

President's Message

By Alan Ford

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Hello and welcome to my first president's report, second time around the block! I can't believe that it has been 6 years since I took on the role of AMT president for the first time but things are very different now ...

The changes that have occurred since we celebrated AMT's 40th birthday back in 2006 have been phenomenal. Our membership has increased by over 70%, our financial situation has shifted from desperate to healthy, and our professional standing is at an all time high since the release of our draft Code of Practice in the public arena last year.

Of course none of the abovementioned could have happened without the hard work and dedication of Head Office staff Katie, Bek and Linda; the guidance, persistence, direction and encouragement of our company secretary, Rebecca Barnett; and the leadership of our immediate past president, Tamsin Rossiter. Our previous and current board of directors should also be applauded for their dedication and due diligence in ensuring the betterment of our association for the benefit of you, the loyal members of AMT.

Thank you one and all.

This edition of In Good Hands will highlight AMT's upcoming Annual Conference being held at the Twin Waters Resort, Sunshine Coast, with articles by two of our conference presenters. If my memory serves me correctly, the Twin Waters resort was the venue for the Commonwealth Heads of Government Meeting (CHOGM) some years ago.

If the venue was good enough for our Queen, then it should be well and truly up to scratch for an AMT conference!

The Annual Conference is a great way to catch up with fellow practitioners in a relaxed and comfortable environment. The workshops will be first rate as usual, with presenters from interstate and overseas bringing their best and most up to date skills to us.

Art Riggs, one of the best international presenters we have ever hosted in Australia, is back again for the conference. He will also be presenting two workshops in Sydney after the conference: Cultivating a Powerful Soft Touch (27-28 October) and Working with Common Injuries and Complaints (30-31 October). Given Art's reception in Canberra in 2010, I have no doubt that he will entertain, inspire and educate those who are smart enough to get in first as earlybird delegates to his conference sessions.

Please, don't miss this great opportunity to network, be educated and informed, and relax all at the same time.

As part of our push to expand throughout the country, AMT is supporting the establishment of regional branches for therapists to meet on regular intervals. Reflecting this commitment to local branch activities, we convened a face-to-face meeting of regional executives in Sydney on March 17 (in association with AMT's AGM). The opportunity for regional representatives to participate in this kind of forum, with the profound benefits of being able to speak directly to AMT's secretary and directors about regional issues, is essential to building a healthy line of communication within the Association. The provision of quality services to all of our members - city, country and remote - is paramount to our ongoing success as an organisation.



in good hands

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Secretary's Report

by **Rebecca Barnett**

Change management is a strange, two-headed beast of a thing. On the one hand, it sucks: it requires a great deal of time, energy, commitment, flexibility, and physical and emotional investment. On the other hand, however, it can provide the foundation and building blocks for a brighter future and the achievement of a great vision.

Thus far, 2012 has been a year of great transition in AMT. There have been changes to our staffing arrangements, our management structure, and the composition of the AMT Board. As Alan mentioned in his report, the presidential baton has been passed to him for a second term. It seems no small coincidence that, again, he has taken on the role in the midst of a major restructure. However, the key difference this time around is that we are making changes from a position of great strength. The change is driven by opportunity and growth rather than dire and desperate necessity. This is a gratifying reflection of how much we have achieved as an organisation over the past six years.

Key staffing changes include the engagement of Rebekah Short on a more stable and ongoing basis (around 20 hours per week) and the departure of Linda Hunter as AMT's Executive Officer. We are also in the process of engaging another full-time staff member, a reflection of our sustained membership growth and the extra workload that has created. I have been formally appointed by the Board as part-time Company Secretary of AMT and am no longer serving in a voluntary capacity as an elected Board Director. I recognise that it's quite confusing to have two Becks on staff at AMT but we'll let you know as soon as we have resolved the argument over who gets to be B1 and who is B2.

Office bearers for the coming year are:

Alan Ford: President
 Dave Moore: Treasurer
 Annette Cassar: Director
 Kerry Hage: Director
 Desley Scott: Director
 Jodee Shead: Director
 Derek Zorzit: Director

Our Annual General Meeting and trivia night was a rip-snorting success, with 70 AMT members pitting their wits against rounds of anatomically-themed questions and general trivia. Sincere thanks to our trivia masters on the night, Derek Zorzit and Alan Ford, for ensuring that all present were constantly engaged and entertained. Thanks also to Bek Short for arranging all the prizes. The competition was surprisingly fierce, matched only by the intense camaraderie. Bonus points to those who can guess the second most flexible muscle in the body ...

Minutes from the AMT can be downloaded from the AMT website and you will receive notification via email when the 2012 Annual Report is available for download as well.

Working with the Australian Skills Quality Authority (ASQA)

Over the past few months, AMT has established a stronger working relationship with the national VET sector regulator, ASQA, cooperating in the prosecution of one of their first major cases against an RTO. We made contact with ASQA at the beginning of March to register our concerns about Nobel College, an RTO operating in Sydney. The college had not been on AMT's radar until mid-January this year when we started receiving a large number of applications from their graduates.

We were informed at this initial contact that the college had lodged an appeal with the Administrative Appeals Tribunal but, due to privacy obligations, we could not be given details of their case or the nature of the appeal.

ASQA's legal counsel made contact with me in mid-April to establish whether AMT was willing to cooperate with the tribunal hearing in connection with the College. We were informed at this time that Nobel's registration was cancelled on 28 June 2011 and that the college had immediately lodged an appeal against the decision with the AAT. However, any qualifications issued by Nobel College after 28 June were in breach of the conditions of their deregistration. Essentially, the qualifications were, at best, worthless and, at worst, fraudulent.

I am pleased to report that the evidence that AMT supplied to ASQA essentially buried the College's appeal. I was on hand at the resumption of the tribunal hearing on April 26 in case I was needed to give oral evidence. However, the documentary evidence supplied by AMT was sufficient to kill the case. The College withdrew its appeal the next morning and ASQA's decision to deregister the college was convincingly upheld.

On the balance of evidence, it seems likely that Nobel College has acted in breach of both the old Vocational Education and Training Act 2005 and the new National Vocational Education and Training Regulator Act 2011. Given that the college website continued to promote nationally accredited massage therapy training for 10 months after their registration was revoked (quoting their RTO registration number and CRICOS number), it also appears likely that the College was in breach of the Competition and Consumer Act 2010.

We have maintained a close dialogue with ASQA to monitor their intentions in relation to pursuing criminal or civil charges against the principal of the college. In the meantime, we embarked on a huge clean up operation, revoking any AMT memberships that had been granted on the basis of bogus qualifications, and notifying health funds and insurance companies of our actions. We will continue to cooperate with ASQA in any intended action and have also made contact with the NSW Police to establish whether we can lodge a fraud complaint against the college.

NORPHCAM research partnership

AMT has been in further dialogue with NORPHCAM to establish a path forward for our research collaboration. The AMT Board has agreed to fund a small, preliminary research study, to lay the foundations for an Australian Research Council linkage grant application in 2013. Please stay tuned for more details of the project as we develop it with NORPHCAM in the coming months.

2012 federal budget announcement regarding natural therapies

Those of you with sharp ears would have tuned in to the federal budget announcement of a planned review of private health fund rebates for natural therapies. In the days following the announcement, the media reports started to feature a 'hit list' of modalities that this proposed review would supposedly be targeting. One report, written by founding members of the Friends of Science in Medicine, declared quite explicitly and specifically that homeopathy, Reiki, aromatherapy, iridology, ear candling, crystal therapy, flower essences, kinesiology and Rolfing were on a target list of therapies that would no longer attract health insurance rebates. On even the most cursory inspection, this list seems a little bizarre since many of the services on it do not currently attract health fund rebates anyway.

Not surprisingly, there has been substantial misreporting of the budget announcement. The actual wording from the budget reads as follows:

"The Government will undertake a review of the private health insurance rebate for natural therapies.

The review, which will be overseen by the Chief Medical Officer, will examine the evidence of clinical efficacy, cost effectiveness and safety and quality of these natural therapies.

Following the completion of the review, the Government will introduce, through regulation, a list of natural therapies that will continue to receive the private health insurance rebate. Natural therapy treatments not included on this list will no longer be eligible for the rebate.

Funding of \$1.0 million will be provided to the Department of Health and Ageing in 2012-13 to undertake the review. The savings for this measure are not for publication until the completion of the review."

A media release, available on the Federal Health Minister's website, further states that:

"...the Government will better target the Private Health Insurance Rebate so that it is paid for insurance products that cover 'natural therapy' services only where it is deemed they are clinically effective. The Government's view is that there must be credible evidence that medicines and treatments are effective."

AMT welcomes this budget announcement. Given the strong clinical evidence base for the efficacy of massage therapy in treating a range of conditions, we are extremely confident that health fund benefits for remedial massage therapy will be preserved. We have written to the Chief Medical Officer, Professor Chris Baggoley, to indicate our support for the review process and will be submitting evidence that demonstrates the clinical efficacy of remedial massage.

Conference 2012

Registrations are officially open for the AMT Conference. We are extremely excited to be hosting Art Riggs again after his smash hit performances at the 2010 annual conference. We're also looking forward to several days of perfect weather, good food and great company at the Twin Waters Resort. The venue and location this year are truly stunning.

You will find the full conference program in this edition of the Journal, along with articles by Art Riggs and Jeff Shearer to give you a taste of what is to come. Online registration is available again this year in addition to the traditional hard copy rego forms included with the conference brochure. If you register online, you receive instant confirmation of your breakout choices. Just follow the online. Just follow the registration link from the AMT home page www.amt.org.au.

Please be aware that popular breakouts are likely to book out. Why not take advantage of our earlybird discount and make sure you get your first choice of workshops by registering as soon as possible? Don't forget - your conference fees, travel and accommodation expenses are fully tax deductible!

Hope to see you there. I'll be the one falling off a Segue. And no, I haven't messed up the spelling.

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June edition

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Lucas et al showed that the presence of latent trigger points can alter activation patterns in the scapular positioning muscles.

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2012 AGM and trivia night - a few snapshots

"Annual General Meetings are an unavoidable necessity of every member association. The AMT is no different. What was different this year was that AMT turned the most avoidable event of the year into a MUST DO event.

Spending some quality time with other members is almost impossible, even at conferences. Who would have thought that the best time I have had with other members would be at an AGM? I would like to send my thanks and gratitude to the organising committee. I took myself to an imaginary recreation of the Titanic experience (minus the icebergs and the sinking) and was challenged to pit my mental capacities in a Trivia Quiz. Oh yes, and we held an AGM.

This is a model of social networking that should spread worldwide to every association and company. I wonder if even Google has done something as imaginative and effective as this. On top of all this, I won a prize due to my efforts at trivia! I'm not sure it was for skill or sympathy, but what a fabulous bonus.

As you have probably gathered, I had a good time. But actually, I had a seriously good time. I have a feeling that the AMT AGM may well become the most popular event on the annual calendar. It's all about connecting, having fun and doing what is important because it is worth doing. This year we did it well!"

Sue Davis

"Whipping together an outfit from the early 1900s was a last-minute challenge but I was surprised what I had at the back of my wardrobe. Sporting a long gown (for the first time ever), a feather boa, velvet sash and cameo brooch, I was easily able to let my imagination take me back in time when I sat in the centre of the beautiful dining room and looked around at the features reminiscent of that era. It was a lovely departure from the modern world, if only for an evening. Thanks to those who made an effort to dress the part and thanks AMT for putting on a great night."

