



amt

in good hands

the journal of the association of massage therapists ltd

march 2008

President's Report

By Alan Ford

Association of Massage Therapists Ltd

Office hours:

Monday-Friday 10.00am - 4.00pm

Level 1 Suite B,
304 King Street
Newtown NSW 2042

Postal address:

PO Box 792, Newtown NSW 2042

T: 02 9517 9925

F: 02 9517 9952

massage@amt-ltd.org.au

www.amt-ltd.org.au

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Welcome to those new AMT members who have joined the fold since the December edition of In Good Hands. I am pleased to announce that we have now reached the first of many specific goals set by the incumbent Executive back in June 2006: AMT membership is at its highest since our establishment in 1966. Howzat?

As members of AMT, we are all required to maintain a level of professionalism in our practice as Massage Therapists. The annual requirement to attain 100 Continuing Education Units (CEUs) should not be viewed as a burden or a tedious obligation but rather an opportunity to improve your skill set, get ahead of the pack, be seen as the best qualified and most up-to-date practitioner in your street, suburb, city or state. Who knows, maybe your clients are even talking about you being the best massage therapist in the world!

Opportunities to upgrade your skills and accrue CEUs have been more plentiful in recent times with AMT recognising the workshops and courses formally endorsed by other Associations.

I have been lucky enough to see the first draft proposal for this year's Annual Conference to be held in Echuca from October 24 to 26 (including pre-conference workshop). At first glance it looks like being a vibrant affair with entertainment, workshops, music and demonstrations from all manner of presenters, performers and groups.

At last year's conference, I was pleased to see many familiar faces, including Peter and Ann Wybenga who had made the effort to travel to the Gold Coast from Canberra. This got me thinking that if I see at least 75 to 100 familiar faces at each conference, then there must be more than 1,000 members I have never met over the past 16 years or so. How about some of those members I have never seen at the Conference making the most of the opportunity to take a few days out of the clinic, see beautiful country Victoria, meet your peers, listen, look, learn and lap up the atmosphere of this year's major event?

Look out 2008. We're back.

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Secretary's Report

By Rebecca Barnett

Well, it turns out that T. S. Eliot was wrong. This year has definitely started with a bang, not a whimper and it's all I can do to cling on for grim life while the G-forces rearrange my face into a more than passing resemblance to Mother Theresa during her famous Blue Period. Or perhaps I am getting her confused with Picasso.

Anyway, I find myself wishing that I had the power to defy gravity, just like T.S. Eliot's famous practical cat Macavity. Except that now I have that turgid song "Memories" running through my head and it's Sarah Brightman singing so this report has taken an unexpectedly grim turn before it has even started making any sense at all.

It must be time to get down to some post post-modern business. To the Bat Subheadings, Robin ...

Department of Veterans' Affairs

Although progress on our submission to have Remedial Massage recognised for rebates is very slow, the Assistant Director of Medical and Allied Health Policy, Kathryn Smith, has formulated her final recommendations. These have to go through several commissions before we can give you a definitive ruling but, at this stage, it seems likely that benefits for Remedial Massage will be available to Gold Card Holders.

I have maintained regular contact with Kathryn and she has indicated that she would like to finalise the DVA policy as soon as she has approval from the various commissions. She mentioned that the Department was satisfied that there were clear clinical benefits associated with Remedial Massage for the Veteran Community so it's heartening to know that we managed to use the available research effectively to strengthen our lobbying position.

This strategy is clearly the way forward for our push towards mainstream medical acceptance.

NSW Health Unregistered Health Practitioners Code of Conduct

The NSW Department of Health have released an Impact Assessment Statement relating to their draft Code of Conduct for Unregistered Health Practitioners. This Draft Code should be of interest to all AMT members nationally as it may form the basis of a very similar national code.

The release of this draft code is a fairly unequivocal signal that Government is not interested in Statutory Registration of the complementary health professions, including Massage Therapy. More effective and rigorous models of self-regulation seem to be the approach that various levels of government are supporting and promoting.

The case for Statutory Registration hinges on the capacity of any given profession to demonstrate a risk of serious harm to their patients/clients. This would seem to be a somewhat counter-productive case for us to argue and lobby for.

AMT has sent a submission to NSW Health in response to the release of the Impact Statement. We strongly encourage all members to read both the NSW Health Impact Statement and the AMT submission and ensure that you are across all the issues raised. Adoption of these Codes will have a profound impact on the regulatory environment in which we currently operate. As clinicians, we need to be prepared for the ramifications associated with adoption of these government-endorsed Codes.

The NSW Health document and AMT's submission are both available from the home page of the AMT website.

MBF

And so the saga continues ...

After 5 solid months of going in to bat on behalf of Advanced Diploma (Myotherapy) graduates, we have finally resolved our differences with MBF. We will sign a new provider agreement with them soon.

In the meantime, they have undertaken to clear the backlog of members that have not been added as providers since August 2007. All eligible AMT members will be backdated as having provider status from when they were first forwarded on our lists so your clients should have no problems getting their claims processed. If you continue to experience difficulties, please notify Head Office so we can act on your behalf.

MBF have asked us to remind Myotherapy graduates that they do not pay out benefits for Myotherapy. Rebates are only payable on Remedial Massage. AMT can only endorse you as providers of Remedial Massage so the Association would be in breach of the terms of our agreement with MBF if you were found to be writing receipts for Remedial Massage when you have been using advanced Myotherapy tools such as Dry Needling.

HBA (BUPA)

AMT members who have provider status with HBA (BUPA) would have received a letter from them in December last year entitled "BUPA Australia's Relationship with you - our Ancillary Provider Terms". This letter suggests that, when you treat a client who is a member of BUPA, you - as the treating practitioner - somehow enter into a direct contractual relationship with BUPA.

AMT's solicitor has advised that this attempt by BUPA to create a contractual relationship is improper and has no basis in law: a person cannot be bound to the terms of a contract unless there is a meeting of minds on the terms of the contract and the consideration passing under the contract.

As such, the letter from BUPA appears to be misleading and deceptive or likely to mislead and is, thus, in contravention of the Trade Practices Act (1974). We recommend that you tear up the accompanying Ancillary Provider Terms document.

AMT's Wiki

I am pleased to announce the launch of AMT's policy development Wiki. For those of you who are not familiar with the concept of a Wiki it is, in essence, a piece of software that allows a community of users to collaborate online in the development of specific kinds of content. Users can create and edit pages and track any changes that have been made to a working document. The most famous example of a Wiki is, of course, Wikipedia, which is an online encyclopaedia project.

The AMT Wiki is an experimental attempt to engender communal dialogue around the issue of policy development and designing a regulatory model that we can deliver to government as a *fait accompli*. We are trailing it as a vehicle to create a National Code of Conduct and a Code of Practice specifically for Massage Therapists. The Executive believes that this is an intrinsic and necessary step towards more effective lobbying and promotion of our profession to government, the medical profession and the general public.

You will find AMT's wiki at:

www.amt-ltd.org.au/wiki

Over time, we anticipate that the Wiki will become the repository of a series of working policy documents, with a broad range of educators and therapists contributing to the process. It is simultaneously a living document and a form of ongoing consultation.

We hope that all therapists with significant industry experience and a commitment to the advancement of our profession will get involved in developing the content of the Wiki.

Please take the time to visit the site and contribute to the development of critical policy documents or use the comments facility to voice your concerns or opinions on the documents as they evolve.

The future of our industry hinges on our commitment to fostering the research agenda and to enhancing our capacity to promote clear, coherent policy to government. A National Code of Conduct and Code of Practice will provide the underpinning framework on which to mount a strong case for recognition as professionals.

Get engaged and get on board now - this is, after all, the future of your profession we're talking about!

Annual General Meeting

Those of you who attended last year's AGM will be aware that AMT has changed financial year reporting from July to June to January to December. (This change was voted on by members who attended the AGM and those who sent in proxies.)

As a consequence of this shift, our Annual General Meeting will now take place sometime between March 1 and May 1 every year.

This year's AGM is scheduled for Sunday April 20 at Ryde-Eastwood Leagues Club. It will be held in conjunction with a Members' Day on 'Tension Headache' featuring a variety of presenters. Please come along and take part in the democratic process of your Association! For details, see the notice of meeting and registration form that came with this Journal.

