike the change in viscosity of gear box oil after several tens of thousands of kilometres—causing friction and expansion of the tendons which, over time, will compress the median nerve.

Specific tests for CTS should be undertaken, in conjunction with length and strength tests for the forearm flexors and extensors, and grip and expansion tests for the hands and fingers. The information gathered from these simple tests and assessments will best guide the therapist toward the next step in the treatment plan.

Depending on the findings of the muscle and joint testing, trigger point therapy would be conducted where appropriate. In the case of shortening in the forearm flexor, biceps, pectoralis, sternocleidomastoid, anterior scalene and subscapularis muscles (the most common cause of CTS that I have observed in my clinic) these muscles are released and lengthened through remedial massage techniques and isometric stretching. The opposing muscle groups may also need trigger point release, in particular infraspinatus, rhomboids and triceps. The forearm extensors more often than not require strengthening, with opening the fingers and back of the hand against a rubber band being the 'pick of the bunch' exercise.

Rehabilitation exercise should be given with extreme caution together with an emphatic direction to the client to STOP the exercise if it hurts. I have often recommended that the client use an ice pack around the wrist, whilst applying a warm towel or wheat bag to the superior forearm flexor attachments.

The warmth in the muscle will encourage lengthening and release to the musculature of the forearm flexors, while the ice will assist in bringing the increased temperature down in the carpal tunnel area, thereby assisting the viscosity of the synovial fluid back to its original composition.

The reverse to the aforementioned is applied if the shortness is found in the forearm extensors and there is tensile stress in the forearm flexors. Splinting of the wrist is also recommended at night if symptoms are slow to dissipate. Furthermore, the client should be willing to modify their lifestyle or work environment to eliminate repeated stress on the hands.

Alan Ford is well known to AMT members as a presenter, journal contributor, active member in the ACT region and, more recently, as a Life Member of AMT. He has a thriving practice in the Canberra suburb of Kingston.

A Remedial Massage Therapist's Perspective

By Colin Rossie

Description

Carpal Tunnel Syndrome (CTS) is an occupational overuse syndrome of the wrist. The tunnel is formed by the carpal bones on the dorsal aspect and by the transverse carpal ligament (and to a lesser extent the flexor retinaculum) on the volar aspect of the wrist. The tendons of the wrist, finger flexor and thumb muscles pass through this tunnel along with the median nerve. The tendons can become inflamed and swell through overuse, thereby compressing the median nerve.

CTS is a mono-neuropathy in that only a single nerve is affected. Muscles that are affected would include the palmaris longus, flexors carpi radialis and ulnaris, flexors digitorum superficialis and profundus, and flexor pollicis longus.

Many references state that CTS is more prevalent in middle-aged females. This could perhaps be partially attributed to physiological changes occurring around menopause, but could also be the result of long-term keyboard use. In practice, I find the condition presenting in both genders, and across a wide range of ages and occupations. In addition to assembly line workers and keyboard operators, CTS also commonly affects any occupation where power or precision grip is constantly required such as musicians, waiting staff, chefs and drivers.

Initially, symptoms are low level and of insidious onset, starting with numbness and tingling in the thumb (I digit), index (II

digit) and middle (III digit) fingers, the radial half of the ring finger (IV digit) and possibly the wrist, gradually becoming chronic. After several months this becomes an acute pain in the wrist and forearm, described as "burning", "itching" and "throbbing" by those with it. Clients will also report that their fingers feel swollen and numb, even though there will be no visible swelling. In fact, after prolonged periods the forearm muscles and fingers atrophy. Power and precision grips weaken, fine motor skills diminish and the ability to distinguish temperature variations can become difficult. Symptoms are not relieved by rest and actually worsen with sleep, especially where there is a tendency to clutch the hand and fingers in flexion.

Differential Diagnosis

Differential diagnosis would include medial epicondylitis, neuropathies of the ulnar and radial nerves, cervical radiculopathies, thoracic outlet syndrome, sub-acromial impingement, osteoarthritis of either the carpal bones, metacarpals or distal radius and ulna, and tenosynovitis. Also, active trigger points from the scalenes, infraspinatus, subscapularis, brachialis, supinator, pectoralis major and minor, serratus anterior, pronator teres, palmaris longus, flexors carpi ulnaris and radialis, and digitorum profundus and superficialis, adductor pollicis and opponens pollicis all refer pain in patterns that mimic CTS.

In closed kinetic chains, I believe that myofascial trigger points are tertiary considerations - more a symptom of stability and core dysfunction than a primary factor (essentially, they are a local symptom of a poor global relationship to gravity). However, in open kinetic chains such as the upper limb, trigger points play a more significant role as manifestations of purely local dysfunctions, occupying a more central role in the treatment protocols employed.

Assessment

Pain from the median nerve can originate anywhere along the length of the nerve, not just the carpal tunnel. Although symptoms may appear the same between individuals, the causes may be completely different. True CTS is over diagnosed, being a convenient catch-all for any wrist pain or pain of median nerve origin. Therefore accurate assessment is vital before commencing treatment.

What follows are the assessment protocols I use and a brief rationale for their use.

This is followed by a description of some treatment approaches, which would vary according to the specific findings of the assessment. Fuller descriptions of the tests can be found in the references provided. Kerry Hage has already described Tinel's Sign and Phalen's test.

- Active Quick Test of the median nerve to determine that it is the median nerve involved (Butler, 2008, p34).
- Tinel's Sign to determine median nerve involvement at the carpal tunnel (Magee, p441).
- Phalen's Test (Magee, p442) to determine carpal tunnel involvement.
- Upper Limb Neurodynamic Test 1 (median nerve), another test to determine median nerve involvement (Butler, 2008, p35-6).

- Upper Limb Neurodynamic Test 2 (median nerve), again to determine median nerve involvement (Butler, 2008, p37-8).
- Adson's Manoeuvre or Halstead Manoeuvre to determine whether thoracic outlet syndrome is involved in the wrist symptoms (Magee, p322),
- Apley's Scratch Test to determine if there is gleno-humeral joint involvement (Magee, p254-255).

I would perform the following to rule out involvement of structures other than the median nerve and to determine what structures to work:

- Passive, active and resisted testing of elbow flexion/extension
- Passive, active and resisted testing of forearm supination/pronation
- Passive, active and resisted testing of wrist in flexion/extension, ulnar and radial deviation

- Passive, active and resisted testing of finger flexion/extension, abduction / adduction

I would also assess power and precision grip (Magee, p422) to determine how these are affected by the CTS. This can also be used as a pre- and post-session yardstick for both the client and practitioner.

Treatment

I would commence by decreasing the hypertonicity of the myofascial structures of the forearm starting with gentle, myofascial release to the forearm flexors. This would be followed by deep transverse frictions to the common flexor tendon, then deep connective tissue massage along the length of the muscles from the distal tendon at the wrist through to the epicondyles, followed by broadening, transverse compression across the muscle fibres.



Photo 1 - DMFT of the forearm flexors & IOM using the proximal phalanges



Photo 2 - AMP: extending the wrist and fingers from a soft fist



Photo 3 - DMFT w/AMP of the forearm flexors & IOM using re-enforced fingers



Photo 4 - DMFT w/AMP of the forearm flexors & IOM using thumbs of both hands



Photo 5 - DMFT w/AMP of the forearm extensors using the palm

A good series of techniques similar to the above can be found at:

<http://www.massagemag.com/Magazine/2004/issue107/assess107.5.php>

Another good source of techniques that could be employed, along with excellent illustrations of the anatomy, can be found in Clay & Pounds 'Basic Clinical Massage Therapy'. The technique illustrated for working with the Flexor Retinaculum is particularly useful. A word of caution though – unfortunately, the photo in the 1st edition of this book looks like the therapist is crushing the nerve. I'm sure this isn't actually the case! Always keep in mind that your intent isn't to crush the nerve (which would exacerbate the client's symptoms) but to free it from the surrounding structures that it might be adhered to, lengthen shortened structures that could be impinging it and decrease the swelling of other soft tissue structures within the carpal tunnel.

Next, I would deactivate trigger points that may be present in the forearm myofascia and tendons. Kerry Hage has already addressed this aspect in her piece. If it is a genuine case of Carpal Tunnel Syndrome, it is likely there will be active TrPs in the shoulder girdle as well. These should be deactivated too.

This could be followed with a 'flushing' effleurage, starting gently but with depth, gradually decreasing the depth and slowing the rate to create a flushing effect on any soft tissue swelling.

I would then use direct myofascial technique with active movement participation (DMFT w/AMP) to the forearm flexors and inter-osseous membrane (IOM) of the forearm.