Leonie Macpherson

"OK. I admit it. I was one of the knockers. Trivia night? What the hell were they thinking? But being a loyal AMT member who welcomes any opportunity to connect with my peers, I registered for the dinner and, somewhat reluctantly, pulled on my best dinner suit. What a surprise package the evening turned out to be. After a brief but informative AGM, the trivia questions commenced. Where else was I going to hear such animated discussion about the muscles of the pelvic floor? Where else would I hear someone suggest, in a moment of sheer, mad enthusiasm, that the uterus was the most flexible muscle in the body? Certainly not your average dinner conversation but the most fun I've had with other massage therapists in a very long time. My team didn't win but we had an absolute blast trying."

Ern Malley



▲ Outgoing AMT President Tamsin Rossiter schmoozes with her team mates



▲ Steerage passengers Paul Lindsay and Desley Scott celebrate their survival



▲ Trivia master Derek Zorzit puts contestant through a grueling round of heads and tails

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The Role of Myofascial Trigger Points in Shoulder Pain. A literature review.

by **Catrin Jonsson**

Introduction

Myofascial Trigger Points (MTrPs) are described by Travell & Simons (1983) as hyperirritable loci within a taut band of skeletal muscle or the fascia that surrounds it. A trigger point is, by definition, painful to palpate and will refer pain in a specific 'referral pattern'. Trigger points can be classified as being either active or latent. An active trigger point will refer pain during rest and activity, whereas a latent trigger point will only refer pain when palpated (Simons, Travell & Simons, 1999). The intensity of the pain and the extent of the referral depend on how irritable the trigger point is. Muscle size has little to do with the pain referral and it is not uncommon for small muscles to harbor trigger points that give rise to very intense pain (Travell & Simons, 1983).

The exact cause of trigger points is unknown but recent studies are attempting to explain the underlying pathophysiology. One suggestion is abnormal electrical activity, called endplate noise (Bron et al., 2011). According to Simons and Travell (1999), trigger points are perpetuated by mechanical stresses such as asymmetry, poor posture, prolonged immobility at one end and overuse of muscles at the other. Nutritional deficits and systemic disease are also considered to be perpetuating factors, along with sudden changes in climate or acute trauma. With this in mind, it is easy to see how a large number of the population may be experiencing pain caused by the presence of myofascial trigger points. Shoulder pain is a very common site of pain with a one-year prevalence of 20% and 50% in several countries. It is also one of the major reasons people present for treatment.

Aside from acute injury, such as rotator cuff tears and dislocations, the most common cause of shoulder pain is thought to be subacromial impingement syndrome (SIS) (Bron et al, 2011). Subacromial impingement can develop secondary to incorrect activation of the rotator cuff muscles, allowing the superior translation of the humeral head under the acromion (Lucas, Rich & Polus, 2010). This mechanical pressure on the subacromial soft tissues can lead to inflammation of the supraspinatus tendon and the subacromial bursa (Bron et al, 2011). It is not uncommon for this type of non-traumatic shoulder pain to become recurrent and eventually chronic.

The challenge when assessing and treating shoulder pain is working out which structure within the shoulder complex is responsible for the pain. If the shoulder pain involves an inflammation of the tissues, then treatment by non-steroidal anti-inflammatory medication (NSAIDs) would be successful, however this is not always the case (Bron et al, 2011). It has become evident that there are other sources within the shoulder complex that can contribute to the pain experienced by people with non-traumatic shoulder pain, and that myofascial trigger points may be one source.

In this literature review, some of the most recent studies on the connection between myofascial trigger points and non-traumatic shoulder pain are presented. It includes an examination of how the presence of trigger points in shoulder musculature can be accurately diagnosed; if there is an obvious difference in the number of trigger points present in a painful shoulder and a pain free shoulder; how trigger points affect the shoulder musculature; and if specific treatment of the trigger points will lead to a decrease in the pain experienced by the client.

Myofascial Trigger Points

Pain originating from muscle, such as trigger points, is by no means new. There are writings on the subject dating back to the 1930s and, even if the terms used to describe these 'spots in the muscle that refers pain to a distant location' sometimes differ, it is clear that the physicians who wrote these early papers are discussing what we now refer to as trigger points.

In the 1980s, Janet Travell and David Simons published an extensive 2-volume work, *Myofascial Pain and Dysfunction, The Trigger Point Manual*, where they presented detailed information on the underlying cause, development, location and treatment suggestions for most muscles in the human body. This work has since been expanded by researchers intrigued by the link between trigger points and musculoskeletal pain and dysfunction. Current research is now available to further show how changes in muscle tissue that lead to the development of trigger points can cause not only pain but also alter muscle activation (Lucas et al, 2010), which in turn can lead to muscular imbalances. Shoulder pain is difficult to diagnose because of the lack of reliable tests as well as the poor understanding of the pathophysiological mechanisms that underlie shoulder pain (Bron, Dommerholt, Stegenga, Wensing and Oostendorp, 2011).

The only way to diagnose myofascial trigger points (MTrPs) is by palpation (Bron, Wensing, Oostendorp, 2007). Questions have been raised as to how accurate diagnosis by palpation can be and if there is sufficient inter-rater reliability when palpating trigger points in shoulder muscles. Bron et al (2007) examined inter-rater reliability by testing three very experienced raters who were blinded to the condition of the subject.

The raters received pre study training in the palpation protocol and a consensus was reached on the palpation of the following muscles: infraspinatus, anterior deltoid and biceps brachii. They used four essential criteria when diagnosing trigger points:

1. Presence of a hyperirritable point in a taut band
2. Pain when applying pressure to the trigger point that refers distant to the point
3. A local twitch response (LTR) in the muscle
4. A jump sign, when the client flinches away from the palpation (Simons et al. 1999).

Bron et al (2007) assessed the pairwise inter-rater agreement (PA) between the raters as to the presence or absence of MTrPs. All raters assessed all subjects and they were blinded to the subject's condition. The subjects were not allowed to mention if they felt any pain in the area being palpated at the time of palpation but they were later asked if pain and referred pain was felt when certain areas were palpated. The results were quite convincing and the inter-rater agreement for the presence of trigger points in the infraspinatus was over 70%. The jump sign had a PA of 93% for the infraspinatus and 63% for biceps. Referred pain was the most reliable criterion even without the immediate patient feedback.

The researchers acknowledge that the pre study training and standardising of the palpation could impact the results in a positive way. However, based on the results, they concluded that trigger point palpation is a reliable tool in the diagnosis of myofascial pain in patients with non-traumatic shoulder pain (Bron et al. 2007).

Myburgh, Lauridsen, Larsen & Hartvigsen (2011) looked at the influence of clinical experience on inter-examiner reproducibility. They found that more experienced clinicians had a higher agreement rate on the presence of MTrPs in the muscles assessed. Their study suggests that, with an experienced clinician and a predetermined protocol for palpation, the presence of myofascial trigger points can be successfully established (Myburgh et al. 2011).

MTrPs and shoulder pain

The involvement of trigger points in producing shoulder pain has been thoroughly investigated over the past 5 years. The mechanism of this involvement is still not fully understood. In fact, the pathophysiological mechanism underlying trigger points is not clearly understood either. Shah et al (2008) found that subjects with active trigger points in the trapezius muscle had higher concentrations of inflammatory mediators, neuropeptides, cytokines and catecholamines in the tissue in comparison to subjects with latent or no trigger points. Interestingly, subjects with higher concentrations of these biochemicals in their trapezius also had higher levels in their gastrocnemius muscle, which was used as a control. Perhaps it is this change in the biochemical concentrations that promotes trigger point formation or perhaps the trigger point induces the increase in biochemicals.

Bron et al. (2011) looked at 72 subjects with unilateral shoulder pain and assessed the number of muscles with trigger points. In total, 17 muscles that act on the shoulder were assessed. Both active and latent trigger points were counted and patients were asked to fill out a Disabilities of Arm, Shoulder and Hand Dutch language version (DASH-DLV) and a Visual Analog Scale for Pain (VAS-P) questionnaires relating to their shoulder pain. The results showed that all subjects had multiple muscles containing trigger points but by far the most frequent presentation was in infraspinatus (56) and upper trapezius (42). There was moderate correlation to both the DASH-DLV outcome and VAS-P, which would indicate that trigger points in shoulder muscles contribute to common shoulder pain problems (Bron et al. 2011).

The researchers suggest that, if trigger points are the cause of the shoulder pain, the standard treatment involving anti-inflammatory medication and exercises may not be suitable. Deactivation of the trigger points using manual compression and/or dry needling followed by heat and dynamic stretching exercises would be a better choice of treatment (Bron et al, 2011).

Hidalgo-Lozano et al. (2010) obtained similar results in their study on pressure pain hyperalgesia in patients with unilateral shoulder impingement. They argued that perhaps the presence of trigger points in muscles had something to do with muscle recruitment and activation. They further argued that, if trigger points can alter the activation of a muscle, perhaps this can lead to shoulder pain. In fact, this was exactly what Lucas, Rich & Polus (2008, 2010) found when they looked at the effects of latent trigger points in the scapular positioning muscles. In 2008, Lucas et al published their study of 137 healthy and pain free subjects who were examined bilaterally for the presence of latent trigger point in trapezius, serratus anterior, levator scapulae, rhomboids and pectoralis minor. Palpation and diagnosis was in accordance with the guidelines set by Simons et al (1999). In this first study, the researchers wanted to establish how common latent trigger points are in scapular positioning muscles. Results showed that there was no significant difference between gender, age or occupation. Of the 137 tested, 89.8% had at least one latent trigger point (LTRP). Of these, 62% had more LTRPs on the dominant side and 25% had more on the non-dominant side. 78.8% had at least one LTRP in the upper trapezius muscle, 77.3% for the serratus anterior and 68.9 for the levator scapulae. The researchers acknowledge that their subjects were employed in desk bound jobs which may predispose them to trigger points, and that this may be the reason for the discrepancy between their findings and those of Sola, Rodenberger & Gettys (1955) where the subjects were military recruits. Sola et al (as cited in Lucas et al. 2008), found that 50% of the 200 young and healthy recruits had 'hypersensitive spots' in the posterior shoulder muscles. Other factors such as palpation protocol may have influenced the results (Lucas et al, 2008). Building on their first study, Lucas and her team decided to look closer at how latent trigger points affect muscle activation patterns in the same scapular positioning muscles during unloaded and loaded scapular plane elevation.

They found that muscle activation patterns (MAPs) were significantly altered in the unloaded movements and that deactivation of the trigger points normalised the MAP (Lucas et al, 2004). No further change was noticed when the muscles were tested under load. The researchers noted earlier onset of activation when the muscles were tested under load and speculated that this might be because earlier activation is needed to preserve the predetermined movement strategy (Lucas et al., 2010). Hidalgo-Lozano et al (2010) investigated the involvement of trigger points and the changes in pressure pain hyperalgesia in patients with unilateral shoulder impingement. They recruited subjects with unilateral shoulder impingement who also showed signs of tendonitis or bursitis and tested positive to the Neer (pain during passive abduction) and Hawkins (pain when arm is in 90 degree flexion and internal rotation) tests. These two tests are used to diagnose shoulder impingement and have a specificity of 53% and 59% respectively. Exclusion criteria included a history of fracture, fibromyalgia, systemic disease, previous history of shoulder or neck surgery, radiating pain from the cervical spine and use of steroids. The control group was age matched, right hand dominant and tested negative to the Neer and Hawkins test.