If you do not wish to attend the members' day, we invite you just to join us for the AGM and a networking afternoon tea. You do not need to pay to attend the AGM but please RSVP so we can cover catering for the afternoon tea!

I look forward to delivering the good news on our financial position as part of my secretary's report! For now, I'm off to Tahiti ...

■ **amt**

MYSTERY OF THE AMT SPACESUIT REVEALED!

Those of you who have diligently attended the last 2 AGMs or assiduously read the proceedings of meetings (available in the AMT forum on our website) will be aware of a festering matter in relation to an amount of \$15,234.43 which was recorded as "Protective Clothing" in the AMT Statement of Financial Performance for the year ended 30 June 2005.

The question of what this amount was actually spent on became an enduring mystery for the incoming Board and attempts to investigate the matter led to various, frustrating dead ends. Given the not inconsiderable size of the sum, a legend arose around the idea that AMT was the proud owner of a spacesuit that was hidden away somewhere in our storage room ...

We sought an explanation from the Treasurer at the time, Geof Naughton, but did not receive a satisfactory response. Attempts to contact the accountant who prepared the financial statements foundered - we were told he had gone overseas and not left a forwarding address with anyone. Obviously, the more we investigated, the more suspicious and worrying the matter seemed.

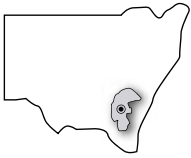
However, we're chuffed to announce that the mystery has finally been solved! In the same year as this amount was recorded for protective clothing, there were no expenses recorded against production of the AMT newsletter (a fact that seemed to suggest that there had been an error in transcription). We can now confirm that there was a simple human error involved in the entering of data into MYOB when the financial report was prepared.

So what exactly happened?

In short, MYOB operates on the basis of 3-letter abbreviations for various items that autofill into particular codes which have been preset within the programme. Within MYOB, the 3-letter abbreviation 'PRO' for protective clothing just happens to be very close to the 3-letter code 'PRI' for print/pack/post newsletter. So, as the data was being entered, the \$15,234.43 amount autofilled to the code number for protective clothing rather than the actual item it referred to which was expenses incurred in connection with the production of the newsletter.

Thus, in the 04/05 financial year it seems we didn't invest in a spacesuit for the NASA arm of AMT's key operations but at least members' received a copy of *In Good Hands!* The Executive are somewhat relieved but we sure as hell miss that spacesuit.

News from the regions



ACT by Ben Connelly

Welcome to 2008 - can you believe that it's March already? I hope that your New Year's resolutions include a generous amount of self-care.

This year, your Association will continue to promote the value of the work you do to Government, other health care professionals and the general public. Your active, positive support will certainly lighten that workload and tailor the results more closely to your needs.

If you have any ideas or issues you would like to discuss for the ACT region, you can call me on 0408 463 696 or email at takecaremassage@bigpond.com.

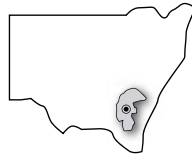
I look forward to working with you through 2008.



Northern Rivers by Keryn Rose

Welcome to the Year of the Rat. It's lucky that rats can swim because it has been a helluva wet summer for the region!

Having said that, it's going to be a heated year for education, kicking off with international presenter, Carol Phelan, who will be presenting workshops over two weekends in March at Kingscliff TAFE. Carol will be sharing with us her passion for finding ways out of past traumatic injuries utilising myofascial and visceral release techniques. I invite you all to take advantage of this great opportunity to see Carol in our own backyard!



Hunter by Elizabeth Matsen

We are fortunate in the Hunter to have a talented group of therapists to draw upon as guest speakers for our bi-monthly meetings. As a result of this deep talent pool, we regularly have 20 to 25 members in attendance at meetings.

In September, Anne Schubert spoke about the history and development of Bowen Therapy and demonstrated techniques used in this modality. Anne demonstrated a specific Bowen move on each member at the meeting so that everyone was able to directly experience the technique.

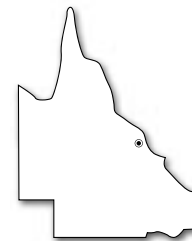
In November our scheduled guest speaker was unable to attend so I gave a "presentation without notice" on the history, development and current practice of Polarity Therapy and how it can be used within remedial practice.

In January, John Cassidy led a hands-on workshop on Positional Release for the lower body and unravelled the mysteries of Jones Points for us.

The next meeting, in March will include our region AGM. Many thanks go to the Hunter Branch committee for their work for the benefit of the branch members over the past year. I will not be continuing as regional secretary this year and wish the new committee all the best for the coming year.

Immediately following the AGM, Alan Ford will conduct his workshop "The Human Machine". This is a full-day workshop that will cover massage and stretching techniques to address specific postural misalignments, as well as strengthening exercises for weakened musculature.

Fare Well!



Mackay by Annie Caruana-Kirchner

We have some exciting guest speakers lined up this year.

The guest speaker for our first meeting of the year was Ana Kolhorst, a Craniosacral Therapist. We also have a Physiotherapist, a Chiropractor, Kinesiologist, Acupuncturist and a Tai Chi instructor lined up for future meetings.

We also have a new venue for our meetings - the Gordon White Library community meeting room at Mount Pleasant. I am really looking forward to seeing great attendances throughout the year. Local meetings are a great opportunity to network with other therapists and gain CEUs while having a cuppa and learning something new.

John Bragg will be presenting two workshops in Mackay this year too: *A Fascial Approach to Shoulder Problems and Neck and Headache Pain*. These will be held on May 17 and 18. For further details contact Allison Adamson on 07 4954 1341.

Thanks to those members who took time out of their busy Christmas schedules to attend the region AGM and Christmas party at Dolphin Heads. The following people were elected to the local committee.

Chairperson - Annie Caruana-Kirchner
Secretary - Claire Kemp
Treasurer - Joy Smith

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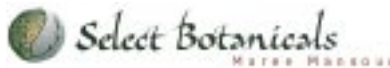
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Side-Effects of Massage Therapy: A Cross-Sectional Study of 100 Clients

Jerrilyn A. Cambron, L.M.T., D.C., M.P.H., Ph.D.,^{1,2}
Jennifer Dexheimer, L.M.T.,¹ Patricia Coe, D.C., C.M.T.²
and Randy Swenson, D.C., M.H.P.E.²

This article was originally published in The Journal of Alternative and Complementary Medicine. Thanks to the publisher, Mary Ann Liebert, and the author, Jerrilyn Cambron, for allowing us to reprint it.

ABSTRACT

Objective: The purpose of this study was to determine the amount and type of negative side-effects and positive (unexpected) effects experienced after a massage session.

Study design: Cross-sectional.

Setting: Massage clinic at a health sciences university.

Subjects: Of the 100 new and returning massage therapy clients who agreed to participate, 91 completed all survey questions.

Outcome measures: Telephone survey and medical chart review 2–7 days postmassage.

Results: Overall, 10% of the massage clients experienced some minor discomfort after the massage session; however, 23% experienced unexpected, nonmusculoskeletal positive side-effects. The majority of negative symptoms started less than 12 hours after the massage and lasted for 36 hours or less. The majority of positive benefits began immediately after massage and lasted more than 48 hours. No major side-effects occurred during this study.

Conclusions: This the first known study to define the rate of side-effects after massage therapy treatment. These data are important for risk–benefit analyses of massage care. Larger studies are needed to verify these data and to assess effects of different massage types and durations.

INTRODUCTION

Massage therapy is a popular form of complementary and alternative medicine (CAM), and use of this treatment continues to grow. Data comparing two random U.S. household telephone surveys in 1990 and 1997 demonstrated that the yearly prevalence of massage use increased from 6.9% to 11.1%.¹ More recent data estimated that, between August 2004 and July 2005, approximately 47 million American adults received a massage, 2 million more than in the previous year.² Currently, massage therapy is a \$6 to \$11 billion-a-year industry.³

Research in massage is also gaining in popularity, with 4 review articles being published in the past few years assessing massage and back pain,⁴ tension-type headache,⁵ mechanical neck disorders,⁶ and pain.⁷ However, each review paper stated that, while the evidence of massage benefits appears promising, more rigorous clinical trials are needed.

As the massage therapy industry continues to grow, one area that needs more attention is the potential for side-effects following massage care. A recent review paper focused on serious side-effects from massage, such as pulmonary embolism and strangulation.⁸ However, of the 16 case reports and 4 case series, the majority of adverse events were associated with “exotic types of manual massage or massage delivered by laymen, while massage therapists were rarely implicated.” The author concluded by saying the “incidence of adverse events is unknown, but probably low.”