For more information on this style of work, see Smith (2005), Stanborough (2004), Riggs (2007) and Schleip (www.somatics.de).

Many of the forearm flexor muscle fibres attach directly to the IOM (Stecco 2004), so working it can have a profound effect on CTS symptoms.

With the client supine and their hand and forearm supinated, I ask them to form a soft fist and flex the wrist, then apply pressure to the appropriate depth at the wrist and move slowly up the forearm toward the common flexor tendon.

At the same time, I ask the client to slowly bring the wrist into extension, at maximum extension gradually opening the fingers and then extending them as well (see photos 1-3). I work up the arm like this several times, paying attention to the feel of the tissue being worked. I also pay attention to the different slips of muscle/fascia I contact, always seeking to differentiate the tissue (see photo 4). I would usually work a second plane of movement by having the client vary the movement with medial and lateral deviation of their wrist. As the radius and ulna move you will affect the IOM, especially if you hone your intent on it. Other techniques I could incorporate would include:

- DMFT w/AMP to the forearm extensors, again with the intention of affecting the IOM (see photo 5), this time from the dorsal side (client supine, forearm pronated). I ask for medial and lateral deviation of the wrist as I work the forearm (figure 1).

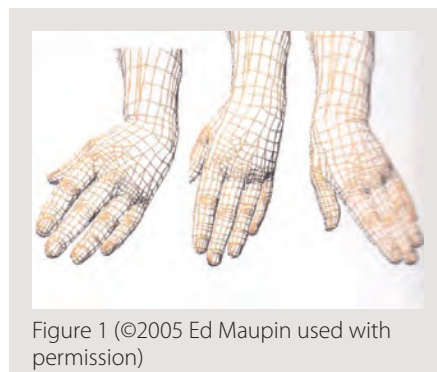


Figure 1 (©2005 Ed Maupin used with permission)

To get a second plane of movement, I request the client slowly lift their hand up and back again (extend and flex the wrist –figure 2).

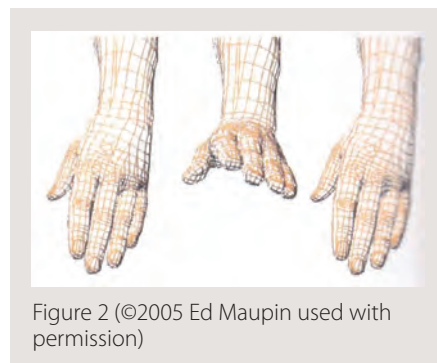


Figure 2 (©2005 Ed Maupin used with permission)

Alternately, as I work, they could gradually press their palm into the table and slowly release it.

Another variation could involve the client pressing their palm into the table to anchor it and moving their elbow medially and laterally as I work up it (figure 3 – see Maupin, 2005, pp80-81).

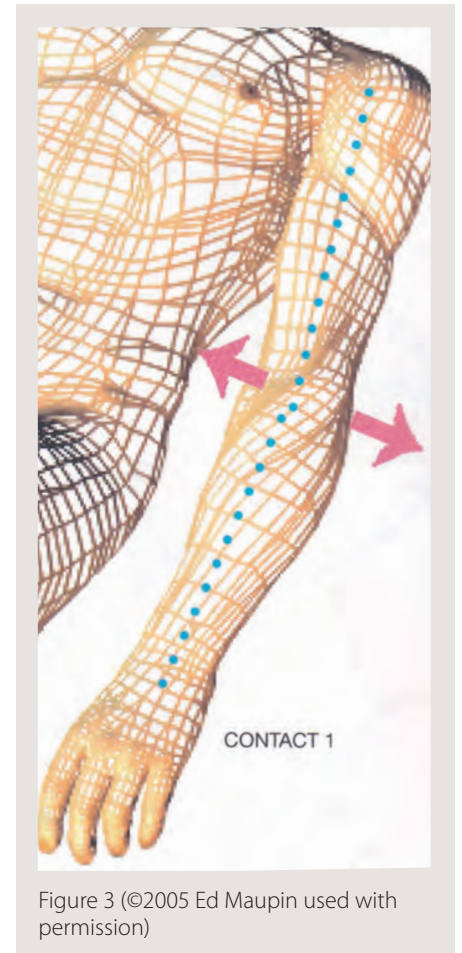


Figure 3 (©2005 Ed Maupin used with permission)

- DMFT w/AMP to the palmar fascia. I do this by applying direct pressure to the palm with either the thumb or finger pads, and slowly moving as the client flexes and extends their digits.
- DMFT w/AMP to the flexor retinaculum. With the client's forearm supinated, I hold the outsides of the client's hand with both my hands, thumbs on the centre of the flexor retinaculum. I ask the client to extend their wrist at the same time opening (abducting) their fingers as I slowly and deeply drag both thumbs out to the sides.

I may also perform a series of neural mobilisations for the median nerve. These are fully described in Butler (2000) pp314-325, (2008) pp41 -43, and Barral (2007), pp161- 169.

They are also demonstrated in the relevant section of the DVD accompanying Butler (2008). These mobilisations can be used as pre- and post- assessment tools or at any stage during the treatment session.

If the client has tested positive to the median nerve tests, the nerve may be impinged at sites other than the carpal tunnel. Neural massage of the median nerve at more proximal locations might be required.

In the upper arm, the median nerve is about the width of a window sash cord and is on the medial aspect of the arm between the biceps brachii and triceps brachii. Here it can be easily palpated and treated for restrictions (Barral, p162 and figure 6.58), also at the ligament of Struthers in the elbow (Barral, p164 and figure 6.59, Hammer, p165), in the forearm (Barral, p165 and figure 6.60), at the wrist (Barral, p165-6 and figure 6.62) and in the hand. The intent of this style of work is to release the nerve from the surrounding structures it could be adhered to. Basically, it is working epineurium. Nerves themselves have the consistency of blancmange and the intent should not be to crush them.

Tom Myers discusses the arm in his 'Anatomy Trains' model of the body, according to 6 myofascial meridians. Of special note in terms of working with CTS in his myofascial meridians paradigm would be the Deep Front Arm Line, which roughly corresponds to the lung meridian in Traditional Chinese Medicine (Myers, 2009, pp151-155) and more importantly the Superficial Front Arm Line, which approximates the pericardium meridian in TCM (Myers, 2009, pp155-158). Myers' model is worth consideration and further study if you are seeing a large number of CTS clients (Myers, 2009, pp 149-169).

Homework

Wearing a wrist splint to bed to prevent wrist and finger flexion during sleep is one option that will help prevent the nocturnal exacerbation of CTS. Stretching the forearm flexors in conjunction helps reduce symptoms and speeds recovery.

Butler (2008) shows a series of exercises in both his book (pp 44- 48) and DVD. I play the relevant median nerve self-management section of the DVD to clients, who have found it particularly useful.

CTS shouldn't be considered from just a local, remedial perspective but in the global context of the whole being. From a structural Integration perspective, this would involve the body's relationship to its centre of gravity. Previous trauma or unbalanced, repetitive work habits affect this relationship. Poor posture will affect the brachial plexus, thoracic outlet and sub-acromial region. Re-education regarding seated posture, shoulder girdle and upper limb usage (relating these to the body's centre of gravity) would be essential in this paradigm, as well as modifying the workstation layout to improve its ergonomic efficiency.

Acknowledgments

My sincere thanks to Ed Maupin for generously allowing me to re-print his diagrams from "A Dynamic Relationship to Gravity: Volume 1-The Elements of Structural Integration". Thanks also to Tania Lambert for her photography.

■amt

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Colin Rossie has over 25 years experience as a bodyworker—initially as a shiatsu practitioner, then as a remedial and sports massage therapist, before becoming a Certified Rolfer® and Rolf® Movement practitioner. His work is firmly grounded in a sound knowledge of anatomy and physiology and Western science. Colin also brings a strong awareness and exploratory approach to kinaesthetics when treating clients. He works mainly from his Lilyfield, Sydney clinic and occasionally in the Tweed Heads/Byron region.