In the study, the tester was blinded to the subjects' condition at the time of assessment. The muscles assessed were levator scapulae, supra and infraspinatus, subscapularis, pectoralis major and biceps brachii. They used the Simons et al (1999) criteria for diagnosis of a myofascial trigger point (ie palpable taut band, the presence of a hyperirritable spot in the band, the local twitch response and referred pain). The trigger points were then classified as active if the patient indicated that palpation of the trigger points reproduced the pain symptoms in the location they recognised as familiar (Hidalgo-Lozano et al., 2010).

Once the trigger point assessment was completed, the researchers tested the pressure pain threshold (PPT), which is defined by Vanderweeen et al (1996) as 'minimal amount of pressure where the sensation of pressure first changes to pain'. All of the above muscles were tested using a mechanical pressure algometer, with the mean of three trials recorded. Patients with shoulder impingement had significantly lower PPT levels in all muscles when compared to the control group (Hidalgo-Lozano et al., 2010). Trigger point activity was also significantly different between the two groups. The control group had only latent trigger points whereas the subjects with shoulder impingement had both latent and active trigger points in their shoulder muscles. When these trigger points were palpated both local and referred pain was present in all patients. This pain corresponded to their familiar shoulder pain (Hidalgo-Lozano et al., 2010).

The researchers also found that, the higher the number of trigger points in a muscle, the lower the PPT for that muscle was. There was also a corresponding increase in the intensity of the pain. They suggest that active trigger points are involved in the pathophysiology of shoulder impingement and that the referred pain can contribute directly to shoulder pain (Hidalgo-Lozano et al., 2010). They also state that the presence of latent trigger points may contribute to the altered activation pattern put forth by Lucas et al. (2004) which, in turn can, lead to increased mechanical pressure on the subacromial structures that lead to shoulder impingement.

Hong-You Ge, Ceras Fernandez-de-las-Penas, Pascal Madeleine and Lars Arendt-Nielsen (2008) collaborated on a study of trigger points specifically in the infraspinatus muscle. They examined 19 subjects suffering unilateral shoulder pain. The infraspinatus muscle is a muscle that commonly has trigger points and the referral pattern from these can extend as far down the arm as the wrist and even into the hand (Travell & Simons, 1983). Ge et al (2008) divided the infraspinatus muscle into 10 smaller squares of 1cm by 1cm.

They placed a pressure algometer on each square and took a measurement. After the PPTs were taken, the researchers also looked for the presence of trigger points by inserting a needle into each sub area. The needle was inserted swiftly and moved into five different directions to elicit the local twitch response and referred pain. They assessed both sides based on evidence showing that injury to deep tissues will result in contralateral pain and dysfunction (Larson et al., 1999), cited in (Ge et al., 2008).

The results showed a significantly higher number of TrPs in infraspinatus on the painful side and that the non-painful side only had latent trigger points. This presentation is of interest as it may indicate a phenomenon called segmental sensitisation of mechanical hyperalgesia. This means that a pain pattern is mirrored on the opposite side to the injury over time mediated by the central nervous system pathways. The PPT was significantly lower on the painful side and PPT levels were lower where there was an active trigger point located compared to a latent trigger point. The most common sub areas for active MTrPs were along the lateral border of the muscle, which were also the sites where PPTs were the lowest on the painful side (Ge et al., 2008). However, Ge et al suggest that latent trigger points should also be given treatment as they can turn into active trigger points when left untreated.

Does treatment of trigger points work?

Physiotherapists, chiropractors, osteopaths and massage therapists use trigger point therapy to treat myofascial pain but the evidence base for this is still contended. These recent studies are encouraging as they give validity to the work many clinicians already do.

Hains, Descarreaux & Hains (2010) used digital ischaemic pressure (DIP) to treat trigger points in 41 patients with chronic, non-traumatic shoulder pain. They specifically treated supraspinatus, infraspinatus, deltoid and the biceps tendon with the aim of assessing whether the elimination of MTrPs would normalise the area and eliminate the pain.

The subjects, who were blinded to the treatment, were given three treatments a week for five weeks. Eighteen controls received treatment to trigger points in muscles deemed to be outside the referral area for shoulder pain (sham treatment). The outcome was measured using the Shoulder Pain and Disability Index (SPADI) and the results were significant. After 15 treatments the treatment group reported a decrease in SPADI of 44pts, with improvements still present at 6 months after the conclusion of the treatments.

Bron et al (2011) studied the effects of trigger point treatment on chronic non-traumatic shoulder pain, especially the type of shoulder pain that falls under the umbrella of subacromial impingement syndrome. The study was a single blind, randomised controlled trial where both the lead researcher and the research assistant were blinded to the patient allocation during the entire study period. One group of subjects received the intervention of one physiotherapy treatment a week for twelve weeks and a control group adopted the 'wait and see' approach. The treatment consisted of inactivation of active trigger points using digital ischemic pressure, deep stroking, cross fibre friction, ice and stretching. Detailed history, DASH and VAS-P and GPE scores were among the pre study requirements and these tests were also administered at 6 and 12 weeks. A stop rule was in place, so treatment was stopped when the patient was free of symptoms or if the therapist judged that no further benefits were possible. The control group meanwhile would continue with their normal management routine for their pain and they were told that their treatments would start at the end of 12 weeks.

The results showed that, at 6 weeks, there was not much difference between the control group and the intervention group. However, at 12 weeks, some of the more noticeable changes were that 50% of the intervention group improved more than 10 points on the DASH and their VAS-P scores were significantly lower. 55% of the intervention group reported improvement in the Global Perceived Effect (GPE) score.

The number of muscles with latent trigger points did not change a lot but the number of muscles with active trigger points was significantly lower after the 12 weeks, indicating that trigger point therapy is a promising approach for people with chronic unilateral non-traumatic shoulder pain (Bron et al, 2011).

Hidalgo-Lozano et al. (2011) investigated changes in pressure pain sensitivity in patients with unilateral shoulder impingement. Patients received digital ischemic pressure (DIP) on each active trigger point along with longitudinal deep stroking to the muscle at an intensity that did not induce pain. All participants were treated two days a week for two weeks. A VAS for pain measurement was used because of its validity and reliability in assessing changes in pain. PPTs in levator scapulae, supra and infraspinatus, pectoralis major were also assessed, with tibialis anterior used as a control point. Even though this study was a case series with only 12 participants, the results were interesting. Patients experienced a significant increase in PPTs after treatment and also one month later. Their pain also significantly decreased after treatment. The findings of this study suggest that TrPs in the shoulder musculature may contribute to shoulder pain and sensitisation in patients with unilateral shoulder impingement. However, the small sample size and lack of a control group indicate that larger randomised controlled studies need be undertaken to support this conclusion. However, the researchers state that trigger point assessment and treatment should be included in the management of patients with unilateral shoulder impingement.

Hidalgo-Lozano et al (2011) investigated elite swimmers and shoulder pain. Swimmers frequently experience shoulder pain and dysfunction, with prevalence slightly higher than in the general population at 43%-72%. The shoulder pain can be related to repetitive overhead shoulder movements that may increase joint laxity and supraspinatus tendinopathy (Sein et al, 2010).

Seventeen elite swimmers with shoulder pain, 18 elite swimmers without pain, and 15 elite athletes made up the study. The duration of the shoulder pain had to be more than three months and a positive Neer and Hawkins test was part of the inclusion criteria. Trigger points and PPT were explored in the levator scapulae, sternocleidomastoid, upper trapezius, infraspinatus, subscapularis and scalenes. Tibialis anterior was used as a control site.

A blinded trigger point examination took place, where questions related to the patient's pain were only asked after the palpation was completed. The PPTs were assessed in all muscles in a randomised order. The results were similar to other studies, with a significant increase in the number of active trigger points in the elite swimmers with shoulder pain compared to the elite swimmers with no pain and the controls. The number of latent trigger points was higher in the elite swimmers without pain compared to swimmers with pain and the control group. The number of trigger points in upper trapezius, levator scapulae and infraspinatus was significantly higher for the elite swimmers with pain compared to the elite athlete controls. PPT was lower in both the elite swimmer groups when compared to the elite athlete controls (Hidalgo-Lozano et al, 2011).

The higher number of latent trigger points in elite swimmers without pain is interesting in the context of the Lucas et al study (2004) that shows altered muscle activation when latent trigger points are present in shoulder stabilising muscles. It is possible that shoulder pain develops secondary to the changes in activation caused by latent trigger points or that pain comes from the presence of latent trigger points that, over time, become active trigger points.

'Based on the current findings, Hidalgo-Lozano et al (2011) suggest that trigger point evaluation and treatment is included when working with elite swimmers with shoulder pain.

They also suggest that longitudinal studies are undertaken with larger sample groups to look at the role of mechanical sensitisation and active trigger points in the development of shoulder pain in elite swimmers (Hidalgo-Lozano et al, 2011).

Conclusion

The aim of this literature review was to present some of the most recent studies on the connection between myofascial trigger points and non-traumatic shoulder pain. Sixteen studies undertaken since 2004 by researchers from across the globe have produced positive results stating that there is a definite and perhaps multi-modal connection. Studies by Hains et al (2010) and Hidalgo-Lozano et al (2011) were single blinded controlled trials. This generally gives more credibility to the results.

Two recent studies investigate the accuracy of trigger point diagnosis and inter-rater reliability. Bron et al (2007) and Myburgh et al (2011) showed that inter-rater reliability can be quite high if the clinicians are experienced, receive pre-testing training and a set protocol is designed for the palpation examination.

The majority of studies showed that active trigger points were present in subjects with shoulder pain and that these were found in the musculature acting on the painful shoulder. Bron et al (2011) found that all 72 subjects with unilateral shoulder pain had multiple trigger points in the muscles assessed. The trigger points were most frequently located in infraspinatus and upper trapezius. Hidalgo-Lozano (2010) had similar results, where all patients reported feeling familiar pain when the examiner pressed on the location corresponding to the trigger point. This study also concluded that pressure pain thresholds are much lower in muscles containing trigger points, especially if they are active.

Lucas et al (2004) found that latent trigger points, even in pain free shoulders, will alter the muscle activation pattern, which in turn can lead to imbalances.

This altered pattern was normalised if the latent trigger points were deactivated using specific treatment. Treatment options include digital ischaemic pressure, dry needling, ice, deep longitudinal gliding and injection.

There was strong agreement by the researchers that assessment and treatment of trigger points should be standard practice for patients with shoulder pain. It is certainly less invasive than surgery and there would be no need for anti-inflammatory medication. There was also agreement that further research is needed that includes larger samples and a longitudinal study design.

In spite of the fact that the sample sizes in some of the studies were quite small and there were no double-blinded trials, the results strongly imply that both latent and active trigger points have an involvement in the pathophysiology and symptoms associated with non-traumatic shoulder pain.

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Refine Your Touch: working sensitively with your client

by Art Riggs

"Refine your touch!" These three words of admonishment from a partner on my first day of Roling training were probably the best single lesson I've received in my bodywork career. I realised that my touch was, indeed, harsh: if I attempted to make things happen against the will of my clients and their tissue, my work was less effective and could be a cause of alienation rather than creating a rewarding and close connection.