The purpose of this cross-sectional study is to determine the amount and type of side-effects experienced after a massage session, and potential factors associated with such sideeffects. As an addition to the collection of negative side-effects, positive (unexpected) secondary effects were also collected for exploratory data. This initial study focuses on a small convenience sample of clients who were treated by student massage therapists.

METHODS

Subjects participating in this study were consecutive new and returning clients at a massage therapy clinic within a metropolitan CAM-integrated university. Each client was presented with an Institutional Review Board–approved informed consent form prior to their scheduled massage and met with a research assistant in a confidential setting to discuss any questions about the study. Nonparticipants were not discriminated against in any way. If the client did agree to participate, staff collected the informed consent and arranged a follow-up telephone call.

Each individual client underwent his or her usual and customary massage with the scheduled student massage therapist. The interns were not made aware of which clients were participating in this study. Two (2) to 3 days after the client’s massage, a research assistant called the client to ask a series of questions regarding his or her experience. If the client was not available at the time of the telephone call, the research assistant called daily for up to 1 week.

This study was funded by the National University of Health Sciences, Lombard, IL.

¹ Department of Research, National University of Health Sciences, Lombard, IL.

² College of Allied Health Sciences, National University of Health Sciences, Lombard, IL.

The telephone survey included demographic questions along with questions regarding side-effects. Negative side-effects were assessed by asking: "After the previous massage, did you experience any additional discomfort or any unpleasant reactions?" Any affirmative response led to follow-up questions regarding the type of negative side-effect, the level of discomfort, the timing of when the discomfort began and ended, and how much the discomfort affected the client's activities of daily living. Positive side-effects were assessed via the question: "Sometimes after treatment our clients report positive changes that were unexpected. An explanation for such positive changes is that the treatment of the muscular system affects the nervous system as a whole. Have you experienced any positive changes that do not seem to have anything to do with the reason you came to our clinic?" Questions regarding what type of positive side-effect and the timing of such followed each affirmative response.

If the client consented, the research assistant collected medical file information that included body areas treated during the visit, types of massage provided, and number of massage therapy visits in the past 3 months.

Information on client demographics and negative and positive side-effects were descriptively compiled. Chisquare analysis and t tests were completed to determine factors independently associated with side-effects. Factors independently associated with side-effects were included in multivariable logistic regression models using SAS 8.0 (SAS Institute Inc., Cary, NC) to determine the factors associated with presence of positive and negative side-effects.

RESULTS

Of the 142 clients asked, 100 agreed to participate and 91 completed all survey questions. The majority of subjects were female (71.4%), white (90.1%), currently or previously married (69.2%), and the average age was 46 (range 19–77).

Clinically, most subjects were returning clients (71.4%), had an average of 4 massages in the previous 3 months (range 1–31), and described their primary reason(s) for seeking massage as relaxation (56.0%), back pain (56.0%), and/or neck and shoulder pain (34.1%).

Types of massage and body areas treated during the massage visit can be seen in Table 1.

Table 1. Types and Areas of Treatment received by Massage Clients at a Teaching Clinic (N = 91)^a

Treatment type	n (%)
Swedish massage	90 (98.9%)
Deep tissue massage	13 (14.3%)
Trigger point therapy	11 (12.1%)
Other	7 (7.7%)
Treatment area	n (%)
Back	91 (100%)
Neck	85 (93.4%)
Lower extremity	79 (86.8%)
Upper extremity	78 (85.7%)
Head/face	52 (57.1%)

^aSome clients received >1 types of massage over >1 body areas.

No questions were asked regarding improvement in primary complaint or client satisfaction after the massage, as this was not part of the study's objectives.

Of the 91 subjects surveyed, 9 (9.9%) stated that they experienced one or more additional types of discomfort or unpleasant reactions to the massage. The most common complaint (Table 2) was increased discomfort or soreness (9.9%) at a discomfort level of 5 of 10 (range 3–7 of 10). The majority of clients stated that the discomfort did not affect their "normal activities at home and/or at work," and that the majority of symptoms started less than 12 hours after the massage and lasted for 36 hours or less. No major side-effects occurred during this study.

In terms of unexpected positive effects, 21 (23.1%) of the 91 subjects experienced 1 or more positive changes unrelated to their primary complaint.

The most common positive side-effects (Table 3) were nonmusculoskeletal including improvement in mood and emotional well-being (9.9%), digestive function (5.5%), and respiration (5.5%). The majority of positive benefits began immediately and lasted more than 48 hours. When asked how they would rate their benefit on a scale of 0 (no benefit) to 10 (extreme benefit), all subjects reported an 8.

Table 2. Number of Clients with Negative Side-effects after Massage Car (N = 91)^a

Negative side-effect	n (%)
Bruising	1 (1.1%)
Headache	1 (1.1%)
Tiredness/fatigue	1 (1.1%)
Increased discomfort/soreness	9 (9.9%)
Total number of effects	12
Total number of clients	9

^aSome clients noticed more than one negative side-effect.

Factors independently associated with a negative side-effect were being female ($p = 0.04$), having previously received massage therapy ($p = 0.01$), having a positive sideeffect after massage ($p = 0.0001$), having neck/shoulder pain as primary reason for massage ($p = 0.05$), not having the neck treated ($p = 0.049$), upper extremities treated ($p = 0.007$), and lower extremities treated ($p = 0.0038$). However, in a multivariable model that included all potential factors, only previous massage ($p = 0.002$), having a positive side-effect after massage ($p = 0.001$), and not having the lower extremity treated ($p = 0.03$) were significantly associated with a negative side-effect after treatment.

The only factors independently associated with positive side-effects were experiencing a negative side-effect ($p = 0.0001$) and not having the upper extremities treated ($p = 0.03$). In multivariable analysis, only experiencing a negative side-effect ($p = 0.001$) continued to be a significant variable associated with experiencing a positive side-effect.

No specific massage type (Swedish, deep tissue, etc.) was significantly associated with a negative or positive side-effect in independent or multivariable analyses.

DISCUSSION

In this first known study on the side-effects of massage care, we demonstrated that 10% of clients receiving massage care had a minor negative side-effect and 23% had unexpected positive effects. The importance of these data is fourfold. First, the decision to pursue any form of medical treatment should be based on the client's informed consent, with the information including a risk-benefit ratio. The data from this study can be used for such purposes prior to any client's acceptance of care. Second, the types of side-effects are important to document and disclose prior to treatment because a client may accept the risk of one form of negative side-effect (i.e., muscle soreness) but not another (i.e., nausea). Third, knowledge of potential side-effects may lead to preventative measures, particularly if specific associated client characteristics are identified. Finally, knowledge of common secondary positive effects may lead to better understanding of how massage affects the body as a whole and may lead to new discoveries of how massage may benefit clients.

As in any cross-sectional study, there are several limitations. First, there may be a selection bias because we used a convenience sample of volunteer clients. We did not track the clients who refused to complete the survey. Therefore, we were not able to compare the 51 subjects who did not agree to participate with those that did complete the survey. The percent of clients who experienced side-effects may differ between those who participated in this survey and those who did not. Second, this study included a relatively small sample size. Studies with a larger sample size are needed to determine whether these data are reproducible. Third, this was a cross-sectional study focusing on only one treatment session.

Future studies will focus on longitudinal assessment to determine presence of side-effects over a course of several treatments. Finally, this sample was drawn from a clinic in which students were the therapists. The clients who attend such a clinic may be different in some manner from other massage clients. Also, the massage provided by the student interns may be different from massage provided by experienced therapists. Future studies should focus on licensed massage therapists to determine whether these data are reproducible.

Exploration of side-effects within this study demonstrated that clients had more than twice as many unexpected positive effects than negative. Future studies are needed to determine whether these unexpected positive effects are due to the placebo effect or to somatovisceral reflexes related to massage therapy. Future studies are also needed to determine the consistency of the negative side-effects in larger and more diverse populations.

Table 3. Positive Side-effects (Unexpected Areas of Improvement) Noticed after Massage Care (N = 91)^a

Area affected	n (%)
Vision	1 (1.1%)
Immune response	1 (1.1%)
Sexual function	2 (2.2%)
Sensation	2 (2.2%)
Posture	2 (2.2%)
Circulatory function	3 (3.3%)
Respiratory function	5 (5.5%)
Digestive function	5 (5.5%)
Mood/well-being	9 (9.9%)
Total number of effects	30
Total number of clients	21

^a Some clients noticed more than one unexpected positive side-effect.