The DIY of Massage Therapy Research

Ed's note: Originally published .
p.6 March 2010, *In Good Hands*.

by Rebecca Barnett

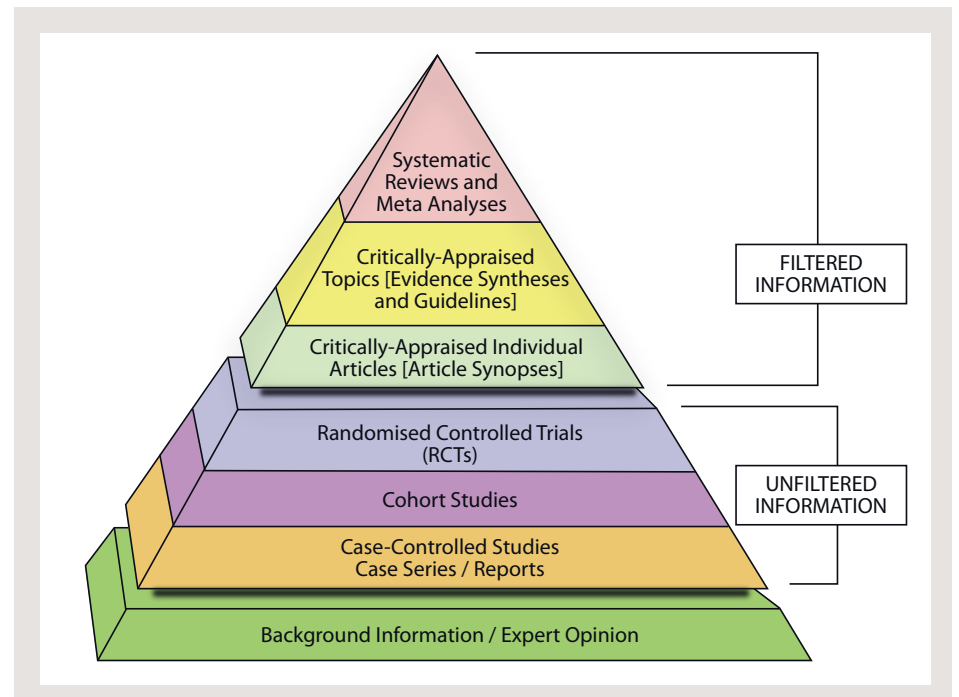
As busy clinicians working within a rapidly-evolving treatment context, the research agenda can seem both burdensome and remote. With clients to treat and businesses to run, how can we be expected to keep up with the proliferation of evidence-based information and knowledge, let alone participate in the process of growing an evidence base that supports, explains, validates and ultimately serves to promote the specific work we do in our clinics?

In his keynote address at the AMT conference last year, Associate Professor Jon Adams spoke about the challenges of evidence-based practice for health clinicians. Ironically, research has demonstrated that the results of health research are only poorly understood by clinicians and even less well applied in clinical practice! This might sound a little like a snake eating its own tail but the principle holds whether you are a GP working in a family medical practice, a physio specialising in back pain or a massage therapist treating within a wellness and prevention framework.

The massage therapy profession cannot avoid the reality of evidence-based practice even if many of us would like to throw in the towel and admit defeat in the face of the research juggernaut. It is an all-pervasive influence on health policy-making, third party payment systems, health economics and the biggest dealmaker and breaker with the gatekeepers of public health referrals, the General Practitioner.

The Evidence Pyramid

The best evidence pyramid (pictured above) is a guideline to the hierarchy of evidence available in the medical literature. It is central to the concept of evidence-based practice.



As you move up through the levels of the pyramid, the amount of available literature decreases, but the information therein is perceived to increase in relevance in the clinical setting. The elements at the top of the pyramid are considered the most relevant to clinical reasoning and application, and the bottom layers are considered to be the least clinically relevant.

The massage therapy community is at a particular disadvantage in the context of the health evidence pyramid since the kind of data that is privileged as the most clinically relevant is in relatively scarce supply within our field. Concomitantly, the kind of information that we could easily produce given the nature of our clinical practice - and that constitutes the majority of the content we publish in our professional association journals - sits at the bottom two levels of the pyramid. Put simply, the vast bulk of the research that occurs in the field of massage therapy happens at the clinic level and much of that is not formalised or recorded in a systematic fashion.

Those who share their clinical experiences and knowledge via the AMT journal are often, in this sense, pioneers in our field and we are deeply indebted to them.

Getting on with the business of gathering the kind of higher-level data that sits at the top of the evidence pyramid poses significant challenges to us due to the peculiarly labour-intensive nature of the work we do. A clinical trial with a large number of subjects requires significant resources and labour. Additionally, it is impossible to blind subjects to whether they are receiving massage and even more entertaining to contemplate the concept of blinding the practitioner to whether they are delivering massage! (though some of the more outspoken in our professional community may beg to differ with me on the latter). Because of this, massage therapy can only be compared in effectiveness against no treatment and/or other forms of treatment, rather than against a placebo, thereby compromising the validity of the research in the eyes of some hard-bitten skeptics.

Our other big handicap is that we don't have the multi-million dollar research and development budgets of the pharmaceutical industry. This funding has traditionally been the engine of a significant and, many would argue, overly influential portion of the health research pie. A great deal of health policy has been developed off the back of pharmaceutical dollars and enormous sums are invested in subtle marketing to the medical community via indirect incentives and inducements.

Doing it for ourselves

All of these factors make it easy to fall into the trap of believing that our cause as a professional community is hopeless ... or that research is somebody else's job - the domain of a PhD scientist investigating the mating habits of the gall wasp, rather than that of the humble working clinician. However, as a professional community, we do have significant resources to draw upon that could help to foster our research agenda. The most potent and under-utilised of these resources is ourselves.

In his breakout sessions at the conference, Jon Adams opened the door for us on the qualitative research paradigm, and the potential power of action research to advance our understanding of health outcomes. Part of Jon's mission is to bring the practitioner and the patient back into the centre of the frame. How can we continue to call something "evidence-based practice" if it is so far removed from real clinical conditions and the realities of day-to-day practice?

Jon clearly demonstrated that the qualitative paradigm has the capacity to empower us in furthering our own research agenda. But are there options available to us in the more 'medically accepted' quantitative paradigm?

Let's take a look at the maths, starting with AMT's member base alone. Assuming that AMT's 1400-strong membership performs an average of 10 consultations a week, that adds up to a whopping 14,000 consultations each week or approximately 670,000 consultations a year (allowing for holidays and sick leave). That's potentially an enormous amount of data - waaay more than the average clinical trial.

Imagine if we could harness the power of those numbers in a meaningful way!

"But I don't know how to conduct research", I hear you protest, "I am just treating clients, not collecting data".

Actually, that's not true. The notes you keep in your client file are a kind of data, perhaps not necessarily formalised or systematic but it's data nonetheless. If you have ever used a simple tool like a visual analogue pain scale to track and record your client's progress, then you've conducted a tiny piece of research. The VAS is perhaps the simplest form of outcome measurement we have in the business.

Free research tools

Therapists who treat WorkCover clients will already be familiar with some of the available outcomes measurement questionnaires and tools, such as the Oswestry Disability Index (otherwise known as the Oswestry Low Back Pain Disability Questionnaire). Third party insurers require therapists to report back to them using these sorts of surveys to quantify and monitor patient progress. In the context of third party payment, the questionnaires are principally employed as a rationale to justify further treatment. They answer a basic fiscal question "Should we continue to pay for this form of treatment"?

We are far more empowered and knowledge-rich than we might think.

However, questionnaires such as Oswestry are also a research tool. They provide us with a recognised and accepted framework to organise and quantify our clinical data. As such, we could readily make use of them in our clinics to conduct practice-based research.

Fortunately, there are dozens of questionnaires available in the public domain, including surveys that help us investigate specific conditions such as neck pain and headache. Given that they are freely available, we could begin making use of them in our practices tomorrow to organise and record results, identify trends, validate our work and perhaps even contribute to the research base of our profession.

After all, the top levels of the evidence pyramid would not exist without the foundations of practice-based discovery and investigation. Research always begins with an idea or hypothesis begging for validation: without the insights that clinical practice and individual practitioners bring, the systematic review and meta-analysis would not exist.

I have compiled a short list of some of the available questionnaires (see overleaf), along with a brief description and links to where you can download them for free. This list is by no means exhaustive but contains some of the more commonly used surveys that are in the public domain. You'll see them turn up repeatedly as the measurement tools used in clinical trials.

There are many other surveys available, some of which are subject to copyright and attract a fee.

Perhaps the best way to select an appropriate survey for something you'd like to explore in practice-based research is to check out the available literature in a comparable area and see which measurement surveys have been selected. A quick search in PubMed is likely to yield hundreds of results and the published extracts always include a summary of how results are measured.

Did you know that PubMed can filter results according to whether full text versions of a citation are available or whether it's just an abstract?

<http://www.ncbi.nlm.nih.gov/pubmed/>

There are two surveys I would like to feature in a little more depth before you race off to puddle around in PubMed!