Recently, I was working very deeply with a client in a particularly recalcitrant area when she suddenly volunteered, "You have such a comforting touch!" I was a bit surprised at such a nice compliment because I'm often concerned that I sacrifice soft touch when I become overly focused on the outcome of my work. I asked my client if she could explain what she meant and she responded, "Well, first, I always feel safe, so I can relax knowing that you know your anatomy and precautions, and that you are always tuned in to how I'm accepting the work. Mostly, your hands, elbows and all your tools seem 'soft' even when you're working hard or very deeply, and you always let me determine how fast I can let go. Sometimes there might even be something that could feel like pain but it seems necessary. I feel that it is more like the pain when my mother would remove a splinter—kind of intense but really giving a feeling of relief and actually comfort."

In a nutshell, she encapsulated what I've tried to teach for the past 20 years: the sensations your clients receive are a function of your relationship with them and their trust of your competence, mechanical skill, sensitivity to their reactions and the focus of your attention to remove tension in areas of holding.

CULTIVATING SENSITIVITY

Your relationship with your client

Pain does not exist in a vacuum. Much of our perception of this sensation is influenced by context, as in my client's analogy of removing a splinter. Of course, the mechanics of your techniques—including speed, pressure, direction and depth of work—are major factors. But the context of your relationship with your clients and your intention can provide the confidence and feeling of being cared for that can make the difference between a tense struggle or a relaxed session as your clients realise the benefits of a mutually focused commitment to solve problems.

Since our bodies and minds are conditioned to interpret pain as the messenger that says, "Something is wrong here", fear is often a primary emotion we deal with when working deeply with our clients. The first few minutes of your session can be your major ally in allaying the fear and bodily tension caused by this emotion. Following are some suggestions for consideration.

Establish rapport

It is crucial to build a relationship with your clients based on mutual trust and connection. Taking time to chat with them, especially if it is the first time you have seen them, can set the tone for everything you do in the session. Just a few minutes of relaxed conversation can let your client feel like a person you actually care about on a personal level, rather than a set of symptoms.

Cultivate confidence

Incrementally introducing your skills and working style can help ease the process. Rather than immediately working on sensitive or troublesome areas, address areas that will feel good to lower the fight-flight charge in the nervous system.

Let your clients become familiar and relaxed with your touch in areas where they feel safe before venturing into more thorny territory.

Explain the rationale behind your strategies, especially in sensitive areas, and communicate that you realise the area may sometimes be uncomfortable and that you appreciate how they are working with you. Intense therapy with a clear intention will be perceived very differently from work that appears to be insensitive and without a purpose.

The most important gift of trust you can give to your clients is the knowledge that you will stop immediately if they ask you to. However, there is a delicate balance between being receptive to feedback and relinquishing your control of the session and appearing to be less than confident. Constantly asking your client if the work is too intense can call attention to the issues of pain. The client should be able to relax with confidence in your sensitivity rather than having to be overly vigilant in giving feedback.

Err on the side of caution rather than overworking and having to interrupt the flow of the session by frequently stopping work and having to regain the trust and relaxation of your clients after overstimulation. If you sense that your client is tightening against your intention, don't suddenly interrupt the stroke. The speed at which you are working is usually the culprit—just slow down, slightly ease up on pressure, wait for both of your energies to mesh and then continue.

The Intangibles

It is important to recognise that your mindset can determine the quality of touch as much as your specific biomechanical techniques. Probably the single most important cause of work being perceived as painful or too intense is working too quickly.

Often, therapists feel a generous sense of urgency to get too much work done or cling to routines that emphasise covering the whole body with equal attention to all parts. They may end up spending unneeded time on relaxed areas and rushing on areas of holding. Many therapists report fear of clients feeling short-changed if they don't perform a full-body massage. Although educating clients about the benefits of detailed spot work is helpful, it is also possible to have the best of both worlds by simply educating clients on the advantages of longer massages that leave enough time for a thorough unravelling of the client's holding patterns while still covering the entire body with varying degrees of focus depending on the need.



▲ **Figure 1:** In tender areas such as the iliotibial band, the side-lying position enables you to observe your client's face for subtle reactions to your pressure. This position also allows for powerful use of your own weight, the ability to rotate your forearm for precise use of the ulna or a softer touch. The use of the other hand provides stability, rotates the tissue around the femur for better alignment, or anchors and stretches strokes when applying force in the opposite direction with the forearm.

Soft hands

A Rolfer friend of mine has huge, strong and soft hands that seem to be a cross between a bear's paw and a frog's foot. I always marvel when I see his hands remain totally relaxed as he slowly sinks into the tissue like quicksand. Having soft hands (along with elbows, fists, and knuckles) has been my major goal in touch and I find myself continuing to improve but must remain constantly vigilant when tension creeps in. Virtually everyone holds some unnecessary tension in their hands that will add a harshness of touch and diminish sensitivity in reading the subtle signs that tissue gives us.

One easy way to soften your hands is to make them stronger so that you can relax with the same amount of pressure being a smaller percent of your maximum effort. If you can apply the same amount of force with more relaxation and less effort, your work can become more effective and nurturing. Squeezing balls and slowly building your strength to work with your fingers bent, rather than stiff and hyperextended, will not only make your work easier but will soften your touch. Work for this extended but relaxed joint function in all areas of your body.

Having your fingers slightly flexed and spread will greatly benefit your touch in "snowplow" strokes, pushing to stretch tissue. Everyone can achieve this with some work.

Notice the difference between Figure 2 and Figure 3.



▲ **Figure 2:** When freeing tight pectoral fascia and muscles, a rigid hand and wrist applying vertical force with fingers held tightly together will feel harsh to your client.



▲ **Figure 3:** The slightly flexed and spread fingers act as springs while still maintaining mechanical integrity and precise focus of intention as you stretch tissue in any direction. You'll have a broader working area if you use your other hand to increase your effectiveness.

The pain threshold

The point where your work becomes too intense varies between individuals and also between different areas on a single client. The key to providing effective but pleasant work is to hone your awareness of the subtle preliminary signs of resistance to your pressure that precede crossing the threshold into pain. Even if you feel less effective in your strategies, it is much better to hover at a level safely below the pain threshold than risk overstimulation and the disruption that stopping a stroke causes in the smooth flow of your session. Of course, instructing clients to inform you when you are working too hard is an option but then it is often too late and they aren't able to relax with confidence if they need to be vigilant.

Notice the signs that may indicate you are nearing your client's pain threshold:

- Changes in breath—either stopped breathing or deeper, more frequent breaths.
- Changes in facial expression, especially with tightening lips or eyes.
- Curling fingers, toes or other areas of the body.
- Resistance or tightening of the tissue you are working on.

Whenever possible, I try to position my body so that I can have eye contact. You will quickly develop a rapport and awareness of how your work is being accepted and a connection that will allow your client to relax.

It helps to have some tools to gauge client reactions to your work. A one-to-10 scale is a safe way to begin until you hone your non-verbal sensitivities but has the drawback of some clients becoming too involved in controlling the session rather than relaxing. Trust that you will know their limits. Some people are afraid of being wimps and it is important they feel perfectly relaxed about communicating their limits. When I occasionally use this technique, I explain that I never want to cause pain, which I arbitrarily define as "around an eight". Of course, one person's five might be another's eight but the number is high enough for people to feel like they aren't being overly sensitive.

Most important is to have clients tell you when they are at a seven so that they are comfortable but don't have to worry about your applying more pressure.

Most importantly, notice the cooperation of the tissue you are addressing and distinguish between tight tissue and tissue that is tightening against you. When you feel the tissue is beginning to resist your pressure rather than cooperating, it is time to ease up.



▲ **Figure 4:** Working with the psoas. The rigid fingers and small area of contact look more like surgery than bodywork. All of the client's attention will be focused on a small and sensitive area, and relaxation and release will be difficult.

Habits to avoid

Wasted or ineffective strokes take precious time from the areas that need additional and slow care, and can spell the difference between work that feels good at the time but doesn't leave lasting benefits or a session that brings significant change. Consider increasing your effectiveness by overcoming some of the following common habits that waste time.

Superficial strokes

Do you take up too much time at the beginning of the session with superficial strokes in order to relax clients when their tension and holding patterns are deep? Related to this is an overemphasis on warming up tissue.

Of course, we don't want to just dive in but I often see therapists warming up tissue that is superficial and unrelated to actual tightness: spending



▲ **Figure 5:** The non-working hand provides a nurturing connection, while the palm of the primary hand rests comfortably on the superficial abdomen. The bent and slightly separated fingers have the ability to easily sink to the level of the psoas, where individual fingers can differentiate specific areas of tightness.

inordinate time working on the gluteal muscles when the actual tightness is in the deeper rotators; working on the gastrocnemius when the soleus is the problem; or warming up the pectoralis major when the tightness is in the pectoralis minor. I also frequently see practitioners spending excessive time on the external abdominals and then diving in too quickly to address the psoas, which is a totally different muscle and layer of the body.

The key is to slowly sink vertically to the layer of the body that begins to push back against you and then work horizontally at that layer to lengthen short tissue. You will benefit the more superficial areas when you focus your attention on deeper areas anyway. By the same token, don't be too attached to long, mechanical strokes performed with the same speed and pressure. Individual muscles have great variation in where their restrictions lie.

Move quickly along relaxed sections of long muscles like the hamstrings, quadriceps, calves, the erectors, iliotibial band, and arms so that you can slow down and do focused, repetitive strokes in isolated areas of tightness along these areas.

Equal time

People hold tension in very different parts of their bodies, often with vast differences from one side to the other. Each session should be a bit of a treasure hunt looking for the gold of hidden tension. Relaxed tissue can receive great benefit from quick work that enables you to concentrate on other areas. When I encounter an area that needs minimal work, I often explain to the client, "This leg feels relaxed and fluid ... I won't need to spend as much time here. That will give me more time for the shoulder that bothers you."

Forced results

We massage therapists are a generous lot when it comes to wanting to give our clients the best and most helpful work possible, sometimes emphasizing our objectives at the expense of comfort. Attempting to give too much benefit or offer miracles can make us work too hard and actually overstimulate our clients. Even with the best mechanics, we also can try too hard, which will give our touch an abrasive nature as well as create unnecessary strain in our own bodies. If you find yourself shaking or feel stress or pain in the joints of your hands, shoulders, back or legs, then you are working too hard. It is important to choose realistic goals and work within yourself, even with those clients who crave intense work.

BASICS OF PAIN-FREE WORK

The following guidelines can help you modify your work in ways that may be more appealing for your clients—and you.

Use minimal lubrication

The goal of most deep structural work is to stretch short tissue rather than just applying pressure and squeezing. I prefer the term grabbing rather than the increasingly popular term hooking, which can imply a harsh or overly aggressive intention thus contributing to the misperception that deep work needs to be painful.

Using too much lubrication requires significantly more unpleasant pressure in order to grab and stretch short tissue rather than sliding over adhesions and other holding patterns.

Move slowly

When people complain of painful bodywork, it is often due to strokes moving faster than the tissue can adapt to and relax. Imagine you are pushing a heavy boat away from a dock. It takes a while to conquer inertia with slow steady pressure. When you feel the tissue melt, that is the time to lighten your pressure and let the tissue dictate depth and direction of release.

Pace your sessions

Although my early career motives were well intentioned, my greatest sin in my early practice was trying to accomplish too much. I wish I could give recall notices to my early clients as I watched them levitate off the table as a result of my overgenerous attempts to be a miracle worker. Make your sessions a journey rather than a destination and don't become too attached to the outcome of your work. It also helps to clarify your goals with reasonable expectations. Some therapists appear to be trying to win an argument with stubborn holding patterns rather than having a give and take dialogue and allowing for the great educational benefit of voluntary release on the part of the client.