CONCLUSIONS

This is the first known study to define the rate of side-effects after massage therapy treatment.

Overall, 10% of the massage clients experienced some minor discomfort after the massage session; however, 23% experienced unexpected, nonmusculoskeletal positive side-effects. These data are important for risk-benefit analyses of massage care. Larger studies are needed to verify these data and to assess effects of different massage types and durations.

ACKNOWLEDGMENTS

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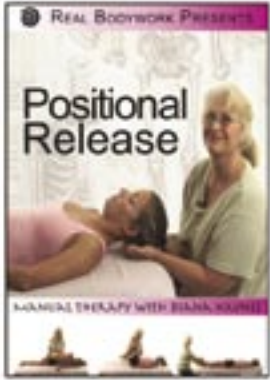
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DVD Review

By Tyraus Farrelly

POSITIONAL RELEASE



Supplier: Terra Rosa

Presenter: Diana Hayes

Format: DVD - All regions, PAL/NTSC

Duration: 2 Hours 56min

Price: \$69.00 (Discounts apply to AMT Members)

Contact: terrarosa@gmail.com

Producer: Real Bodywork

Website: www.terrarosa.com.au

Terra Rosa, one of AMT's preferred business partners, was kind enough to supply this DVD for review.

In keeping with other productions by Real Bodywork, this is a professionally produced DVD with very good audio and video quality.

Explanations of the various body structures being treated are often accompanied by anatomical slides and the presenter, Diana Haye, explains and demonstrates each technique in a clear concise manner.

Positional Release, also known as 'Orthobionomy', 'Strain Counter-Strain' and 'Neuromuscular Re-Education', is a treatment modality that uses the body's nervous system to remind the muscles to relax, according to the blurb on the back cover. It consists of finding the precise points which cause pain and dysfunction (these could be acupressure points, neuro-lymphatic points, Jones tender points, Myofascial Trigger Points or fibrotic contracted tissue) and monitoring each point as the muscle is placed in a position of support and relaxation.

The presenter of this DVD postulates that, by putting the muscles in a relaxed shortened position, the nervous system is reset and blood supply released. Diana suggests that the mechanism by which Positional Release works is that, after trauma, feedback from various proprioceptors becomes garbled and inaccurate, causing the central nervous system to "shut off" the "noise". When the muscle is placed in a relaxed, supported position it allows the malfunctioning proprioceptors to cease their activity thereby allowing the original trauma to resolve. It has been speculated that at least some of the therapeutic response to positional release is due to the enhancement of circulation and subsequent normalisation of oxygen and metabolic needs.

The indications for Positional Release are:

1. Postural distortion
2. Symptoms of pain or strain
3. Limited mobility or ROM
4. Dense, ropy or fibrotic tissue

Diana takes us through an introduction to Positional Release, followed by a brief history, then an explanation of how positional release works and its basic techniques.

The next section of the DVD is devoted to evaluation procedures. Both a standing postural evaluation (plumb-line evaluation) and a table evaluation are shown consisting of:

1. Shoulder
2. Upper ribs
3. Lower ribs
4. Hips
5. Knee
6. Ankle
7. Leg length

Chapter 3 explores a variety of positional release techniques for the neck, shoulders and arms, thoracic and lumbar spine, pelvis and legs. Basically positional release for the entire body!

The last chapter integrates everything that has been covered.

This is a 3-hour DVD packed with a huge number of positional release techniques that are easily integrated into any treatment routine and can be used in conjunction with a wide array of other bodywork modalities.

Although some of Diana's anatomical pronunciations are a little funny (the US twang perhaps?), she clearly knows her stuff!!

With the apparent proliferation of modality-based training within the physical therapy domain, it is sometimes a little hard to distinguish the good, from the bad and the downright ugly! Positional release is one of those modalities that hasn't gained the same mainstream acceptance as Myofascial Release or Trigger Point Therapy but does offer practising therapists a wide array of alternative techniques and a whole new modality of bodywork to explore.

Definitely worth the price of admission if you want to delve into the world of Positional Release.

At a glance:

- Excellent quality
- Good value for money
- 3 hours of information & techniques
- Covers positional release for the entire body
- Easily integrated into any practice
- Valuable training aid for any level AMT member

Overall Rating

★★★★★

Valuable resource, highly recommended!

Tyraus Farrelly is a senior level 2 AMT member. He completed the TAFE Associate Diploma of Health Science in 1995. He was the head Massage Therapist for the Illawarra Steelers and the St George Illawarra Dragons for 4 years and the head consultant Therapist for the Australian National Martial Arts team for the World Karate Championships. He has conducted post graduate workshops privately and for the Illawarra Steelers and delivered workshops on Massage for Pain Relief within a pain management course. He has worked with many Physiotherapists, Musculoskeletal Specialists, Chiropractors, Exercise Scientists and Sports Physicians within a rehabilitation environment and within an elite sports environment. He currently runs a full time clinic in Wollongong, with a focus on sports and occupational injuries. For comments or suggestions please contact Tyraus at tyraus@hotmail.com

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Survey of Musculoskeletal Injuries among Massage Therapists in Australia

By Budiman Minasny

INTRODUCTION

Prevalence of musculoskeletal injuries is of great interest among manual therapists. While Massage Therapists strive to ease pain caused by work-related injuries, we can also be extremely vulnerable to the very thing we are trying to relieve in others.

Due to the physical demands nature of the work, Massage Therapists may have a high prevalence to musculoskeletal injuries. Despite posture education and warnings on the use of thumbs in training institutions and textbooks (e.g. Riggs, 2007), anecdotal evidence suggests a high incidence of thumbs problem among Massage Therapists.

In a survey conducted in Canada with 502 respondents, Albert et al (2008) found a high prevalence of musculoskeletal pain reporting to all areas of the upper extremity. Despite the majority of the respondents indicating they had received proper training in therapy postures and self care, there is still a high prevalence of injuries. The highest reporting of pain and discomfort was in the wrist and thumb (83%), followed by the lower back (65%), and neck and shoulders (64%).

In a large survey conducted in the Australian Physiotherapy community (961 respondents), McMahon et al (2006) found that the prevalence of thumb problems in Australian physiotherapists is high, with a lifetime prevalence of thumb problems of 65% and current prevalence of 41%. Furthermore, from those who reported thumb problems, 19% had changed their area of practice and 4% had left the profession.

In a survey of 161 visually impaired massage practitioners in Taiwan, Jang et al (2006) found that that 71% had at least one musculoskeletal problem in 12 months, with a prevalence of 50% in the fingers or thumbs, followed by shoulder (32%), wrist (29%), neck (25%), arm or elbow (24%), forearm (20%), and back (19%).

In another study conducted in Canada, Buck et al (2007) investigated the postural and low back demands of performing a standard 45-minute massage and reported that the percentage of time spent in non-neutral wrist, shoulder and trunk postures was placing therapists at risk of soft tissue injury. The authors also found that chair massage required more muscular activity of the upper extremity and non-neutral postures of the wrist and shoulders. Table massage placed greater demands on the trunk posture and musculature with similar non-neutral postures of the wrist. The authors reported that therapists adopted compromised trunk and wrist postures that would increase the risk of upper extremity injury while using either the massage chair or table.

Following these reports, we conducted a survey to evaluate the prevalence of musculoskeletal injuries amongst Massage Therapists in Australia. This preliminary study could serve as a baseline for quantifying the prevalence of musculoskeletal injuring among therapists. It may also serve as a sobering warning.

THE SURVEY

The survey was conducted on the internet during August through December 2007. An invitation to participate in the survey was sent out by email to around 300 Massage Therapists every month from August to October 2007.

Furthermore, an ad was placed in the Massage Association of Australia (MAA) newsletter in September and December 2007, courtesy of Jenny Millar of MAA.

The format of the survey follows that of Alberts et al (2008). The survey contains 4 parts: demography; education in posture and self-care; injuries due to work; and treatment to injuries. A descriptive analysis was used to find out the incidence of work related injuries (pain / discomfort) on: lower back, shoulder, neck, and wrist/thumb experienced by massage therapists.