Measure Yourself Medical Outcome Profile (MYMOP)

MYMOP is a patient-generated, individualised outcome questionnaire. It is designed to measure the outcomes that the client considers to be the most important - in other words, it is a patient-centred measurement tool. This approach to survey design acknowledges the underlying principle that medical outcomes belong to the patient and that their experience of illness should be incorporated into the measurement process. It marks a shift toward acceptance that subjective perceptions of health are a valid area of inquiry and should be encompassed in research.

When a MYMOP survey is completed for the first time, the patient does this in consultation with the therapist. They choose one or two symptoms that they are seeking help with and that they consider the most important. The patient also chooses an activity of daily living that is impacted by this problem. The choices are recorded in the patient's own words and then scored for severity over the past week on a 7 point scale. General wellbeing is also scored on a similar scale. In subsequent questionnaires, the wording of the previously chosen items is unchanged and the patient can fill out the questionnaire independently.

The most recent version of the initial and follow up MYMOP forms are available for download here:

http://sites.pcmd.ac.uk/mymop/files/MYMOP_questionnaire_initial_form.pdf

http://sites.pcmd.ac.uk/mymop/files/MYMOP_questionnaire_follow-up_form.pdf

Short Form 36 Health Survey (SF36)

The SF-36, sometimes referred to as the Rand 36-item Health Survey, consists of only (you guessed it) 36 questions. It contains a set of generic, coherent and easily administered quality-of-life measures. Like MYMOP, these measures rely on patient self-reporting. Also, it is a general measure rather than one that targets a specific age, disease or treatment group. As such, it is incredibly useful in differentiating the health benefits produced by a wide range of different treatments. It's commonly used in health economics to evaluate the cost-effectiveness of a particular treatment.

The survey consists of 8 scaled sections that evaluate the following: physical functioning, bodily pain, role limitations due to physical health problems, role limitations due to personal or emotional problems, emotional wellbeing, social functioning, vitality and general health perceptions.

The original SF36 arose from the Medical Outcomes Study (MOS), a two-year study of patients with chronic conditions. The work was undertaken by Rand Health, an organisation dedicated to improving policy and decision-making through research and analysis.

SF36 is available for download from the Rand website:

http://www.rand.org/health/surveys_tools/mos/mos_core_36item_survey.html

Conclusion

The research agenda is not as remote and high-falutin' as we might sometimes think. There is much that we can contribute to our own body of knowledge if we're willing to turn our clinics into mini-laboratories and systematise the way we record our client's data. Many of the resources we need are both literally and figuratively at our fingertips.

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Oswestry Disability Index

Oswestry is one of the most commonly used and recommended tools for measuring the disabling effects of low back disorders.

Available for download from:

http://www.rehab.msu.edu/_files/_docs/Oswestry_Low_Back_Disability.pdf

Roland Morris Disability Questionnaire (RMDQ)

The RMDQ is also a widely used measure for low back pain.

Available for download from:

<http://www.rmdq.org/Download.htm>

Neck Disability Index (NDI)

This was designed to assess pain-related disability associated with activities of daily living in people with neck pain. The NDI consists of 10 sections that measure both pain and function.

Available for download from:

https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0016/10960/NDI.pdf

Headache Disability Index (HDI)

The HDI is a standard questionnaire for assessing the functional status of a person with headaches.

Available for download from:

http://www.nwcchiro.com/wp-content/uploads/2015/02/Headache_Disability_Index.pdf

MOS Sleep Scale

The MOS Sleep Scale measures six dimensions of sleep, including initiation, maintenance (e.g. staying asleep), quantity, adequacy, somnolence (e.g. drowsiness), and respiratory impairments such as shortness of breath and snoring.

Available for download from:

http://www.rand.org/health/surveys_tools/mos/sleep-scale.html

Perceived Stress Scale (PSS)

The Perceived Stress Scale is a 10-item self-report questionnaire that measures a person's evaluation of the stressfulness of the situations in the past month of their lives.

Available for download from:

<http://www.mindgarden.com/docs/PerceivedStressScale.pdf>

Beck Anxiety Inventory (BAI)

The BAI is a 21-question survey that is used for measuring the severity of an individual's anxiety.

Available for download from:

http://www.brandeis.edu/roybal/docs/BAI_website_PDF.pdf

Wrist, hand and finger pain: a guide to self-treatment

Ed's note: Originally published
p.18 September 2010, *In Good Hands*.

by Jodie Goode

As massage therapists, it is our job to use our knowledge and skills to take care of others - reducing pain, increasing range of motion, providing rehabilitation, preventing injury, promoting wellness, and restoring overall balance. Our focus is our clients' health and wellbeing. We advocate take-home or self-care methods such as heat and ice, liniments, stretching and strengthening for muscle balance, posture and ergonomics, a proper balance between rest and work, and avoiding activities that may aggravate the condition.

It is therefore all the more startling that many of us do not take the time to look after ourselves properly in spite of knowing the importance of these methods and the repercussions of not following them. It is especially surprising given the postural and physical demands we place on our own bodies on a day-to-day basis. The expression "Physician heal thyself" seems very apt.

I have worked in the massage therapy industry for a number of years and networked with many therapists of varying levels of experience. The majority suffer from a number of issues but they still put off treatment, whether it be in the form of appropriate self-care or from another healthcare provider.

Injury statistics

I find that my forearms, wrists and hands (particularly the thumbs) are major areas of concern. Searching for some hard statistics, I was not at all surprised to learn that 80% of therapists, particularly those specialising in deep tissue work, are forced to drop out of the industry after approximately 2 years due to injury of the hands, wrists and arms. A further 78% who stay in the industry still experience pain in these areas.¹

A 2008 Canadian study showed that 'the highest reporting of pain and discomfort was in the wrist and thumb, followed by the low back, neck and shoulders respectively'.²

Another study published in the Journal of Occupational Rehabilitation revealed that work-related musculoskeletal disorders within the massage industry predominately occurred in the fingers (80%) and that 'finger or thumb symptoms were the most frequent cause of massage practitioners missing work (7.5%) and of decreased work productivity (29.8%)' and was the most common area for outside help or treatment to be sought.³

These statistics should be enough to motivate therapists to take care of themselves, not only to protect their bodies but also their careers.

Anatomical and biomechanical considerations

The anatomy of the forearm, wrist and hand is quite complex because of the fine motor movements produced. Each is made up of 29 bones - the radius and ulna, 8 carpal bones, 5 metacarpals and 14 phalanx (5 proximal, 4 mid and 5 distal) - and over 25 joints with a large number of ligaments to provide them with support. In addition, there are nerves, blood vessels and other structures that may be damaged and impinged, and over 30 muscles and their tendons, 18 of which are intrinsic.^{4,5}

It is really important to know the optimal joint positioning to prevent injury and to use the correct tools to support these ergonomic principles.³ This means keeping the wrists as straight as possible, keeping the forearms in a neutral rather than in a deviated position, and bending the elbows.¹

It is not uncommon to see a therapist treating with the table too high, causing extreme hyperextension of the wrist and elevation of the shoulder girdle. This causes muscle tightening in the forearm extensors as well as levator scapula and the upper trapezius. A higher table also means that the therapist cannot rely on body weight to create pressure and must instead use strength, leading to fatigue and imbalance.

Using the correct table and table height will not only improve the position of the arms and hands but the whole body, putting less unnecessary stress on the joints.⁶

However, even with the table at the correct height, many therapists treat with postures that put their body at risk. Therapists need to remember to use core muscles, bend the knees slightly, ensure that the shoulders are not rounded, and avoid forward head posture.

Therapists should also be aware of alternate ways to position clients during treatments. This could mean treating standing or seated at a different angle to the client or positioning the client in a way that avoids strain on the wrists and hands, and may also have the added benefit of putting the area being treated on stretch.

Various methods that take the strain off of the wrist and finger joints must also be considered, such as using elbows, knuckles, massage aids, needles, cups and many other methods like PNF stretching, positional release techniques and muscle energy techniques.^{7,8}

DeStefano, Hooper and Kelly point out that issues of the elbow, wrist and hand are usually due to over use.⁹ Breaks and rest are a factor here - listening to your body and taking frequent breaks between treatments is a simple preventive factor that is often overlooked by hard-working therapists. Use heat, ice, liniments and stretching during breaks. Receiving treatment from others should all be part of a sound self-care regime.