I have learned a great deal from going to yoga classes. In some poses, when I'm sweating bullets and considering crying out, the teacher will sometimes say, "We only have 30 seconds left." Suddenly, my perception of overwhelming pain dissipates as I realise that an end is in sight. I relax and move to a new level of release.

When you feel that your clients are working with you for important release but are on the edge, let them know you are aware of and grateful for their cooperation and that relief is around the corner. The very tension of conscious withholding is often the last obstacle in the way of dramatic and lasting change so lightening up in force and speed may be all that is needed to achieve that last release.

Sink vertically, then work

One of the biggest errors I see is when therapists "sink and work" vertically at the same time before encountering the layer where they want to work and before the body can adjust. Slowly sink through superficial tissue at a fairly vertical angle until you encounter resistance and then alter your direction obliquely.

Once you decide to work obliquely, only apply as much force as is necessary to grab the tissue and stretch it. A common error is to apply too much pressure so that the muscles actually contract out of discomfort thus negating your efforts to teach them to relax and lengthen. Imagine pulling on a rope in a tug of war—you only need enough pressure in your grip to hold the rope; any additional pressure will only cause tension and waste energy.



▲ **Figure 6:** Applying force distally allows short hamstrings to lengthen and also allows for the additional benefit of decompressing the hip joint. The left hand can facilitate the stretch by moving in the same direction or can anchor tight fascia proximally to localize the stretch.

Allow for rest

A friend once gave me some excellent advice "In life, as in music, the rests are as important as the notes". I apply this wisdom to my sessions. Intense work has a cumulative drain on the nervous system and the capacity of the client to cooperate. When performing intense work, I give frequent short breaks where I actually just break contact or lighten my touch or do feel-good work to nearby areas. This allows for a rest and the chance to evaluate, appreciate and solidify the good work you have performed. It is difficult for the gelatine to set if it is constantly stirred.

Work towards the core

The areas that need the most work are often the most defensive and have a lower pain threshold.

You can gain the trust of your client by beginning work in less sensitive areas on the periphery and extending the relaxed area into the core of holding rather than starting at the epicentre.

Contact large areas

Use your non-dominant hand to broaden your contact. This gives the brain some other input to consider and can actually direct attention away from sensitive areas.

Direct your strokes

Students who cling to their early Swedish massage training—where the emphasis is on working distally to proximally—may conflict with therapeutic goals of distracting joints and lengthening muscles away from their origins. I have my students apply the same pressure to sensitive areas and they are surprised how much more comfortable the stroke feels when moving in the direction of muscle lengthening (usually distally). Applying significant force to muscles such as the quadriceps, hamstrings, iliotibial band, rotators, and gluteal in the direction of lengthening allows them to stretch and relax, rather than buckling them into a shortened position.

The issue of pain is emotionally charged, both for our clients and ourselves. It is important to acknowledge that pain, albeit with lots of real, variable and emotional considerations, also has a great deal of cultural loading. I see absolutely no purpose or benefit in imposing unnecessary discomfort in a session. However, fibrosed tissue or long-held contraction may need considerable patient force near the threshold of discomfort. Don't berate yourself if you occasionally overstep the limits of your clients' sensitivity. As my Catholic friends remind me "It isn't a sin unless you enjoy it". For intense work, a careful dialogue—both with your touch and your unique relationship with each person—of communication and negotiation (rather than coercion) can be the difference between an overcautious lost opportunity and profound release.

Art Riggs is the author of the textbook Deep Tissue Massage: a Visual Guide to Techniques and the acclaimed seven volume DVD series Deep Tissue Massage and Myofascial Release: A Video Guide to Techniques. This article is part of an expanded chapter in an upcoming textbook edited by Erik Dalton. Art is presenting at this year's AMT annual conference and presenting two workshops in Sydney in late October.

Management of blood and body spills: aka Spills Kits are easy!

by Desley Scott

The release of AMT's draft Massage Therapy Code of Practice last year engendered a lot of vigorous dialogue and healthy self-reflection. For some AMT members, there were elements of the draft Code that were a little confronting, specifically those relating to aspects of clinical practice that have undergone substantial change and evolution since the introduction of national health training package qualifications in 2002.

One significant focus of change in the current training of massage therapists is the introduction of specific units of competence related to infection control and workplace health and safety. For many therapists who graduated prior to 2002, this is strange, new and foreign territory. However, these units of competence apply across the entire health training package, not just to the massage therapy qualifications within the training package. Their content reflects current health care setting standards and policy. In other words, no matter when you graduated from your initial training, you need to be able to apply these principles and standards in your clinic.

The release of the draft Code of Practice has created a great opportunity for all therapists to identify gaps in their knowledge and training, and get up to speed with current practice. To support the release of the final Code of Practice in October, AMT will be producing practice guidelines to assist all practitioners in meeting the national requirements for infection control and workplace health and safety. You will also notice an ongoing series of articles in this journal aimed at contextualising key standards in the Code, including this article on the management of bloody and body spills by AMT Director and Educator, Desley Scott. The December 2011 issue of In Good Hands featured an article on professional standards and risk management in relation to requirement for clients to wear underwear in the clinic.

Getting behind AMT's Code of Practice and welcoming the opportunity it presents to identify and address any gaps in your practice is a fantastic way for the massage therapy profession to move forward together. Rather than being confronted by change, we can embrace the business principle of continuous improvement and commit ourselves to delivering the highest possible standards of care to our clients, demonstrating our professionalism through the currency of our knowledge.

Health care facilities, including massage clinics, should have a management system in place that meets national, state and territory work, health and safety requirements for dealing with blood and body substance spills. These protocols should follow Standard Precautions, including the use of a Spills Kit as outlined in the Infection Control and Hygiene Standard from the draft AMT Code of Practice.

Don't be alarmed - spills kits are easy to use and integral to sound infection control practice.

The basic principles of blood and body fluid/substance spills management are:

- standard precautions apply, including the use of personal protective equipment (PPE)
- spills should be cleared up before the area is cleaned. Adding cleaning liquids to spills increases the size of the spill and should be avoided
- generation of aerosols from spilled material should be avoided.

Using these basic principles, the management of spills should be flexible enough to cope with different types of spills, taking into account the following factors:

- the nature (type) of the spill (e.g. sputum, vomit, faeces, urine or blood)
- the size of the spill (e.g. spot [few drops], small [<10cm] or large [>10cm])

- the type of surface (e.g. carpet or impervious flooring)
- whether there is any likelihood of bare skin contact with the soiled (contaminated) surface.

Spills Kit

A spills kit should be stocked and available in the clinic area for immediate use in case such spills occur. The spills kit should contain:

- a large reusable plastic container or bucket with fitted lid, containing the following items:
 - appropriate leak proof bags and containers for disposal of waste material
 - a designated, sturdy scraper and pan for spills (similar to a 'pooper scooper')
 - disposable rubber gloves suitable for cleaning
 - eye protection (disposable or reusable)
 - a plastic apron
 - surgical mask
 - absorbent material such as absorbent granules
 - detergent

Single-use items in the spills kit should be replaced after each use. With all spills management protocols, it is essential that the affected area is left clean and dry. Care should be taken to thoroughly clean and dry areas where there is any possibility of bare skin contact with the surface (e.g. on a massage table).

Spill kits can be purchased commercially or put together yourself. Video clips on their application can be accessed on youtube. Here is one example: <http://www.youtube.com/watch?v=a2blaKVPjws>

Procedure

According to the National Health and Medical Research Council (NHMRC), the following procedures are appropriate when managing spills in the healthcare setting:

Spot cleaning	<ul style="list-style-type: none"> • Select appropriate PPE • Wipe up spot immediately with a damp cloth, tissue or paper towel • Discard contaminated materials • Perform hand hygiene
Small spills (up to 10cm diameter)	<ul style="list-style-type: none"> • Select appropriate PPE • Wipe up spill immediately with absorbent material • Place contaminated absorbent material into plastic bag for disposal • Clean the area with warm detergent solution, using disposable cloth or sponge • Perform hand hygiene
Large spills (greater than 10cm diameter)	<ul style="list-style-type: none"> • Select appropriate PPE • Cover area with an absorbent agent (kitty litter) and allow to absorb • Use scraper and pan to scoop up absorbent material and any unabsorbed blood or body substances • Place all contaminated items into plastic bag for disposal • Discard contaminated materials • Mop the area with detergent solution (The bucket and mop should be thoroughly cleaned after use and stored dry) • Perform hand hygiene

Source: NHMRC (2010) Australian Guidelines for the Prevention and Control of Infection in Healthcare. Commonwealth of Australia.

Use of bleach (sodium hypochlorite)

It is generally unnecessary to use chemical disinfectants such as sodium hypochlorite for managing spills but it may be used in specific circumstances. It is recognised, however, that some health care workers/members of the public may feel more reassured that the risk of infection is reduced if sodium hypochlorite is used. Health care workers and members of the public should be aware that there is no evidence of benefit from an infection control perspective.

I hope this information allays concerns about the use of Spills Kits in standard infection control practices. Happy scooping!

Sources:

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<http://ideas.health.vic.gov.au/bluebook/appendix5.asp>
<http://www.health.nsw.gov.au/>

AMT NEW MEMBERS

ACT

Tegan Coltman, Tess Dennes

NSW

Tim Bowman, Scott Brailey, Darren Bulmer, Hafize Cakir, Daniel Catlin, Andrew Coombe, Demee-Lee Cramp, Wenming Dang, Xinxin Du, Xiaona Duan, Dennis Finn, Michelle Freeman, Xiao Dan Fu, Linda Fuda, Amber Fullalove, Benjamin Gray, Li Jun Guo, Gaye Harvey, Charlotte Hendriks, Bartosz Hendzel, Chotika Klingsurai, Shinobu Layt, Min Lin, Chunying Liu, Chun Fung Lo, Hong Hoi Ly, Catherine Macgregor, Sujittra Makatham, Valerie Malone, Carly McDonald, Jennifer McGurgan, Connie McNamee, Tony Mitrovski, Sharon Osborne, Karen Palmer, Jason Perin, Silvia Ruano-McLerie, Brett Schultz, Jurai Taeng-on, Yelena Townsend, Thi Oanh Tran, Lea Tsekouras, Megumi Tsuruoka, Jenna White, Hayley Windisch, Anthony Wong, Suiying Wu, Xiaoqing Zhao

QLD

Diane Eden, Emily Nielsen, Kate Noble, Katrina Rabbitt, Adam Rendalls, Chieko Roberts, Michelle Sharrock, Huberta Van Akkeren

SA

Yang Cao, Shi Chao Li, Peng Fei Liu, Wei Qi Liu, Jing Yuan Ye, Bo Zhao, Yu Zheng, Shengde Zhu

VIC

Eliza Allender, John Bowley, Susan Dodson, Paloma Macura, Goce Mitrovski, Tania Nalesnyik, Alfio Tomaselli, Li Zhao

Are you into social media yet?

by Jeff Shearer

I don't know if you've heard yet but there is this hip new thing called social media. What's that? You have heard? You've heard and you don't see the point?

Well I'm here to help you not only see the point but embrace social media as a means of connecting people with your business without going crazy.

Why?

Social media is the cheapest form of marketing you will ever find for your business. It's free. And it is where a huge portion of the population is spending a lot of time. I managed to increase my database contacts by 200 percent in one month just by using Facebook and YouTube to promote my business. That is 200 percent more people who now receive my message.