SURVEY RESULTS

Only 64 therapists responded to the online survey. While this is a low number of respondents, I believe this preliminary study is a statistically valid indicator of the prevalence of injuries in Australian Massage Therapists.

Although the main objective if this survey is to establish the incidence of injuries due to work, the demographic data also provides an interesting snapshot of the Australian Massage Therapist population and work behaviour.

The results of the survey are summarised in Table 1 (demography), Table 2 (education in posture and self care), 3 (injuries / pain encountered by therapists), and 4 (treatment of pain/ discomfort).

DEMOGRAPHY

As shown in Table 1, the participants were mostly female (79%) with a range of age groups. Most striking is that half the respondents are greater than 40 years old. However, half of the participants had only worked in the industry between 3 to 5 years suggesting that most therapists choose a career in massage later in their life, after having other careers previously. Only 13% of the respondents had worked more than 10 years in the industry. Most therapists worked only 10-20 hours per week.

Population wise, most were from New South Wales, followed by Queensland and Victoria. Most participants worked in the area of 'Remedial Massage'.

Table 1. Demography of 64 survey participants

Age Group	
Less than 30 years	17%
31 - 40 years	33%
41 - 50 years	27%
Greater than 50 years	23%
Sex	
Female	79%
Male	21%
State/Territory	
NSW	31%
Queensland	25%
Victoria	19%
Western Australia	11%
South Australia	6%
ACT	3%
Northern Territory	3%
Tasmania	1%
Years worked as Massage Therapist or Bodyworkers	
0 - 2 years	20%
3 - 5 years	50%
5 - 10 years	17%
11 - 20 years	8%
Greater than 20 years	5%
Hours per week performing treatments	
Less than 10 hours	20%
10 - 20 hours	61%
21 - 30 hours	16%
Greater than 30 hours	3%
Modality	
Remedial massage	42%
Deep tissue, trigger points	24%
Swedish, relaxation	14%
Acupressure, Shiatsu, Reflexology	11%
Myofascial release, Rolfing	6%
Bowen therapy, Lymphatic drainage	3%

EDUCATION IN POSTURE AND SELF CARE

Most participants are educated in self care or maintenance of their physical being (77%) and also in proper posture for conducting massage (70%). 91% are currently involved in self care, primarily in the form of stretching, exercise, and massage.

Table 2. Education in posture & Self Care among survey participants

Educated on Self-Care/Maintenance	
Yes	77%
No	23%
Received formal training in proper posture for massage	
Yes	70%
No	30%
Currently involved in Self-care/Maintenance	
Yes	91%
No	9%
Current Self-care	
Stretching	38%
Exercise	17%
Massage Therapy	17%
Yoga	13%
Pilates	6%
Tai Chi or Qi Gong	2%
Meditation	3%
Other	6%
Hours per week performing treatments	
Less than 10 hours	20%
10 - 20 hours	61%
21 - 30 hours	16%
Greater than 30 hours	3%
Using massage aids to prevent injury	
Yes	26%
No	74%

MUSCULOSKELETAL INJURIES/ PAIN DUE TO WORKING AS MASSAGE THERAPISTS

Table 3 summarises the current status of injuries, pain or discomfort experienced by Massage Therapists. About 22% of therapists experienced pain in the lower back and shoulder daily to often (once a week). This is followed in prevalence by neck pain (28%).

Around 20% of therapists found that pain in the back, neck and shoulder has reduced their work. The highest injuries were to wrist and thumbs with 12% experiencing this daily and 31% weekly. 42% reported that the wrist/thumb pain had reduced their work.

If we consider daily to weekly pain as a serious problem, the prevalence to wrist and thumb is 43%, and if we include 'sometimes' frequency as a chronic problem, the prevalence is 69%. This percentage is smaller in comparison with the results from the Canadian research where 83% reported pain on the wrist and thumb, 66% on the neck, 65% on lower back and 62% on shoulder.

cont. next page

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Table 3. Injuries, pain or discomfort due to bodywork among participants

	Lower Back Pain	Neck	Shoulder	Wrist & Thumb
Pain/discomfort during or after work				
Daily	6%	14%	12%	12%
Often (at least once a week)	16%	14%	11%	31%
Sometimes	4%	31%	31%	26%
Rarely	3%	28%	23%	19%
Never	9%	12%	22%	11%
Has the pain reduced your work? (Y/N)				
Yes	17%	17%	20%	42%
No	83%	83%	80%	58%
Prevalence				
Serious (Daily – Often)	22%	28%	23%	43%
Chronic (Daily, Often, Sometimes)	26%	59%	54%	69%
Other Injuries				
Yes	16%			
No	84%			

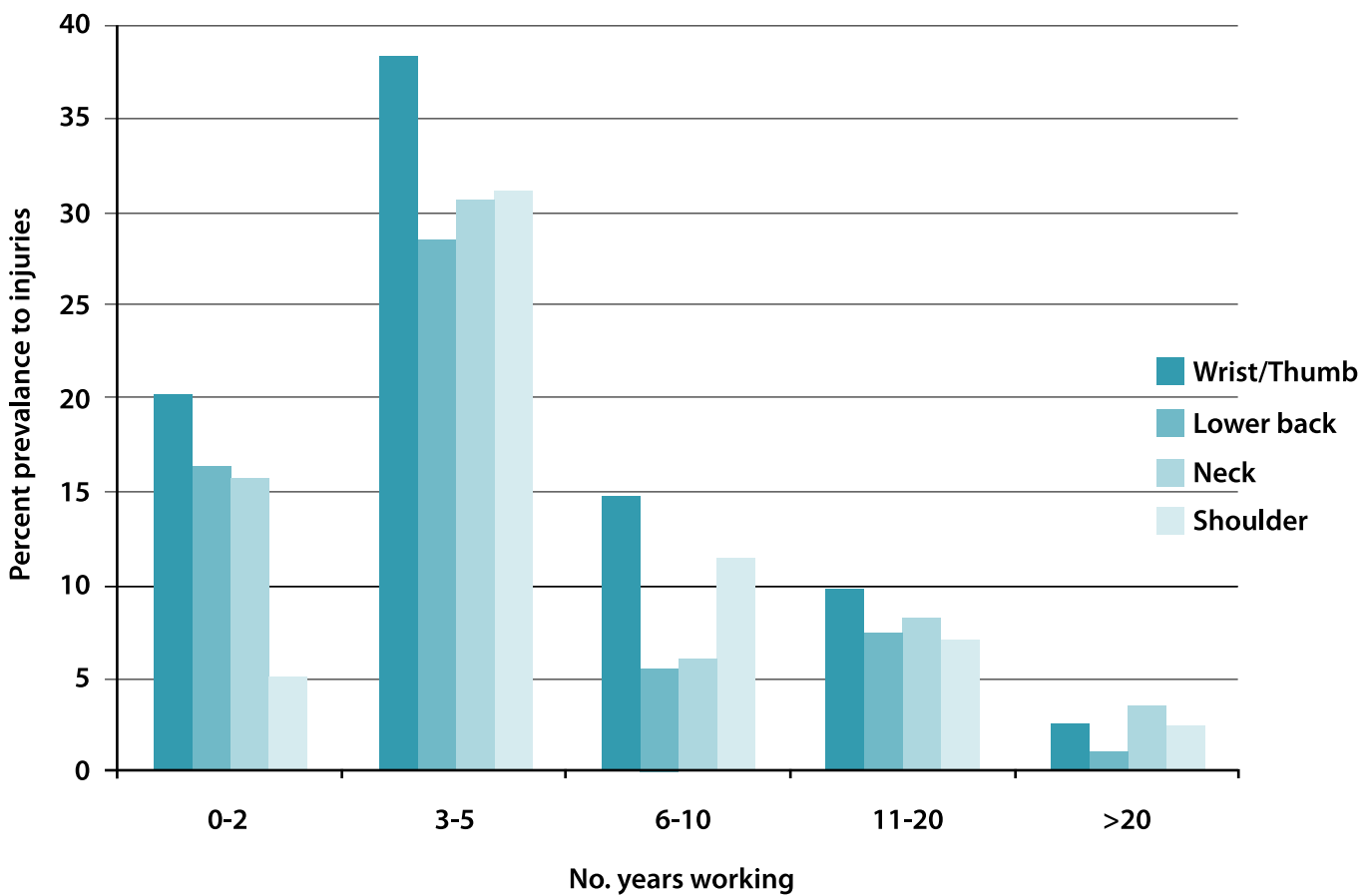


Figure 1 above shows the distribution of prevalence to injuries grouped as number of years working in the field. Most reported injuries are in the group of 3 to 5 years working in the industry

TREATMENT FOR INJURY AND PAIN

34% of respondents seek medical treatment for their pain and 59% use alternative therapies as treatment. Massage Therapy and other forms of bodywork are the most popular form, followed by acupuncture and Osteopathy, Chiropractic and Physiotherapy.