Therapists can become aware of which aspects of their biomechanics and posture need improvement through observations, either by another person with a good knowledge and understanding of ergonomics or through self observation with a mirror or camera. Creating this kinaesthetic awareness enables us to retrain the body to create good habits or reinforce them. Williamson explains this principle in detail in *Muscular Retraining for Pain-Free Living*.¹⁰

However, even with the best equipment, mechanics and techniques, the joints and soft tissue of the forearms and hands are still being loaded. On top of receiving regular massage, therapists should be using self-treatment methods daily. This includes warming up and stretching the areas before treatments, and applying heat packs and liniments when appropriate.

Self care regime

Keeping to a schedule of stretch and strengthening exercises is an important part of self care. It prevents the build-up of adhesions, encourages healthy range of motion (which in turn minimises strain to other areas), increases circulation and helps to prevent the occurrence of muscle imbalances.⁹

Muscle groups that should be targeted for stretching are:

- Flexors and extensors of the wrist and fingers
- Pronators and supinators of the wrist
- Ulna and radial deviators
- Muscles controlling movement of the thumb
- Intrinsic muscles of the hands.

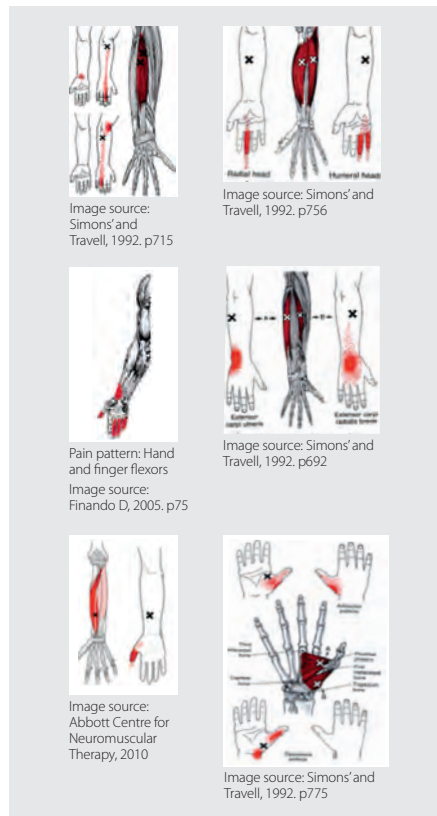
These stretches should be repeated at least daily. Strengthening exercises can be used to build up the areas under strain so that the muscles become conditioned and fatigue less. This will also help prevent injury to the area.¹¹ You should determine which areas need strengthening based on noted postures, pains and imbalances.

Self massage should also be a key part of your care regime. Placing an arm on an elevated object allows access to the muscles and trigger points of the forearm and hand using the opposite elbow, forearm and knuckles (for example, kneel on the floor and rest your arm on the massage table).

Massage aids such as hand-held massagers, needles and pump cups are a good way to self treat without adding extra strain to already overworked arms.

Trigger Points

According to Travell and Simons, many common problems in the fingers, hands, knuckles, thumbs and wrists are caused by trigger points.¹² They assert that the pain and referral caused by these trigger points are often mistaken for other conditions such as arthritis, tendinitis, carpal tunnel, peripheral neuropathy and even ligament damage. (Please refer to the images of trigger point patterns in the muscles of the forearm and hand.)



Wrist pain, and what may feel like a wrist sprain, very often comes from trigger points in the extensor carpi ulnaris or flexor carpi ulnaris. Prolonged tension and untreated adhesions in these muscles commonly lead to wrist tendinitis.¹¹

Trigger points in the extensor digitorum are the prime cause of stiff fingers, sending pain to the second knuckles of the third and fourth fingers. Knuckle pain referred from this muscle feels just like the pain of arthritis.¹²

Trigger points in the abductor pollicis muscle can display a referral pattern similar to the pain of De Quervain's Disease.¹³ The inflammation of the tendons connecting this muscle and the extensor pollicis brevis causes this condition.

Wrist, finger and thumb pain, and pain in the web of the thumb can be traced to muscles of the forearm as shown in the trigger point referral chart above, although it is not uncommon for it to be caused by more distal muscles.

Conclusion

Don't become a statistic in the alarming injury epidemic within our community! Take the time to listen to your body, try new techniques and rest to ensure the longevity of your career.



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After completing her Diploma of Remedial Massage and working as a Remedial Massage Therapist for a while, Jodie returned to college to further her education. She now holds an Advanced Diploma of Myotherapy. Jodie has gained experience in a number of fields and has worked with a range of different health care professionals. She is passionate about getting results with her clients and has a strong focus on injury prevention and rehabilitation.

Deep Seated Hip Pain

Ed's note: Originally published p.18 December 2010, *In Good Hands*.

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.

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	

Table 1: Tonic and Phasic Muscles

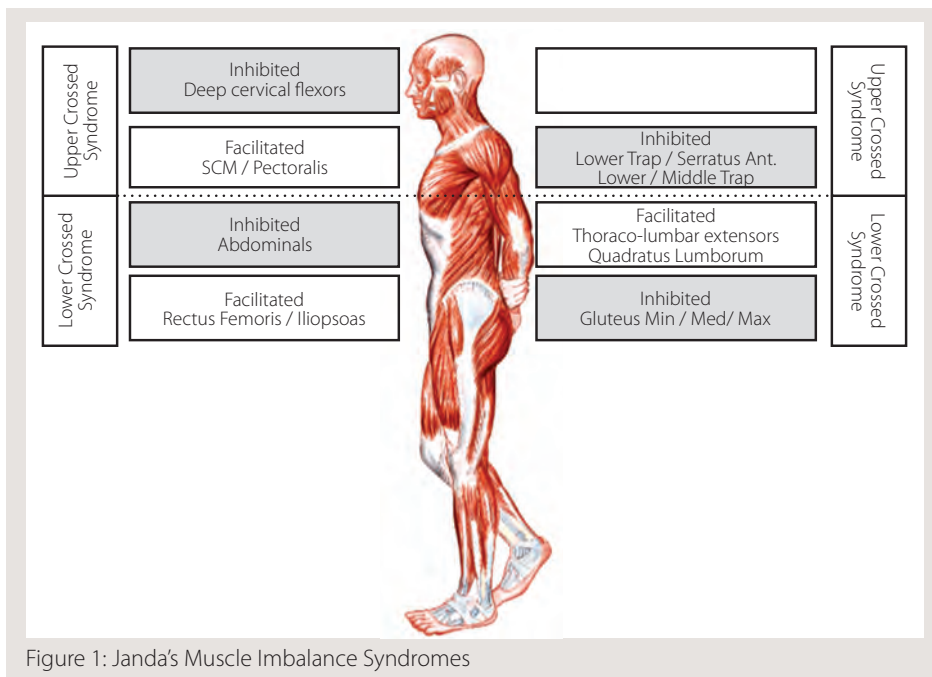


Figure 1: Janda's Muscle Imbalance Syndromes

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.

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 iliacus, psoas, 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.

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.