The major social media players in Australia are Facebook, Twitter, LinkedIn, YouTube, Pinterest and Google+. It is a long list but you needn't feel overwhelmed. If you want to start with just one, my pick would be Facebook. There are over 800 million users worldwide and the average person spends 50 minutes a day there. You can also link accounts so you can post once to multiple accounts. Google+ is a sleeping giant because it is part of Google and has the ability to increase your ranking on the web (we all want this) but it is yet to take off like everyone expected.

How?

The trick to social media is to remember the first word: social. This is not the place to sell, sell, sell. Rather, it's the place to connect with people and build relationships. Push the sales angle and you will likely turn people away from your business. Engage them with questions, interesting articles and relevant information and you will improve the status of your business in their minds.

The more this happens, the more likely that this will translate into people utilising your services. And that is what we are really aiming for - more people we can help.

Social media can also be a place to build relationships with other therapists. Let's face it, private practice can be a lonely place sometimes but social media can enable you to create support networks. You can bounce ideas off other therapists, check if someone has the answer to a particular problem or build a referral base. The opportunities are endless.

Simple tips to make it easier

We are all already incredibly busy so trying to fit in one more thing, like social media, seems impossible. Coming up with content for posts and then being able to post them at regular intervals while keeping an eye on comments makes us want to put our hands over our ears and start rocking in the corner.

However, there are four simple tricks that will make it easy:

1. Google Alerts

Use Google Alerts to provide you with content. You can set up an alert on any topic you want and you can elect the frequency of the notifications for relevant posts. I receive Google Alerts daily on a range of topics, not just my modality. My focus is on health and practitioner support, so I use search terms like social media tips, massage research, nutrition, etc. This gives me loads of articles I can just cut and paste into my social media account.

2. Post scheduling

There are applications that allow you to set up schedules of posts. I normally spend a couple of hours on a Sunday night or Monday morning scheduling the majority of posts I want to make for the coming week.

This ensures they are regular and I don't have to be checking my account every 20 minutes. Hoot suite and Postcron seem to be the two most popular applications that allow you to do this.

3. Connect and share

By connecting to relevant and appropriate pages you will be able to receive their posts and share them. This gives you another angle on creating content more easily. I always acknowledge the page as a way of saying thanks and helping to build a stronger and more collaborative relationship.

4. Take a break

Many social media experts say you should be constantly connected to your account to ensure quick response to comments. I say 'phooey'. If you attempt to do this, you will become shackled by social media and slowly become an addict, always checking, hoping for and needing the next comment. Make social media something that is going to work for you, rather than you working for it. I recommend checking your account a couple of times a day and having a break over the weekend. Set some firm boundaries otherwise you will get sucked into the social media vortex.

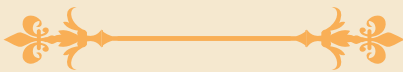
Setting up

There are tons of simple videos and articles on how to set up and manage your Facebook page (or any other social media accounts). All you need to do is Google it. Just make sure you keep the page(s) promoting your business completely separate from your personal account. The aim is to connect clients to your business, not to the potentially lurid details of your private life!

Like anything unfamiliar, establishing a social media presence for your business can be daunting at first but with small steps it becomes more familiar and comfortable. Start your first step today.

Jeff Shearer is a Massage Therapist of over 17 years who now runs a training business called Ethical Practice, designed to help practitioners manage the hurdles of running a practice without selling their soul. Jeff will present a session on marketing with soul at AMT's Annual Conference on the Sunshine Coast.

AGM FOLLOW UP



At AMT's March AGM, there was a couple of questions about AMT's audited financial statements. The treasurer undertook to provide follow up on the questions via the AMT journal.

Superannuation payable

The zero amount under "Superannuation Payable" for the 2011 financial year relates to the fact that AMT met all of its superannuation liabilities within the financial year.

Workshop expenses

Workshop income for 2011 was significantly higher than in 2010 due to the profit earned from sponsoring Advanced Trainings to Australia. Workshop expenses in the financial statements are subsumed under "Other Expenses".

Exact workshop expenses for 2011 are \$17,673.04.

The e-Journal^{club}

Join AMT's e-Journal club and be in the running for a great prize every quarter.

When you opt in to receive the AMT journal electronically, you instantly become a member of AMT's e-journal club.

Just send an email to AMT Head Office and write "Electronic Journal" in the subject line.

DEADLINE

Deadline for the September 2012 issue of In Good Hands is: 1st August, 2012

Please email contributions to:
journal@amt.org.au
or phone: 02 9517 9925

AMT Member Representative

Ever wondered what goes on during an Executive Board meeting?

Ever feel like there is a gap between the Board and the membership that needs to be bridged?

Ever wanted to ask a Director a question but wasn't sure who to address it to?

We have a solution!

Enter Michelle McKerron, who is taking up the challenge of a new role as AMT's Member Representative.

Michelle has been a member of AMT since 1996 and manages a small clinic in the south of Sydney. She has been actively engaged with where AMT is heading throughout her whole career as a massage therapist and is now adding to her skill set, participating in AMT Board meetings. She will be acting as the eyes and ears for you - the members!

You can contact Michelle at memberrep@amt.org.au with any questions or feedback you have for the AMT Board.

For all the latest research news, events and AMT gossip...

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News from the regions



Hunter by Paul Lindsay

The business section of our March meeting included a discussion of the face-to-face Regional Executive meeting that was held in conjunction with AMT's Annual General Meeting. Some members objected to the awarding of CEUs for the AGM/Trivia Night. This led to a broader discussion around CEU recognition for reference book purchases and attending non-AMT courses etc. Since the AMT secretary was scheduled to attend the May Hunter branch meeting, further discussion was held over until that time.

The guest speaker for the March meeting was Louise Maye, a senior podiatrist with Hunter New England Health. Louise gave a presentation on foot care and foot problems, complete with wince-inducing photographs. The talk showed therapists that it was necessary to look after their own feet, due to the time spent standing, as well as being able to recognise infectious conditions in clients that would require additional health precautions.

Our July meeting will be our local AGM and workshop. The presenter will be James Walsh and the topic will be a cut-down version of his 'Myofascial Moves' course. Cost of the workshop is \$143 for AMT members and attendance will attract 35 CEUs.

Wade Boeree spoke about the "Scenar Advantage" pain relief system at our January meeting. He described the Scenar process with personal stories of successful treatments, and showed examples of the equipment used. Interest was high with an excellent attendance for a January meeting.



Riverina by Jodee Shead

The following meetings and workshops were planned at our last meeting:

23 June 2012 - 7pm

AGM in Rochester Victoria.

27 July 2012 - 1pm

Wet lab day at Charles Sturt University. We also have the option of a 10am start if enough people are interested. A flyer has been sent to head office for distribution to all members.

16 September - 12 noon till 3pm

a short workshop with Kay Fredericks in Corowa

23 November - 7pm

a Christmas Break-Up and tea at Andrew Hendy's house in Cobram. We will be planning the activities for the first six months of 2013 at this meeting so bring your diaries!

Kay Fredericks is in contact with Michael Stanborough and we are hoping to have him run a Myofascial Release workshop in Key Valley in either August or September.

We hope to see more Riverina members at these meetings and workshops.



Melbourne by Ross Housham

Our May meeting featured Jodie Dundon, who gave a presentation on Pilates followed by a Pilates mat session.

The schedule of meetings for the rest of the year is as follows:

5 August

Guest speaker Kerry Hage on Cupping and Dry Needling, followed by a treatment swap. Please bring towels, oils etc.

16 September

Annual General Meeting followed by guest speaker Jo Griffiths on Preparation of Treatment Plans. Please email Jo regarding any topics you would like her to cover in her talk at this meeting - joannegriffiths2001@yahoo.com.au

11 November

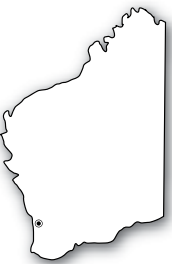
Possible presentation on Bowen Therapy
All meetings commence at 10.30am.
We hope that the varied presentations will lure more of you to attend the Melbourne Branch meetings. C'mon people - get out and network!



Sunshine Coast by Lesley Carter

Our next meeting will be on 17 June at the Seventh-day Adventist Church Hall, Coes Creek Road, Nambour, and the topic will be "Poulticing and Hydrotherapy". We are fortunate to have a member who has been involved in this area for many years and is happy to share with us how to make and use a number of poultices, and explain how these can be added to our massage work. Bring notepaper and a pen. Books will be available for purchase (\$15.00). Registration will commence at 9am, with the session running from 9.30am to 12.30pm. Morning tea will be provided and the cost is \$20 for AMT members, \$25 for non-members.

The branch will meet again on 19 August for a full-day workshop with Deby Atterby. We all enjoyed Deby's last presentation on aromatherapy. This time she will be building on the basic knowledge presented at that session.



Perth by Leigh-ann Hunter

The WA branch will be holding a local AGM on Sunday 17 June at the Australian Academy of Wellness Therapies, Canning Hwy, East Victoria Park. We would love to see any new or existing members there.

We are trying to organise a Wet Lab for members who are interested. It will be on a Saturday some time in July.

Please contact Leigh-Ann via email for any queries you may have - emma-holly@bigpond.com.au



Sydney South by Maria Earley

It has been a great first quarter for the Branch, with new members continuing to join.

The guest speaker at our February meeting was Reflexologist and lecturer Tony Pullin. In his presentation, Tony explained the Ingham method of reflexology and then gave a practical demonstration. The presentation was very informative and well received by all present.

Our June meeting will be the branch AGM, followed by an open forum on the topic of "How to market your own business". Our facilitator for this forum will be Andrew Schwartz. Everyone will have the opportunity to participate and contribute.

On behalf of AMT Sydney South Branch, I wish to thank members who regularly attend meetings for their support and contribution towards the continued growth of the Branch. Please mark the following dates for coming meetings in your diary:

- 6 June 2012
- 1 August 2012
- 3 October 2012

Contact:

Maria Earley

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Mobile: 0419 241 258



ACT by Karin Cavanagh

ACT held our AGM on the April 1 with the same executive returned to their respective positions:

Chairperson: Karin Cavanagh

Secretary: Maxine O'Callaghan

Treasurer: Husam Sahib

Because our local AGM immediately followed AMT's national AGM and face-to-face regional executive meeting, much discussion centred on those events. We talked about the format of the AGM and why there was a Trivia Night and not a workshop. The Trivia Night was actually a lot of fun but we may return to the traditional workshop/AGM format next year.

Another hot topic was the fact that the CEUs for First Aid courses are now different. If you do your refresher "Senior First Aid" update every 3 years, you will earn 35 CEUs. If you choose to do the annual update, you will earn 12 CEUs each time you do so.