Table 4. Treatment for injury/pain due to bodywork

Seek for medical treatment for your injury or pain due to bodywork	
Yes	34%
No	66%
Seek for alternative medicine treatment	
Yes	59%
No	41%
Alternative treatment	
Massage Therapy and other bodywork	56%
Acupuncture/TCM	31%
Chiro/Osteopathy/Physio	18%
Energy therapy	8%
Yoga/Pilates	5%
Enar Therapy	5%

CONCLUSIONS

There appears to be a high prevalence of musculoskeletal injuries among Australian Massage Therapists. Although the number of respondents is small (64) I believe it is still a statistically significant sample. Seventy percent of respondents have received training regarding posture and self-care, and 90% are currently involved in self-care. Despite this, there is a high prevalence of reported pain in the wrist and thumb (69%), neck (59%), shoulder (54%) and lower back (26%). The most troublesome reported pain is in the wrist and thumb with 42% indicating daily to weekly pain that affects their work.

The problem of thumb and wrist injuries among Massage Therapists appears to be universal, as observed in Canada (Albert et al., 2008), USA (Greene, 2005) and Taiwan (Jang et al., 2006). Although the incidence of wrist/thumb pain is lower in Australia than in Canada according to this survey data, it is on par with the figures reported for Australian physiotherapists (65%).

This work does not infer any mechanism or source of pain/injuries, but merely reports on the current status experienced by therapists. Although many books and manuals, have stressed the importance of posture and body mechanics (for example Riggs, 2007), injuries due to compromised posture and overuse of thumbs are still problematic. Many therapists are accustomed to using thumbs to perform massage.

This report should serve as a reminder for therapists on the importance of good posture, technique and avoiding extensive use of the thumbs. Readers who would like to participate in the ongoing survey are invited to do at: <http://www.terrerosa.com.au/poll/index.htm>. More participants will definitely give a clearer picture of the overall status of work-related injuries among Massage Therapists.

ACKNOWLEDGEMENTS

We wish to thank all the survey participants for their time. Thanks to Jenny Millar from MAA for publicizing the survey in the MAA newsletter.

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DEADLINE

Deadline for the June 2008 issue of In Good Hands is: 1ST MAY, 2008

Please email contributions to: **Rebecca Barnett** newsletter@amt-ltd.org.au or phone: 02 9517 9925

AMT NEW MEMBERS

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The Ankle and Foot

By Ron Saleh

Introduction

The foot and ankle consist of a complex bony composition enveloped by static and dynamic soft tissue that amasses to 28 bones, 55 articulations and 34 joints. The result is a unique design consisting of the upper functional and lower functional units. These two units work in synchrony to serve two vital functions: to support the weight of the body in standing and walking, and to act as a lever in propelling the body forward during locomotion¹. The foot is also subject to the forces of ground contact with every step, cushioning the body on landing and launching the frame forward immediately thereafter. This seemingly simple manoeuvre is accomplished through a series of complex biomechanical motions within the foot. These motions are collectively called the 'stance phase' of the joint cycle. Stance presents the greatest risk to musculoskeletal integrity because the foot is subjected to dual forces: the ground shock of strike and the vertical stress of weight from above. The issue of weight bearing problems arises because of the body's orderly response to ground. Contact and locomotion can be disrupted by alterations on foot biomechanics. The client may not experience pain in the feet, but rather complain of discomfort in the knees or back and exhibit poor posture².

Anatomy of the ankle

The ankle joint consists of three bones: the tibia, fibula and talus. The ankle joint is a synovial articulation bounded medially by the malleolus at the distal end of the tibia, superiorly by the flat surface of the tibial plafond, and laterally by the malleolus of the distal end of the fibula, and the inferior transverse tibiofibular ligaments. Together, they form a deep recess in which the body of the talus is embraced. The talus consists of mostly articular surfaces and has no muscular or tendinous attachments. Its dome articulates with the fibula and tibia.

It is wider anteriorly than it is posteriorly. This saddle-shaped dome gives the ankle its stability both in flexion and extension (plantar and dorsiflexion), with only a modest amount of anterior-posterior glide.³

Unlike other large synovial articulations, the ankle is immune to the observed degenerative changes of aging. This may be due to the extreme degree of stability and the ankle's requirement of limited freedom. Also, the ankle is complemented by a complex accessory of articulations that accommodates to the severe stresses of daily activities and changes in ground surfaces. The most important articulation of these is the subtalar articulation that aids the ankle to achieve its function, being the transmission of all weight bearing forces between the body and the foot.⁴

Anatomy of the foot

The foot has 26 bones distributed among three sections: the hindfoot, the midfoot and the forefoot. Each section is in turn composed of multiple mobile and semi-rigid articulations that afford foot conformity to varying surface topographies.

The hindfoot represents one third of the total length of the foot. It comprises the two largest bones of the foot: the calcaneus and the talus. The talus is the only bony link between the leg and the foot. It articulates with the tibia in the middle of the hindfoot.

The midfoot represents slightly more than one sixth of the overall length of the foot. It contains the navicular, cuneiform and cuboid bones. Little movement occurs within the midfoot articulation.

The forefoot represents the remaining one half of the overall length of the foot. It is composed of miniature long bones, five metatarsals and fourteen phalanges.

In addition, a number of joints are associated with each of the regions in the foot and give the foot the ability to perform its varied functions. These joints act in concert to make the foot either a flexible adaptor to the activity surface or a rigid structure for propulsion³.

Biomechanics of the foot and ankle

The foot/ankle structure is a complex biomechanical unit. The foot acts as the interface between the rest of the body and the ground. It is specialised for support and bipedal locomotion. This anatomic structure is remarkable in that it must adapt to many types of surfaces while sustaining great weight bearing stress.

The best approach to understand the biomechanics behind this complex structure is to break it down into individual sections and study how each in turn contributes to the whole function of the foot/ankle structure.

Ankle joint

The ankle joint is a composite joint of a syndesmosis between the distal tibia and fibula (distal tibiofibular joint), and a diarthrodial mortise between the distal malleolus of the tibia, fibula and the talus.

The axes of movement are along a line just distal to the palpated tips of the medial and lateral malleoli.



Picture 1: Ankle Mortise, a uniplanar hinge joint. Foot⁵

From a functional viewpoint, the joint allows motion in one plane about a single, stationary axis. Dorsiflexion and plantarflexion are the principal components and subsequently account for most of the motion occurring at the ankle joint. Although the average axis of motion for this joint lies approximately 8 degrees to the transverse plane and 20-30 degrees to the frontal plane, numerous investigators have demonstrated that the irregularly curved contour of the medial talus allows for constant repositioning of the axis as the ankle is moved. Wyller likens the shift of the ankle axis to the rotation of a badly mounted wheel. The normal range of motion (ROM) for plantar and dorsiflexion is 20 and 10 degrees respectively.⁶

Maximal ankle joint ROM has not been identified as one fixed value. Morris reported that ROM is 70 degrees, whereas Sammarco et. al. reported a value of 40 degrees. Different ROM values can be explained due to error created by movement of the tarsal bones.

The fibula plays both a kinetic and kinematic role in ankle joint function. The fibula transmits one-sixth of the weight-bearing force in each leg to the ankle joint, beginning at the proximal tibiofibular joint and extending distally at its point of application on the lateral articulating surface of the talus.⁴

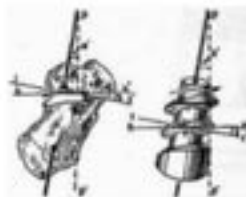
Subtalar joint

The subtalar joint contains the distal talar articulations between the inferior talus and superior aspect of the calcaneus. Subtalar joint function is generally believed to be a rotational motion about a single axis functioning as an oblique hinge. Orientation of the subtalar joint axis shows a mean medial deviation of 23 degrees from the longitudinal reference of the foot when viewed superiorly, a view reported by Inman and Inman. In another study done by Manter, a value of 16 degrees was reported.⁷ These wide ranges illustrate the different alignments that are possible between individuals.