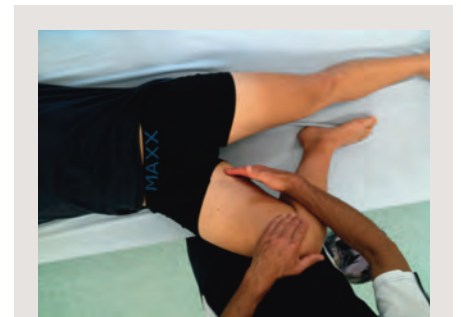


Figure 3: Locating adductor longus

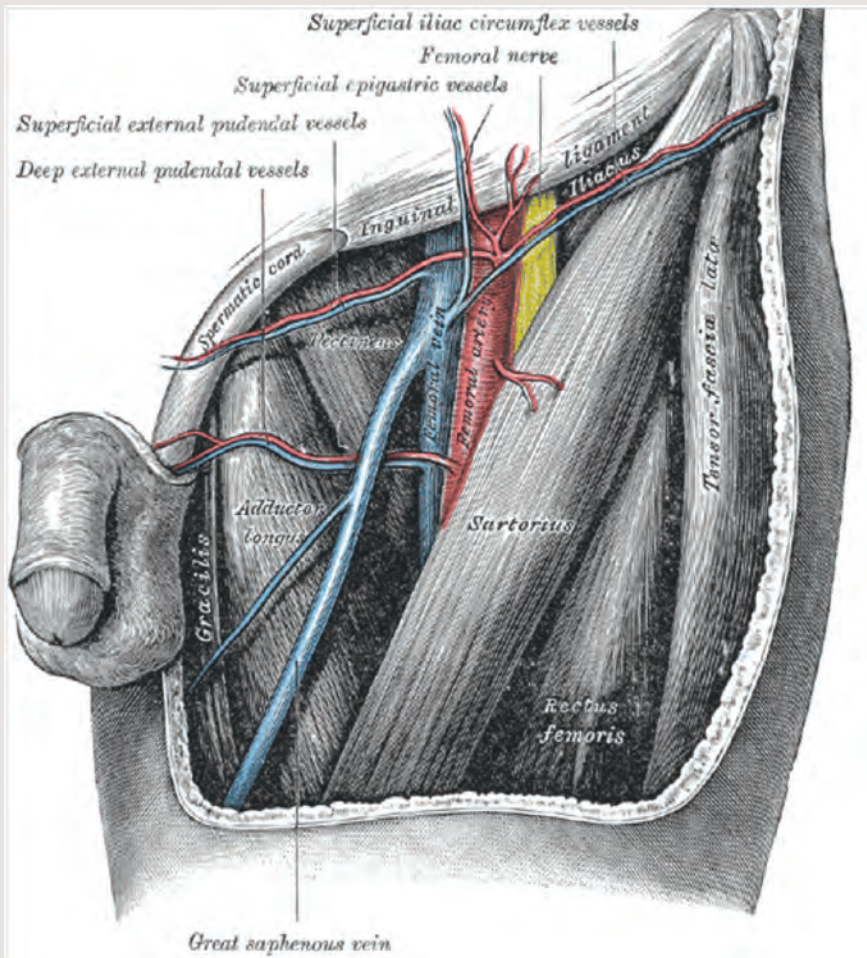


Figure 2: Femoral Triangle (Grays Anatomy)

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.



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 fibering 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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Clinical Perspectives: Tension Headache

**Ed's note: Originally published
p.18 March 2011, In Good Hands.**

In our first clinical perspectives since December 2009, we feature two views on how to treat tension headache. Jodie Goode and Jeff Murray generously share their treatment protocols and insights into this condition.

A Myotherapist's Approach by Jodie Goode

The majority of headaches experienced by clients are tension-type headaches. This kind of headache is extremely common and has - or will - affect most people at some time in their life.

Tension headaches are described as a constant pressure in and around the head which may last for minutes, hours, days and sometimes longer if left untreated.

Obviously, a full history must be taken before commencing treatment. A number of specific questions relating to the headaches must be asked including:

- What are your normal daily activities at work/home?
- Where is the pain located? (e.g. general all-over tension, back of the head, behind the eyes, jaw/tooth)
- Is the headache unilateral or bilateral?
- What is the nature of the pain? (e.g. throbbing, sharp, dull)
- What is the frequency and duration of the headaches?
- Are there any aggravating/relieving factors? (e.g. sleep, stretching, certain positions, work or driving)
- Do you have a vision impairment / wear glasses or contacts?

The above questions may help to pinpoint which muscles are the main cause of the headache. They may also paint a clearer picture of the postures and positions that are causing the tightening of these muscles.

Ruling out the possibility that the headache is caused by non-musculoskeletal factors is important. Inform your client of the importance of keeping well hydrated and rested, and using pillows that support the curves of their spine. If necessary, suggest tips such as ensuring adequate lighting. Refer to an optometrist if you suspect that eyestrain might be the culprit.

General posture of the client should be observed, as muscle imbalance can be a cause of headache. Check for forward and sideward head posture and uneven shoulder height, and note any asymmetry or tightness in the jaw.

Testing the ROM of the neck and shoulders will help to paint an even clearer picture of the main muscles to work. It is also a good way to heighten the client's awareness of muscular tension and provides an objective measure of the effectiveness of your treatment, when you re-assess.

Dry needling is a fantastic method for releasing tension and I often use this approach when treating tension headaches. However, it is important to warn the client that the insertion of a needle into muscles with active trigger points can reproduce the pain quite suddenly and intensely. If the client has reported sharp pain, I usually don't needle until the second or third session.

To begin hands-on treatment, I would normally have the client laying prone and start by loosening up the thoracic and shoulder region, namely the trapezius (especially upper) and levator scapulae muscles. I have often found that, if adhesions in these muscles are broken down and the fibres are allowed to lengthen, many of the muscles of the neck, head and jaw will follow suit.

I then typically move into the neck region with the client still prone, concentrating on the occipitals quite firmly. Clients often report that they feel as if a great weight has been lifted from around the forehead and eyes once the occipitals have been released.

Using pecking with a 10mm needle has proven very effective in this area.

I also work on splenius cervicis and capitis in this position but I prefer to treat these muscles with the client supine as the neck can be positioned so that the muscles are on stretch.

Next I have the client supine and work on the pectorals to address any associated postural issues. The amount of time and focus dedicated to this varies greatly between clients. The same applies to the scalenes, as they play a part in releasing surrounding muscles and facilitating better posture but are generally not the primary cause of headaches.

If there is substantial jaw tension implicated in the headaches, I focus quite a bit of attention on the sternocleidomastoid (SCM), which is often responsible for headache pain on and around the face. SCM will be particularly tight at the insertion in clients who clench their jaw.

Working specifically on the muscles of the jaw is usually next on my agenda. I have found that some therapists overlook this area because they do not realise what a large role it plays in tension headaches. However, if the muscles of the jaw have stress-related adhesions, then the muscles and fascia of the face and head will usually become tight as well. Temporalis, masseter and pterygoids are particularly important muscles to address.

General work through the head and face area is also part of my treatment plan.

Using PNF to lengthen neck muscles towards the end of treatment is also quite effective. I also always finish by stretching the neck from the supine position.

Home care recommendations for the client should include basic neck stretches, especially of the upper trapezius, levator scapula, cervical erector spinae/occipitals and SCM. Strengthening exercises for the deep neck flexors should also be incorporated.

Tips such as using wheat bags and basic ergonomics are also useful.

After completing her Diploma of Remedial Massage and working as a Remedial Massage Therapist, Jodie returned to college to further her education. She now holds an Advanced Diploma of Remedial Massage (Myotherapy). Jodie has gained experience in a number of fields and has worked with a range of different health care professionals. She is passionate about getting results with her clients and has a strong focus on injury prevention and rehabilitation.

Looking outside the box - a structural approach
by Jeff Murray

Most of us would be aware of the role that a tight upper trapezius and associated trigger points can play in creating tension headaches. In this brief overview, I would like to step outside the box and provide another perspective that some of you may not have considered when treating clients with headaches.

Scapular stabilisation is a very important facet of shoulder movement. Additionally, an unstable scapula could be one of the reasons a client is suffering from headaches.

When viewing the scapula, we need to address its position in relation to the spine. The spine of the scapula extends from the acromion at an inferiorly medial angle towards the medial border of the scapula. The junction of the spine of the scapula and its medial border should be adjacent to T3. A measurement should be taken at this junction point, across to the spinous process of T3. The distance should be within the range of 50-60mm. Deviation from this means there is either protraction or retraction of the scapula.

Protraction would indicate tight pectoralis major and / or serratus anterior with weak medial and lower trapezius muscles. Retraction would indicate tight medial trapezius and / or rhomboids.

Other important aspects of scapular deviation to look out for are winging of the medial border and tipping of the inferior angle, or a combination of both. Winging without protraction would indicate a weak serratus anterior muscle. Winging with protraction could indicate weak medial trapezius and serratus anterior muscles. Tipping would indicate a tight pectoralis minor muscle.

Two other scapular movements to consider are upward and downward rotation. This is determined by the position of the glenoid. Upward rotation would indicate a tight upper trapezius muscle. Downward rotation would indicate a tight long head of triceps brachii muscle.

In all of the scenarios I have listed above, there are muscles that are short and tight under a concentric load and others that are long and weak under an eccentric load.

Let's look at the example of a client who has a downward rotation of the scapula resulting from a tight triceps brachii. Tight triceps brachii may present in a diverse range of clients, from the elite swimmer to a stacker in a supermarket. Both the swimmer and the stacker would use the triceps brachii extensively - the swimmer particularly during the freestyle stroke and the stacker when lifting heavy items onto high shelves.

When triceps brachii is under a concentric load, it pulls on the inferior glenoid tubercle of the scapula region and forces the scapula into downward rotation. This downward rotation then places upper trapezius under an eccentric load due to its attachment on the distal one third of the clavicle, across the acromion and down along the spine of the scapula. When the upper trapezius muscle is under an eccentric load, it will constantly attempt to rectify the position of the scapula which will, in turn, create stress in the muscle. This will create an increase in acetylcholine, forming trigger points along the taut bands of muscle. As we all know, these trigger points will refer pain and cause headache over the temporal and forehead region.