Finally, this year we will attempt to run a workshop with each meeting to pique your interest. Please find below a list of dates for 2012/13. Workshop topics are yet to be determined:

- 5th August meeting/workshop
- 16th September meeting/workshop
- 11th November meeting/workshop
- 17th February (2013) meeting/workshop

Health Fund Status

HEALTH FUNDS AND SOCIETIES	CRITERIA
CBHS Health Fund Ltd	This fund recognises all AMT practitioner levels.
ACA Health Benefits Fund Cessnock District Health Benefits Fund CUA Health Limited Defence Health GMF Health GMHBA Heath Care Insurance Limited Health Partners HIF WA Latrobe Health Services (Federation Health) Mildura District Hospital Fund Navy Health Fund Onemedifund Peoplecare Health Insurance Phoenix Health Fund Police Health Fund Queensland Country Health Ltd Railway & Transport Health Fund Ltd St. Luke's Health Teachers Federation Health Teachers Union Health Transport Health Westfund	ARHG recognises all AMT practitioner levels. They require you to use their provider number. This number is AW0XXXXM, where the X's are your 4-digit AMT membership number.
Australian Unity GU Health	These funds recognise members with HLT40302/07 and all Senior Level One and Two members.
NIB	This fund will recognise members with HLT50302/07 Diploma of Remedial Massage; HLT50102/07 Diploma of Chinese Remedial Massage; HLT50202/07 Diploma of Shiatsu and Oriental Therapies; Advanced Diploma of Remedial Massage (Myotherapy)
Victorian WorkCover Authority	This fund recognises Senior Level 1 and 2 members.
HCF Manchester Unity	These funds recognise members with HLT50302/ HLT50307 Diploma of Remedial Massage Advanced Diploma of Applied Science (Massage) Diploma of Health Science (Massage Therapy) 21511VIC/21920VIC Advanced Diploma in Remedial Therapy (Myotherapy). Existing HCF providers remain eligible. Manchester Unity will recognise HLT50202/07 Diploma of Shiatsu.
ANZ Health Insurance (HBA) Cardmember Health Insurance Plan (HBA) CSR Health Plan (HBA) HBA (formerly AXA) HealthCover Direct (HBA) MBF Mutual Community (HBA) NRMA Overseas Student Health Cover (HBA) SGIC (MBF Alliances) SGIO (MBF Alliances) St George Protect (HBA) VSP Health Scheme (HBA)	BUPA recognises members with HLT5030207 Diploma of Remedial Massage, HLT50102/07 Diploma of Chinese Medicine Remedial Massage, HLT50202/07 Diploma of Shiatsu and Oriental Therapies, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy).
Australian Health Management Group Medibank Private	These funds recognise Senior Level One & Two members.
HBF	HBF recognises Senior Level 2 members.
The Doctor's Health Fund	Doctors' Fund recognises members with HLT 50302/07 Diploma of Remedial Massage, Advanced Diploma of Applied Science (Remedial Massage), Advanced Diploma of Soft Tissue Therapies, Advanced Diploma of Remedial Massage (Myotherapy) and Bachelor of Health Science (Musculoskeletal Therapy). All Senior Level One and Two members remain eligible. They require you to use their provider number. This number is AMXXXX, where the Xs are your 4-digit AMT membership number.

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

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

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

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

www.amt.org.au

Calendar of Events

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

June 2012		CEUs
1-3	Oncology Massage Module 1. Presented by Tania Shaw. Canberra. Ph: 07 3378 3220 or 0410 486 767	120
1-3	Oncology Massage Module 1. Presented by Tubi Gully. Adelaide. Ph: 07 3378 3220 or 0410 486 767	120
2	Orthotic Therapy and its Clinical Application for the Massage Therapist. Presented by Mal Walker. Melbourne. Ph: 03 5152 6585 or 0409 526 933	40
2-3	Remedial Cupping. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	70
3	Muscles and Pelvic Alignment. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
6	South Sydney Branch Meeting. Hurstville. Ph: 0419 241 258	15
8-10	Oncology Massage Module 1. Presented by Eleanor Oyston. Perth. Ph: 07 3378 3220 or 0410 486 767	120
13	Gua Sha Day. Presented by Bruce Bentley. Townsville. Ph: 03 9576 1787	35
15-19	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley. Townsville. Ph: 03 9576 1787	175
15-17	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Townsville. Ph: 03 9576 1787	105
15-17	Onsen Volume III Structural Assessment and Correction of the Cervical and Thoracic Vertebrae. Tweed Heads. Presented by Jeff Murray. Ph: 07 5599 2514	100
15-17	Oncology Massage Module 1. Presented by Lizzie Milligan. Sydney. Ph: 07 3378 3220 or 0410 486 767	120
16-17	Pregnancy Massage. Presented by Catherine McInerney. Perth. Ph: 03 9532 8144	60
16	Orthotic Therapy and its Clinical Application for the Massage Therapist. Presented by Mal Walker. Sydney. Ph: 03 5152 6585 or 0409 526 933	40
17	Sunshine Coast Branch Meeting. Nambour. Ph: 0403 647 754	15
18-19	Remedial Cupping. Presented by Bruce Bentley. Townsville. Ph: 03 9576 1787	70
22-24	Infant Massage Training. Presented by IMIS. Melbourne. Ph: 1300 558 608	120
23	Orthotic Therapy and its Clinical Application for the Massage Therapist. Presented by Mal Walker. Gold Coast. Ph: 03 5152 6585 or 0409 526 933	40
23-24	Remedial Cupping. Presented by Bruce Bentley. Cairns. Ph: 03 9576 1787	70
23-24	Neurostructural Integration Technique Introductory. Presented by Marianne Grainger. Perth. Ph: 0407 036 047	70
26	Illawarra Branch Meeting. Formal Meeting. Corrimal. Ph: 0417 671 007	15
29-30	Oncology Massage Module 1. Presented by Tania Shaw. Buderim. Ph: 07 3378 3220 or 0410 486 767. Part of a 3 day programme, completion date 01/07/2012	120
30	Neurostructural Integration Technique Introductory. Presented by Michael Howse. Canberra. Ph: 0417 047 412. Part of a 2 day programme, completion date 01/07/12	70
July 2012		CEUs
1	Neurostructural Integration Technique Introductory. Presented by Michael Howse. Canberra. Ph: 0417 047 412. Part of a 2 day programme, commencement date 30/06/12	70
1	Oncology Massage Module 1. Presented by Tania Shaw. Buderim. Ph: 07 3378 3220 or 0410 486 767. Part of a 3 day programme, commencement date 29/06/2012	120
2-6	Somatic CST 1. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	160
8	Ortho-Bionomy Phase 4. Presented by Anthony Swan. Canberra. Ph: 0412 286 385	70
9-13	Somatic CST III. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	175
15	Hunter Branch AGM/Workshop. Adamstown. Ph: 02 4953 2252	35
15	Ortho-Bionomy Phase 4. Presented by Anthony Swan. Canberra. Ph: 0412 286 385	70
18-23	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Melbourne. Ph: 03 5255 5229 or 0419 380 443	175
19-21	Oncology Massage Module 1. Presented by Kate Butler. Hawthorn. Ph: 07 3378 3220 or 0410 486 767	120
21-22	Pregnancy Massage. Presented by Catherine McInerney. Sydney. Ph: 03 9532 8144	60
21	Orthotic Therapy and its Clinical Application for the Massage Therapist. Presented by Mal Walker. Adelaide. Ph: 03 5152 6585 or 0409 526 933	40
21-23	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	105
21-22	Neurostructural Integration Technique Introductory. Presented by Robert Monro. Brisbane. Ph: 07 3269 7250	70
27-29	Infant Massage Training. Presented by IMIS. Sydney. Ph: 1300 558 608	120
28-30	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Gold Coast. Ph: 03 9576 1787	105
31	Illawarra Branch Meeting. Presentation. Corrimal. Ph: 0417 671 007	15
August 2012		CEUs
1	South Sydney Branch Meeting. Hurstville. Ph: 0419 241 258	15
3-5	Oncology Massage Module 1. Presented by Lizzie Milligan. Sydney. Ph: 07 3378 3220 or 0410 486 767	120
5	ACT Branch Meeting. Wanniasa. Ph: 0408 238 274	15
6-10	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	140
10-12	Oncology Massage Module 2. Presented by Eleanor Oyston. Perth. Ph: 07 3378 3220 or 0410 486 767	120
10-12	Oncology Massage Module 2. Presented by Kate Butler. Canberra. Ph: 07 3378 3220 or 0410 486 767	120
12	Gua Sha Day. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	35
13-17	Somatic CST 5. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	210
17-21	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	175
17-19	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	105
18-19	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	140

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CONFERENCE PROGRAM

FRIDAY 19 OCTOBER

7.30AM – 9.00AM	Registration
9.20AM – 9.30AM	President's Welcome – Alan Ford
9.30AM – 10.15AM	AMT Code of Practice - Implications for Practitioners - Professor Michael Weir
10.15AM – 10.45AM	Where to now? Launch of the AMT Code of Practice
10.45AM – 11.15AM	Morning Tea and Trade Exhibit
11.15AM – 11.45AM	Complaints as an Opportunity for Improvement – Peter Johnstone, Health Quality Complaints Commission
11.45AM – 12.30PM	Marketing with Soul - How to Get Busier Without Selling Out – Jeff Shearer
12.30PM – 1.30PM	Lunch and Trade Exhibit

BREAKOUT WORKSHOPS

1.30PM – 3.00PM	<ul style="list-style-type: none">• Mobilisation of the Ribs – Art Riggs• Massage Safely - Working with People with Cancer - Leonie Dale• Hyperkyphosis: Postural Considerations and Treatment for Sagittal Thoracic Dysfunction - Colin Rossie
3.00PM – 3.30PM	Afternoon Tea and Trade Exhibit
3.30PM – 5.00PM	Breakout Sessions continued

SATURDAY 20 OCTOBER

8.00AM – 8.30AM	Relaxation Session with Dr Judy Lovas
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MORNING BREAKOUT WORKSHOPS

9.00AM – 10.30AM	<ul style="list-style-type: none">• Pregnancy Massage – Catherine McInerney (Part 1)• Mobilisation of the Ribs – Art Riggs• Introduction to Psychoneuroimmunology - Judy Lovas
10.30AM – 11.00AM	Morning Tea and Trade Exhibit
11.00AM – 12.30PM	Morning Breakout Sessions continued
12.30PM – 1.30PM	Lunch and Trade Exhibit

AFTERNOON BREAKOUT WORKSHOPS

1.30PM – 3.00PM	<ul style="list-style-type: none">• Pregnancy Massage – Catherine McInerney (Part 2)• Visceral Manipulation - Bronwen Kendall• Building and Maintaining a Client Base – Kay Fredericks
3.00PM – 3.30PM	Afternoon Tea and Trade Exhibit
3.30PM – 5.00PM	Afternoon Breakout Sessions continued
6.30PM	Conference Dinner

SUNDAY 21 OCTOBER

9.00AM – 5.00PM	Post Conference Workshop Creating Pelvic Balance – Art Riggs
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■ PROFESSOR MICHAEL WEIR

KEYNOTE ADDRESS: AMT Code of Practice - Implications for Practitioners

Michael Weir has broad professional experience as a solicitor in private legal practice in commercial and property law. He has a research interest in Medicine and the Law with a focus on complementary and alternative medicine, and law and ethics. This interest is reflected in the student textbook *Law and Ethics in Complementary Medicine: A Handbook for Practitioners* in Australia and New Zealand. Michael is currently Associate Dean (Research) of the Law Faculty at Bond University.



■ JEFF SHEARER

PLENARY ADDRESS: Marketing with Soul

Jeff has been a remedial massage therapist for over 17 years. His practice styles have ranged from a small mobile massage business to operating a multiple-practitioner Chinese Medicine Clinic. Through trial and error, Jeff has learnt many valuable lessons about how to achieve better results for clients, build a successful practice and maintain quality of life without sacrificing standards of care. This experience has inspired him to create 'Ethical Practice, an information-based business designed to assist natural therapists in developing a successful practice with integrity.