These variations can alter the manner in which the subtalar joint functions, both in terms of the actual motion produced and the ability of the subtalar joint to transmit transverse plane rotation of the lower limb into the foot. Motion about the subtalar joint axis consists of the triplanar motions of pronation and supination. The principal movements of pronation in the weight bearing position are plantarflexion and adduction of the talus combined with frontal plane eversion of the calcaneus. Weight bearing supination incorporates the opposite motions of talar dorsiflexion and abduction with calcaneal inversion.⁷

Noting that subtalar joint function includes motion of the calcaneus in the frontal plane, mobility of this joint can be assessed by the degree of calcaneal inversion (being 20 degrees during supination) and eversion (being 10 degrees with pronation), and it has been modeled as 'screw-like' in nature.⁵

Analogy between (A) right-handed subtalar joint function and (B) a right-handed screw. The helix of the screw, s , is equal to the angle between the plane of the posterior calcaneal facet, bp' , and perpendicular to the subtalar joint axis, cc' . the helix angle, s , equals the angles', which is derived by dropping a perpendicular from the subtalar joint axis to the plane bp' .



Picture 2: Screw-like Analogy. Foot⁷

Midtarsal joint

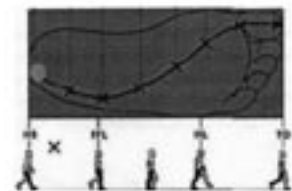
Themidtarsal joint consists of the calcaneocuboid joint and the talonavicular joint. The two joints divide the hindfoot from the midfoot.⁴ Themidtarsal moves because of the movement of only the tarsal and calcaneus on the navicular and the cuboid bones, since the cuboid is fixed during weight bearing. There are two independent axes around which themidtarsal joint moves: a longitudinal axis that is slightly inclined upward and medially, and an oblique axis that is almost parallel to that of the talocalcaneonavicular joint.

Both axes provide pronation and supination actions. The degree of ROM at themidtarsal joint is dependant on the position of the subtalar joint because these two joints are interrelated. ROM around the oblique axis is reported to be 22 degrees, whereas that around the longitudinal axis is around 4 to 6 degrees.⁷

Metatarsals and MTP joints

The metatarsals are composed of five bones: the first three each articulate with a cuneiform bone, the fourth and the fifth articulate with the cuboid.⁷ The axes of the first and fifth metatarsal are oblique. The axis of the first metatarsal allows dorsiflexion accompanied by inversion and abduction, and plantarflexion accompanied by eversion and abduction. On the other hand, the fifth metatarsal axis has the opposite arrangement. The second and fourth metatarsal axes are not as oblique as the first and fifth. Meanwhile, the third metatarsal axis allows the predominant motion of plantarflexion/dorsiflexion.⁴ MTP joints consist of the distal end of the five metatarsals. They have a wide range of motion depending on whether the motions occur in a weight or non-weight bearing activities. They allow the bending of the foot so the heel can be lifted off the ground.

It should be noted that during load transmission in the foot all the metatarsal heads are in contact with the ground during stance. Fifty percent of the load is borne by the metatarsal heads and 50% by the heel. The load on the first metatarsal head is twice that on each of the metatarsal heads.^{4,5}

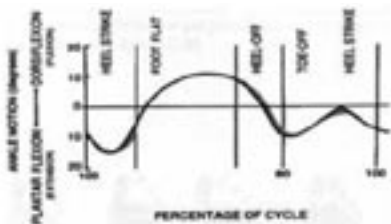


Picture 3: Load Transmission in the Foot⁵

As the foot progresses to toe-off, the load is transmitted mainly through the second metatarsal head, which is longer than the others. The biomechanical significance of the metatarsal structures being of different lengths is the formation of two functional axes. Each axis will allow the muscles and ground reaction forces to operate during the propulsive phase of gait.⁴

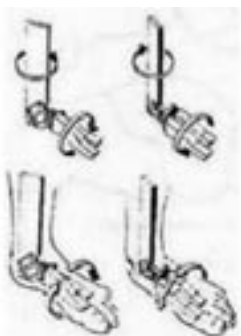
The Gait Cycle

The average free walking gait cycle is composed of two phases: stance, which constitutes approximately 60 to 62 percent and swing, which constitutes approximately 38 to 40 percent of the entire cycle. The stance phase includes heel strike, foot flat (occurring at 15%), and heel rise (at 30%), terminating at toe-off. As for the swing phase, it is partitioned into acceleration, toe clearance, and deceleration phases. The walking cycle has two double limb support events, at the initial 12% and final 15% of stance phase. The gait cycle varies according to the type of motion, for example with running; the stance cycle diminishes down to 33% of the whole cycle. The kinetics of the lower extremity in gait is a complex sequence of events involving the hip, knee, ankle and the joints within the feet.⁴



Graph 1: The Gait Cycle. Foot⁵

Beginning at heel strike, foot pronation occurs in conjunction with hip extension, knee flexion, and ankle dorsiflexion to absorb forces in the order of 2 to 3 times body weight while running. The lower extremity rotates passively internally in conjunction with hindfoot pronation, and the transverse tarsal joint axes align to unlock the midtarsal joints to further absorb the initial shock. Later in the stance phase, when the centre of gravity moves forward over the foot, external rotation of the stance limb is associated with inversion of the subtalar joint.



Picture 4: Gait and Foot Motion. Foot⁵

This serves to create a stable and rigid tarsal construct in preparation for toe-off. The mechanism of walking involves a start with the foot ahead of the body where it tends to slow the body down, and then it passes under the body and to the rear, where it tends to speed the body up again.^{4,5}

Biomechanical disturbances

The normal posture of the foot may be determined by taking a footprint. In the healthy foot, pes rectus (A) the print should show impressions of 5 digits, and anterior and posterior parts of the sole in the strip joining them. The main load on the healthy foot (E) lies medially on the calcaneus in (1) and the head of the first metatarsal (2). In an unhealthy foot, the print shows either flattened impressions (flatfoot or pes planus, B), or a two parts footprint (pes cavus, C), or a medially bulged footprint (pes valgus, D).⁸



Picture 5: Foot Pathologies. Foot⁸

One of the most common causes of biomechanical disturbance is excessive pronation, which occurs when contact accounts for more than 27% of the stance cycle. The calcaneus continues to tilt inward, and the longitudinal arch remains relaxed and flattened. Soft tissues strain to achieve stability and, over time, may become permanently weakened by plastic deformation. Joints cannot lock to form a rigid lever, so propulsive force is reduced. Pronation and supination are essential elements in the gait cycle, and when they are performed properly they result in minimal energy expenditure by the individual. When there are imbalances in these motions, they can cause a variety of injuries.

Excessive pronation has been implicated in a range of musculoskeletal complaints. Overpronators typically get heel pain, shin splints, stress fractures, bunions, and medial and lateral knee pain. However, oversupination is a rare type of foot strike, but it does take place. Plantar Fasciitis and ankle sprains are common problems related to supination.^{2,4}

It can therefore be seen that the foot and ankle must function perfectly in the human body to allow appropriate locomotion. The foot and ankle is subject to hundreds of varying biomechanical forces. These include body weight and gravitational forces during both locomotion and upright posture, and surface reactions due to alterations in topography. The impact forces felt by the foot are also greatly affected by varying footwear, and also the absence of protection on the foot during locomotion. As the foot sustains these large forces, it is also making the final adjustment to the ground and must compensate for motions or deviations at the knee or hip to keep the centre of gravity within the small base of support. A deep understanding of this unit's functionality and impairments is required for adequate maintenance, treatment and rehabilitation.

References:

1. Eugene Sherry, Disorders of the foot and Ankle in Adults, http://216.239.39.100/search?q=cache:dntB_zRDS5EC:www.worldortho.com/database/etext/ankfoot.html+disorders+of+the+foot+and+ankle+in+adults&hl=en&ie=UTF-8
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3. Gross J., Fetto J., Rosen E., 1996, Musculoskeletal Examination, Blackwell Science, USA
4. Sammarco G.J., 1995, Rehabilitation of the Foot and Ankle, Mosby-Year Book, Inc, St. Louis, Missouri
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6. Structural and Functional Anatomy of the Foot and Ankle, week 13 Handout.
7. Hunt G.C., McPoil T.G., 1995, Physical Therapy of the Foot and Ankle, 2nd edition, Churchill Livingstone Inc, USA
8. Platzer W., 1992, Locomotor System, 4th edition, Germany Thieme Medical Publishers, Inc, New York

Health Fund Status

HEALTH FUNDS AND SOCIETIES

CRITERIA

Commonwealth Bank Health Society
Manchester Unity

These funds recognise all AMT practitioner levels.