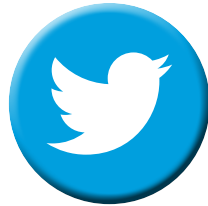
On palpation, you will obviously feel a tight upper trapezius. However, it is not necessarily the upper trapezius muscle that needs to be released but rather the concentrically loaded triceps brachii. Once triceps brachii has been relaxed, it will allow the scapula to return to neutral which in turn will take the eccentric load off the upper trapezius. Once triceps brachii has been released, I would recommend addressing any trigger points in the upper trapezius. ■amt

Jeff Murray originally studied massage therapy at Hunter College of Massage in 1990. In 1998 he was appointed the Director of Sports Massage for the Sydney 2000 Olympic and Paralympic Games. He has a busy practice in Tweed Heads and lectures at Kingscliff TAFE. He was awarded life membership of AMT at the 2016 Annual General Meeting in Brisbane.

celebrating
50
1966-2016 years

Conference in 140 characters or less...

by Anita Mack



Did you know AMT is on twitter? Follow @RamblingAMT or search #amt50 for the full round-up of conference tweets. Following is a compilation of AMT's official tweets from the sessions of keynote speaker Dr Tasha Stanton and plenary speaker Dr Sarah Fogarty.

Dr Tasha Stanton:
New Insights from Pain Neuroscience
(@tash_stanton)

- What's between your ears is more important than your sore back (insights from pain neuroscience)
- ~60% of people without back pain will show disc damage under MRI
- Expectation of pain affects pain experience. Expect pain can equal pain - regardless of reality
- Belief of danger elicits reaction to protect self - body experiences pain
- Believable, credible evidence tells brain there's danger: you experience pain
- Message of danger/threat to brain. Brain assesses using visual/other cues to decide if output of pain appropriate
- With chronic pain everything more sensitive - signal turned up, doesn't mean more tissue damage
- Explaining pain literature review: The efficacy of pain neuroscience education on musculoskeletal pain
- Pain alters perception of how body looks eg OA hand pain = perception hand is larger than reality
- Brain maps that code for movement are affected in OA
- People with back pain have disruptions to movement brain maps
- Studies indicate more contributing to stiffness than joint
- No relationship between subjective and objective measures for stiffness
- Nature of sound matters to effect on perception
- Pain is an incredibly complex phenomenon and what is going on in your brain is often more important than painful area
- Increasing evidence that how brain codes for your body is important in managing pain



Dr Tasha Stanton.
Photographer: James Heighway



Dr Tasha Stanton. Photographer: James Heighway

**Dr Sarah Fogarty:
Massage and Eating Disorders**

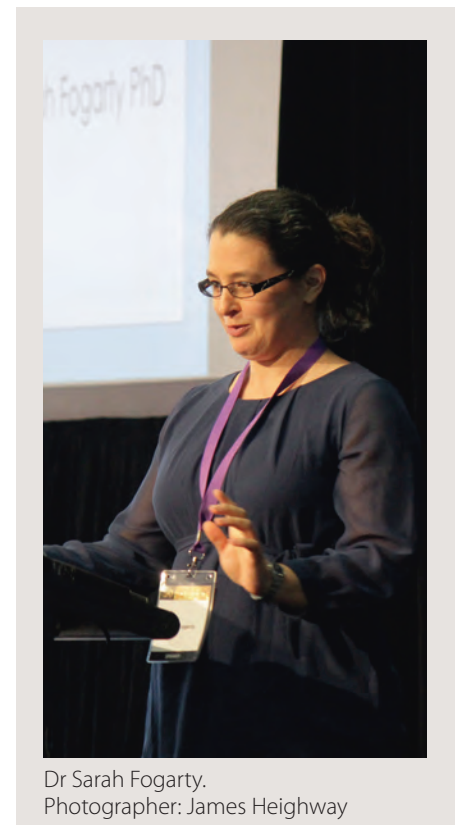
- 🐦 Eating disorders have a disturbance in way they view themselves and in self esteem
- 🐦 Eating disorders: no single treatment approach, but massage has a role in treatment
- 🐦 Massage should generally be an adjunct therapy only (work with client's medical team)
- 🐦 Stick with what you are trained to treat.
- 🐦 Ltd research, but +ve. Important: massage therapy assoc with reducing body dissatisfaction & drive for perfectionism

- 🐦 Massage shown to reduce cortisol stress hormone and catecholamines
- 🐦 Reducing catecholamines helps with improved concentration, sleep and anxiety
- 🐦 Massage therapy associated with increase in serotonin and dopamine
- 🐦 Massage therapy can alleviate tension, support, safe space, place where not judged & hope
- 🐦 The power of hope should not be underestimated
- 🐦 #eatingdisorders clients have been known to borrow therapists' hope when struggling with their own
- 🐦 It's not about the food

- 🐦 Don't expect them to give it up without another coping mechanism. Don't underestimate the courage to 'recover'
- 🐦 Practitioner is role model. So your body confidence influences client's perception
- 🐦 #eatingdisorders not just suffered by women. Men suffer as well, often related to muscle definition (looking like underwear model)



Dr Sarah Fogarty. Photographer: James Heighway



Dr Sarah Fogarty.
Photographer: James Heighway

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Conference Perspectives

1 By Sue Davis

Isn't technology wonderful! I was sitting in Sydney Airport waiting for my flight and settled down to watch the streaming video of the opening of the conference on my phone. When my flight was delayed, I was somewhat consoled by the extended time to watch. It was so good to feel "present".

What to me was so wonderful about the whole day was—I was sitting in the airport waiting to board a delayed plane watch the streaming of the conference. How fantastic was that!? Maybe others would think that was 'Ho Hum'. But I was very impressed that it was organised, freely done and so technically easy.

My flight was delayed long enough to see most of the wonderful plenary by Tasha Stanton, who I have heard speak on other occasions. Unfortunately, and also fortunately, my flight was called before the end of the presentation, but I know that every member benefited from hearing her speak. What struck me as I stood in line to board the plane was, where were the other members who were watching this streaming video? Were they sitting quietly at home; pausing between clients; on a bus or a train in transit to somewhere; or something more surprising?

I felt a powerful sense of new possibilities. The distance between members has always been most obvious during a conference. Now, everyone was able to be present in some way, to be a part of the experience. By the magic of the internet and modern technology we have stepped across another hurdle in the development of the massage therapy profession - we can all connect and feel connected.

I hope that every member was able to feel that connection in some way. That is what is at the heart of the association - creating a connection between therapists, for the benefit of therapists and for the continuing growth of the massage therapy profession.



Screenshot of conference webcast

As I sat watching the drummers beat out an exciting rhythm, I was taken back to the associations humble beginnings: my mother, Cynthia Davis, battling to bring massage into professional recognition; all of us answering phone calls for the fledgling AMT, even while massaging; and the constant flurry of activity to build the social credibility and the functional authority of massage as a profession.

According to the records, I am the longest continuously registered member of the AMT. That is quite humbling and a little surprising. I think there may be others who have been members as long or even longer, but their membership was discontinued in some way or other. I would like to acknowledge them - one being my sister, Wendy Howe in Coffs Harbour.

■ amt

2 By Sarah Harrison, AMT Illawarra

I woke up early on Saturday morning, after staying up way too late in order to make the epic journey north to the big smoke.

As I staggered into the conference room I was greeted with a free t-shirt, a lovely pen and a goody bag with free samples (massage oil, balm etc).

I made my way to the coffee stand and armed with an extra strong coffee was ready for the proceedings to begin.

The tiredness soon left me when we were all awoken by the Soul Drummers, playing bongo drums. The rhythm and energy in their music was captivating. Next thing I know I'm up off my seat having a dance. Now I am awake.

The first speaker was Dr Tasha Stanton – "Why what's between your ears is more important than your sore back: new insights from pain neuroscience".

I found what Tasha had to say very interesting. The key message in the presentation, which was backed up by research and evidence, was that how much pain you experience is not indicative of how much "tissue" damage there is. Your emotions can be responsible for how much pain you feel. The brain is like a protection mechanism and can elicit pain by forming a functional connection between "bending your back" or any other ROM action that the person has had a familiar or similar painful experience with. Feeling anxious can also elicit pain. What goes on in your brain is just as important as the painful area itself.

We then had morning tea, so armed with another coffee and cake I made my way up to the trade exhibition. I got more free samples and even got a 2 min neck massage because I had to try the product for myself.

The second speaker was Sarah Fogarty – “Massage and eating disorders”. Sarah explained the signs and symptoms of a person who has an eating disorder and how we as massage therapists can be supportive, empathetic and non-judgmental and to create a safe environment for someone with an eating disorder.