■ ART RIGGS

BREAKOUT WORKSHOP: Mobilisation of the Ribs

POST CONFERENCE WORKSHOP: Creating Pelvic Balance

International presenter Art Riggs became enthralled with bodywork after a meandering career in academia. He was certified by the Rolf Institute in 1987 and teaches deep tissue massage, myofascial release and Rolfing workshops in the US and abroad. He also maintains a private bodywork practice in Oakland. Art is the author of the textbook, *Deep Tissue Massage: a Visual Guide to Techniques* and the acclaimed seven volume DVD series, *Deep Tissue Massage and Myofascial Release: A Video Guide to Techniques*.



■ LEONIE DALE

BREAKOUT WORKSHOP: Massage Safely - Working with People with Cancer

Leonie has over 20 years experience in remedial massage therapy, following many years in the nursing profession. She has researched, studied and specialised in massage therapy for people with cancer and other medical conditions. Her qualifications include a Masters in Nursing, lymphoedema management (CPT), and oncology massage. Leonie was a senior massage therapist at Quest for Life Foundation and is a massage therapist and consultant for Blue Mountains Cancer Help. She has taught at Blue Mountains College of TAFE since 1996, while maintaining a successful massage therapy practice.



■ KAY FREDERICKS

BREAKOUT WORKSHOP: Building and Maintaining a Client Base

Kay first trained in massage therapy and yoga in Sydney in 1976 and resumed practice full time in 1990. Since then, she has enhanced her knowledge with a wide range of techniques to meet individual client needs as they arise, as well as teaching massage therapy for many years in Canberra. Her overall philosophy is one of creating balance both through muscle pairing and whole body alignment, and through breathing and relaxation techniques.



■ CATHERINE MCINERNEY

BREAKOUT WORKSHOP: Pregnancy Massage

Catherine has specialised in Pregnancy Massage since 1998 and has extensively researched the benefits of specific massage techniques during pregnancy, labour and post-partum. She is passionate about the importance of assisting a healthy pregnant client through the many changes that occur during each trimester and has developed Pregnancy Massage Australia to train other therapists in Pregnancy Massage.



■ DR JUDY LOVAS

BREAKOUT WORKSHOP: Introduction to Psychoneuroimmunology (PNI)

Judy has practised, taught or researched massage therapy since 1985. She investigated the Effects of Massage Therapy on the Immune Response as a Masters of Science degree before completing her PhD in 2009.



■ BRONWEN KENDALL

BREAKOUT WORKSHOP: Visceral Manipulation

Bronwen Kendall is a physiotherapist who integrates visceral manipulation and craniosacral therapy into her practice. Her reward for doing this has been to understand and experience the anatomy of movement in a whole new light. Bronwen has travelled to the USA and Singapore to complete her Visceral Manipulation training, and she assists instructors who visit Australia. Her practice is in South Brisbane.



■ COLIN ROSSIE

BREAKOUT WORKSHOP: Hyperkyphosis: Postural Considerations and Treatment Methods for Sagittal Thoracic Dysfunction

Colin has over 25 five years experience as a bodyworker. After graduating from the TAFE Diploma of Health Science, he became a Certified Advanced Rolfer and Rolf Movement practitioner. He has assisted Art Riggs, Tom Myers, Bethany Ward and Larry Koliha during their visits to Australia and presented workshops for AMT on a wide range of subjects including scoliosis, posture, and Myofascial Treatment of the cervical spine and upper girdle. He also operates a busy practice in Lilyfield.

BREAKOUT WORKSHOPS

MOBILISATION OF THE RIBS

(Friday afternoon, repeated Saturday morning)

Presented by Art Riggs

The articulation of the ribs with the thoracic vertebrae is complex. The joint frequently becomes 'stuck' and prevents proper movement. Many of the muscle spasms that occur next to the spine cannot be resolved without freeing the costo-vertebral articulation. In this workshop, the anatomical articulation will be explained and you will be given tools to successfully free rib movement. Even clients without painful ribs will notice your skills in providing better movement and easier breath.

MASSAGE SAFELY - WORKING WITH PEOPLE WITH CANCER (Friday afternoon)

Presented by Leonie Dale

Not everyone wants to specialise in oncology massage but most massage therapists will come across a client who has cancer and is undergoing treatment, or who has had cancer and is now a survivor. This workshop will provide you with guidelines to safely work with clients who have a cancer diagnosis or a cancer history, including red flags, positioning, site restrictions (when cannulas or catheters are present), and the need to adjust techniques and pressure to suit the client's condition.

BUILDING AND MAINTAINING A CLIENT BASE (Friday afternoon)

Presented by Kay Fredericks

In this workshop, we will explore the professional and personal motivations, attitudes and skills that support a vibrant massage business, where both the client and the therapist feel valued, supported, appreciated and successful. The session will include a formal presentation, group and individual activities, and a full workbook for future reference.

PREGNANCY MASSAGE (Full day Saturday)

Presented by Catherine McInerney

Pregnancy is a very special time in a woman's life. Many physiological changes occur during the three trimesters. Understanding these changes will help you determine the outcome of your treatment.

POST CONFERENCE WORKSHOP

CREATING PELVIC BALANCE (Full day Sunday)

Presented by Art Riggs

Balance in the pelvis and SI joint is a complicated and multi-faceted phenomenon worthy of years of study and practice. In this workshop, we will expand your 'nuts and bolts' skills to work with the soft tissue restrictions that create torsion and dysfunction in the pelvis, including freeing the legs from the pelvis; balancing left/right strain in the posterior pelvis and rotators; working with the anterior pelvis for left/right and anterior/posterior balance; and freeing the transition between the pelvis and spine for easier rotation.

It will give you the confidence and guidance to apply appropriate massage to your pregnant client. The workshop includes an introduction to pregnancy massage and the physiological changes involved in each trimester, endangerment sites, positioning, draping and client comfort.

INTRODUCTION TO PSYCHONEUROIMMUNOLOGY (Saturday morning)

Presented by Dr Judy Lovas

Conventional wisdom recognises that the psyche, emotions and health are intimately linked. Psychoneuroimmunology (PNI) offers scientific evidence of mind and body connections and their influence on health and wellbeing. In this dynamic workshop we will explore both the theory and practical implications of PNI for massage therapists, focusing on the impact of stress and relaxation on physical and psychological health, and incorporating the latest research in PNI.

VISCERAL MANIPULATION (Saturday afternoon)

Presented by Bronwen Kendall

Visceral Manipulation (VM) restores normal movement to internal organs and related support structures. In this respect it is an organ-specific, fascial mobilisation. It gently and precisely addresses restrictions in how organs move in relationship to each other and in relationship to the musculoskeletal system. In this workshop, you will learn the history and development of VM, central concepts, and the VM approach to assessment and treatment. The practical component includes an introduction to VM palpation skills.

HYPERKYPHOSIS (Saturday afternoon)

Presented by Colin Rossie

Many assessment considerations and protocols for the treatment of thoracic spine rotation can be adapted to work with hyperkyphosis. This workshop includes the trunk wedge model of Katerina Schroth and how this can be used in the assessment and treatment of hyperkyphosis. Techniques to work with the fascial shortenings will be demonstrated and you will have the opportunity to practise these.

PARKING

Novotel Twin Waters Resort is pleased to offer complimentary car parking to all in house guests and conference delegates. The Resort does not accept liability for any loss or damage incurred to any vehicle at any time.

ACCOMMODATION

AMT has negotiated special room rates with the Twin Waters Resort that includes breakfast. To book your accommodation here, please download and complete the booking form in the conference section of the AMT website or call Twin Waters Resort on 07 5450 9591.

Name _____

Company name _____

Address _____

Email _____ Contact number _____

AMT membership number _____

If you are not a member of AMT please indicate if you belong to one of the following associations:

 AAMT ATMS ARM

 If you are registering as a student, which college are you enrolled at?

■ CEUs

You will be rewarded with 50 CEUs for each day of the conference you attend. ARM and AAMT members will receive CPEs for attendance.

■ Registration fees

Your registration fee includes morning and afternoon teas and lunch. You can choose to attend the two-day conference only or attend three days, including the post-conference workshop. You can also register for the post-conference workshop only. Take advantage of our earlybird savings by completing your booking before Wednesday 15 August.

■ Conference Gala Dinner

A Gala Dinner ticket is included in all 2 and 3 day registrations. Delegates who wish to purchase extra tickets will need to do so through AMT Head Office.

TWO-DAY REGISTRATION

Attending on:	Earlybird rate	After August 15	Student Rate
Friday & Saturday <input type="radio"/>	\$440.00 <input type="radio"/>	\$520.00 <input type="radio"/>	\$300.00 <input type="radio"/>

THREE-DAY REGISTRATION (includes post-conference workshop)

Attending:	Earlybird rate	After August 15	Student Rate
All 3 days	\$600.00 <input type="radio"/>	\$680.00 <input type="radio"/>	\$450.00 <input type="radio"/>

POST-CONFERENCE WORKSHOP ONLY

Attending:	Earlybird rate	After August 15	Student Rate
Sunday	\$240.00 <input type="radio"/>	\$280.00 <input type="radio"/>	\$180.00 <input type="radio"/>

TOTAL: \$

Dietary requirements (please advise of any special dietary requirements and we will attempt to address these)

 Vegetarian
 Lactose Intolerant
 Gluten free

■ WORKSHOP PREFERENCES

CONFERENCE BREAKOUT WORKSHOPS

Please number your choice for each session in order of preference, beginning with 1 as your first choice. Breakout workshops are 3 hours long, except for the pregnancy massage workshop which runs full day Saturday. (6 hours)

Breakout Session 1 (Friday afternoon)

- ___ Mobilisation of the Ribs
___ Massage Safely - Working with People with Cancer
___ Hyperkyphosis

Breakout Session 2 (Saturday morning)

- ___ Pregnancy Massage (Part 1)
___ Mobilisation of the Ribs
___ Introduction to Psychoneuroimmunology

Breakout Session 3 (Saturday afternoon)

- ___ Pregnancy Massages (Part 2)
___ Visceral Manipulation
___ Building and Maintaining a Client Base

POST-CONFERENCE WORKSHOP (SUNDAY 21 OCTOBER)

- ___ Creating Pelvic Balance

■ WORKSHOP ALLOCATION

Workshops are allocated on a first-come, first served basis. All attempts will be made to satisfy your request for preferences. If your first choice of workshop is not available would you like AMT to:

- Choose your next available preference for you?
Cancel your registration and refund your fee?

REGISTRATION CLOSES MONDAY 9 OCTOBER 2012

I have enclosed my cheque or money order (made out to AMT) OR please debit my Visa/Mastercard (for banking purposes circle correct one)

Cardholder's Name: _____

Cardholder's Signature: _____

Card Number:

Expiry Date: _____ / _____

CANCELLATION POLICY

- Cancellation up to four weeks prior to close of registration - less 15%
- Cancellation less than four weeks but more than two weeks prior to close of registration - less 25%
- Cancellation less than two weeks but more than one week prior to - 50%
- No refund will be given after the event

EFT PAYMENT DETAILS

PLEASE USE YOUR NAME UNDER THE TRANSACTION DESCRIPTION SO WE CAN IDENTIFY THE PAYMENT AND SEND THIS FORM BACK TO AMT
Account Name: Association of Massage Therapists Ltd
BSB: 062-212
Account Number: 1034-0221

Please return to:
AMT
PO Box 792 Newtown NSW 2042
or fax 02 9517 9952

OFFICE USE ONLY Date received _____ Receipt no. issued _____