We then celebrated our past and learnt some fascinating facts about AMT. We met four people who were the longest serving members of AMT. They told us what being a massage therapist was like “back in the good old days”.

Rebecca Barnett then informed us of some very interesting results that have just been cumulated from researching massage therapy patients in Australia. A number of massage practitioners from around Australia in metropolitan areas had their client surveyed. The results will be released very soon.

We then had lunch, for which I sat out in the sun overlooking the harbour. I had one last look at the trade show and then it was time for a group photo. We all had to wear our AMT shirt.

We then partnered up and got taken through some great partner stretches. This was to get us ready for the “great debate”. The debate topic was on “should we remove ‘massage’ from our professional title and replace it with something more credible”. This debate was by no means serious and I don’t even think there was any strong evidence base for or against. They had us laughing, by comparing the name massage to a label such as coke and to that of the fairy penguin. I guess you just had to be there.

That wrapped up the conference. I had a great time at the conference and would recommend to any one that has not been to one before to go. ■amt

3 By Hussam Sahib, AMT Canberra

The 50th Conference was a great two days spent with other massage colleagues at Luna Park under the harbour bridge with the good sunny skies of Sydney.

For me, the Friday workshop was spent assisting Jenny Richardson with her Tricky Tarsals workshop. Going around the room helping and supporting around 40 therapists learn new



Attendees doing Alan and Derek's stretches. Photographer: James Heighway



Conference attendees group shot. Photographer: James Heighway

techniques was an enjoyable experience, although it was different supervising and watching the work being done instead of doing it or having it done to myself.

The next day... woohoo, big bang! What a great start to the day from a good humoured presenter to great drums and dancing – the room was just big enough to contain all that released energy. A great way to celebrate and start the rhythm for the golden era for AMT.

Everything at this conference was well thought out from location and reception to presentation and atmosphere. A very big Thank You to everyone who helped with this conference – I very much appreciated everyone’s efforts.

Tasha Stanton’s pain presentation was very insightful into what makes us feel pain in our body and how we react to what we see, hear, feel or think. For me, it’s the scientific proof as to why pain can be reduced or disappear by just talking or listening to the person in pain, or sending energy to the body. Although, the next question will be: If we are not feeling the pain in that area of our body

anymore, does that mean the issue is no longer an issue? Is it now better for ever?

Finally, it was great to meet and talk to some Facebook therapist friends personally and to meet the person behind the written word, not just their avatar. ■amt



Attendees enjoying the day. Photo: James Heighway





Provider Recognition Criteria

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.

HEALTH FUNDS AND SOCIETIES		CRITERIA
ahm Health Insurance	Medibank Private	These funds recognise Senior Level One and Two members. Providers must also meet Medibank's Diploma duration requirement of one year to be eligible.
A.C.A Health Benefits Fund	Onemedifund	ARHG recognises members with Nationally Recognised Qualifications in Remedial Massage, Myotherapy and Traditional Chinese Medicine Remedial Massage who have completed at least 200 hours of supervised clinic. Existing providers remain eligible.
Cessnock District Health Benefits Fund	Peoplecare Health Insurance	
CUA Health Limited	Phoenix Health Fund	
Defence Health	Police Health Fund	
Frank Health Insurance	Queensland Country Health Ltd	
GMHBA	Railway & Transport Health Fund Ltd	
health.com.au	Reserve Bank Health Society	
Health Care Insurance Limited	St. Luke's Health	
HIF WA	Teachers Federation Health	
Latrobe Health Services (Federation Health)	Teachers Union Health	
Mildura District Hospital Fund	Transport Health	They require you to use their provider number. This number is AWXXXXXM, where the 5X's are your 5-digit AMT member number, for example AW12345M. Members with a 4-digit member number use AWXXXXXM, where the X's are your AMT member number.
Navy Health Fund	Westfund	
Australian Unity		Australian Unity recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), Diploma of Health Science (Massage Therapy), Advanced Diploma of Applied Science (Remedial Massage) and Advanced Diploma of Health Science (Soft Tissue Therapy). Existing Senior Level One and Two providers remain eligible.
BUPA		BUPA recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy).. Existing providers remain eligible. Providers must also meet BUPA's \$2million professional indemnity insurance requirement to be eligible.
CBHS Health Fund Ltd		CBHS recognises all AMT practitioner levels.
The Doctor's Health Fund		Doctors' Fund recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, Advanced Diploma of Applied Science (Remedial Massage), Advanced Diploma of Health Science (Soft Tissue Therapy), Advanced Diploma of Remedial Massage (Myotherapy) and Bachelor of Health Science (Musculoskeletal Therapy). Existing providers remain eligible. They require you to use their provider number. This number is AMXXXX, where the Xs are your 4 or 5-digit AMT membership number.
GU Health		GU Health recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), Diploma of Health Science (Massage Therapy), Advanced Diploma of Applied Science (Remedial Massage) and Advanced Diploma of Health Science (Soft Tissue Therapy). Existing Senior Level One and Two providers remain eligible.
HBF		HBF recognises Senior Level One and Two members.
HCF		HCF recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), 22248VIC Advanced Diploma of Myotherapy, Advanced Diploma of Applied Science (Massage) and Diploma of Health Science (Massage Therapy). Existing providers remain eligible. Providers must also meet HCF's Diploma duration requirement of one year to be eligible.
NIB		NIB recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy)
WorkSafe Victoria		Worksafe Victoria recognises Senior Level One and Two members.

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 up to four practice addresses. Medibank Private will only issue provider numbers for three practices.

Please check the AMT website for further information on specific Health Fund requirements: www.amt.org.au

Calendar of Events

December 2016		CEUs
1-2	Anatomy Trains in Training I. Presented by Ari-Pekka Lindberg. Sydney, NSW Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	70
2-11	KMI Part 2 - Structural Balance Certification Module. Presented by Don Thompson and Julie Hammond. Sydney, NSW Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com Course duration 8 days commencing 2/12/16 and concludes 11/12/16	280
3-4	Anatomy Trains in Training II. Presented by Ari-Pekka Lindberg. Sydney, NSW Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	70
3-4	Acu-Reflexology. Presented by Master Zhang Hao. Strathfield, NSW Contact 0416 286 899. www.chihealing.com.au	70
3-5	Oncology Massage Module Two. Presented by Tania Shaw. Maroochydore, QLD Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
7-11	Neurostructural Integration Technique Basic. Presented by Wendy Eyles. Sydney, NSW Contact 0412 417 719. harmony4massage@gmail.com	175
14	North Shore and Northern Beaches Branch Meeting. Belrose, NSW. Contact Brenda 0410 353 913	15
31	The Shoulder Online Workshop. Developed by Bradley Collins. Contact info@thetherapyweb.com www.thetherapyweb.com This course can be started anytime throughout the year and can be completed at your own pace	25
February 2017		CEUs
18	Rocktape Introduction Course - Full Day. Presented by Rocktape. Donnybrook, WA Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
March 2017		CEUs
25-26	Myofascial Cupping Technique™. Presented by David Sheehan. Melbourne, VIC Contact 03 9481 6723 or info@comphs.com.au www.comphs.com.au/	70
31	The Shoulder Online Workshop. Developed by Bradley Collins. Contact info@thetherapyweb.com www.thetherapyweb.com This course can be started anytime throughout the year and can be completed at your own pace	25
April 2017		CEUs
29-30	Myofascial Cupping Technique™. Presented by David Sheehan. Gold Coast, QLD Contact 03 9481 6723 or info@comphs.com.au www.comphs.com.au/	70
May 2017		CEUs
6-7	Myofascial Cupping Technique™. Presented by David Sheehan. Randwick, NSW Contact 03 9481 6723 or info@comphs.com.au www.comphs.com.au/	70

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Call for Nominations for Association Office Bearers for 2017

Nominations are called for the following positions, which take effect from the close of the 2017 Annual General Meeting:

**Chairperson,
Vice-Chairperson,
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 27 January 2017.

Where nominations equal vacancies on 27 January 2017 then those persons are deemed to be elected.

Where nominations exceed vacancies, a postal ballot of practitioner members that were financial on 1 January 2017 will be conducted during February.

Nomination for Office for the Association of Massage Therapists Ltd

I * (name)

consent to be
nominated for the position of

I have read the Code of Conduct for AMT Directors (<http://www.amt.org.au/downloads/info-about-amt/AMT-BOARD-code-of-conduct.pdf>) and, if elected, will abide by the Code.

Signature Ph

Nominator * Ph

Secunder * Ph

* All must be financial members of AMT



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