ACA Health Benefits Fund (ARHG)
Australian Regional Health Group
Cessnock & District Health Benefits Fund (ARHG)
CrediCare (Credit Union Australia) (ARHG)
Defence Health (ARHG)
Federation Health (ARHG)
GMHBA (ARHG)
Health Insurance Fund of WA (ARHG)
Health Partners (ARHG)
HIF (ARHG)
Latrobe Health Services (ARHG)
Lysaght Peoplecare (ARHG)
Mildura District Hospital Fund (ARHG)
Navy Health (ARHG)
NSW Teachers Federation Health Society (ARHG)
Phoenix Health Fund (ARHG)
Police Health (ARHG)
Queensland Country Health (ARHG)
Railway and Transport Hospital Fund (ARHG)
Reserve Bank Health Society (ARHG)
St Luke's Medical & Hospital Benefits (ARHG)
Teachers Union Health (ARHG)
Transport Health (ARHG)
United Ancient Order of Druids (ARHG)
Westfund Health Fund (ARHG)

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 Health Management Group
Australian Unity
Geelong Medical Benefits Fund
Government Employees Health Fund (AHMG)
Grand United Friendly Society
HCF
National Mutual Health Fund
NIB
Super Health Plan
Victorian WorkCover Authority

These funds recognise Senior Level One, Two or Three members. HCF require new providers to fax your name, practice address and association name to 02 9279 3549.

MBF
NRMA

These funds recognise members with the HLT 50302 Diploma of Remedial Massage. You must send a signed consent form to AMT. Existing Senior Level One, Two and Three providers remain eligible.

Medibank Private
HBF

Medibank Private recognises Senior Level One, Two and Three members. They require you to apply directly to them. You will need to send them a certified copy of your membership certificate and fill out their application form which can be downloaded from the AMT website.

HBF requires you to apply directly. To register call 08 9265 6125.

ANZ Health Insurance (HBA)
Cardmember Health Insurance Plan (HBA)
Gay & Lesbian Health Fund (HBA)
HBA (formerly AXA)
HealthCover Direct (HBA)
Mutual Community (HBA)

HBA require a nationally-recognised, diploma level qualification from a Registered Training Organisation. Existing Senior Level One, Two and Three HBA providers remain eligible.

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. If you are up-to-date with these, there is no need to apply individually to each health fund: your name will be forwarded for automatic endorsement as a provider.

However, you will need to apply directly to Medibank Private and HBF. Medibank registration forms are available for download in the Health Fund section of our website. To register with HBF call 08 9265 6125.

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-ltd.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)

March 2008		CEUs
8-9	Replay of the Fascia Research Congress. Richmond (Greater Sydney). Ph: 02 9517 9925	70
8-9	Muscle Energy Technique. Presented by Paula Nutting. Melbourne. Ph: 03 9481 6724	70
12	Massage for People living with Cancer. Presented by Gayle McDonald. Sydney. Ph: 02 9334 1863	15
13-17	Neurostructural Integration. Presented by Ron Phelan. Launceston. Ph: 0419 380 443	175
14-15	Dorn Spinal Therapy. Presented by Barbara Simon. Perth. Ph: 02 9918 8057	70
15-16	Northern Rivers Branch Workshop. Presented by Carol Phelan. Kingscliff. Ph: 02 9517 9925	70
15-16	Eastern Cupping. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	70
16	The Human Machine. Presented by Alan Ford. Adamstown. Ph: 02 4969 5880	35
25	Illawarra Branch Meeting. Corrimal Community Centre. Ph: 0403 021 627 or 02 4283 8942	15
29-30	Orthobionomy Phase 4 Fundamental. Presented by Anthony Swan. Canberra. Ph: 0412 286 385	70
29-30	Northern Rivers Branch Workshop. Presented by Carol Phelan. Kingscliff. Ph: 02 9517 9925	70
29-30	Eastern Cupping. Presented by Bruce Bentley. Brisbane. Ph: 07 3846 1988	70
30	Business Workshop. Presented by David Sheehan. Melbourne Ph: 03 9481 6724	35
31	Aromatic Medicine for Massage Therapists. Presented by Ron Guba. Melbourne. Ph: 03 9481 6724	15
April		CEUs
2	South Sydney Branch Meeting. Presented by Linda Taylor. Hurstville Library. Ph: 0410 604 510	15
5-6	Manual Lymphatic Drainage. Presented by Michelle Yaffe. Melbourne. Ph: 03 9481 6724	70
5-6	Posture and Structural Master Series 1. Presented by Alan Ford. Canberra. Ph: 02 6232 6883	70
5-6	Eastern Cupping. Presented by Bruce Bentley. Canberra. Ph: 03 9576 1787	70
12-13	Glide Cupping. Presented by David Sheehan. Melbourne. Ph: 03 9481 6724	70
12-13	Traditional Thai Massage. Presented by Bruce Bentley. Canberra. Ph: 03 9576 1787	70
19-20	Trigger Point Workshop. Presented by Stuart Hinds. Melbourne. Ph: 03 9481 6724	70
19-20	Manual Lymphatic Drainage. Presented by Michelle Yaffe. Brisbane Ph: 03 9481 6724	70
19-20	Orthobionomy Phase 4 Fundamental. Presented by Anthony Swan. Hervey Bay Ph: 0429 179 162	70
19	Mid North Coast Branch Meeting. Port Macquarie. Ph: 02 6584 6661	15
19-20	Western Cupping. Presented by Bruce Bentley. Launceston. Ph: 03 9576 1787	70
20	AGM and Tension Headache Day. Sydney. Ph: 02 9517 9925	40
26-27	Western Cupping. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	70
29	Illawarra Branch Meeting. Corrimal Community Centre. Ph: 0403 021 627 or 02 4283 8942	15
May		CEUs
2-4	Onsen Technique® Volume 1. (Thoraco-lumbar, sacrum and pelvic region). Presented by Jeff Murray. Sydney. Contact: 07 5599 2514	105
3-4	Dorn Spinal Therapy. Presented by Barbara Simon. Melbourne. Ph: 02 9918 8057	70
10-11	Dorn Spinal Therapy. Presented by Barbara Simon. Gold Coast. Ph: 02 9918 8057	70
10-11	EasternCupping. Presented by Bruce Bentley. Sydney Ph: 03 9576 1787	70
12	Gua Sha Day. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	35
15	Mackay Branch Meeting. Mt Pleasant. Ph: 07 4942 8481	15
16-17	Dorn Spinal Therapy. Presented by Barbara Simon. Sydney. Ph: 02 9918 8057	70
16-18	AAMT 4th Annual Conference. Adelaide. Ph: 1300 138 872	70
17-21	Akupunkt-Massage according to Penzel (Course A). Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
17	A Fascial Approach to Shoulder Problems. Presented by John Bragg. Mackay. Ph: 0438 773 333	35
17-18	Corporate Seated Massage. Presented by Ron Saleh. Sydney. Ph: 0416 086 426	70
18	Neck and Headache Pain. Presented by John Bragg. Mackay. Ph: 0438 773 333	35
24-25	Chi Acupressure Workshop. Presented by Master Zhang Hao. Sydney. Ph: 02 9899 9823	70
24-25	Muscle Energy Technique. Presented by Paula Nutting. Melbourne. Ph: 03 9481 6724	70
24-25	Glide Cupping. Presented by David Sheehan. Brisbane. Ph: 03 9481 6724	70
24-25	Western Cupping. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	70
27	Illawarra Branch Meeting. Corrimal Community Centre Ph: 0403 021 627 or 02 4283 8942	15
30, 31 May- 1 June	Onsen Technique® Volume1. (Thoraco-lumbar, sacrum and pelvic region). Presented by Jeff Murray. Tweed Heads. Contact: 07 5599 2514	105
31 May -1 June	The Rolfing Touch - Myofascial Approaches. Presented by Michael Stanborough. Sydney. Ph: 02 9522 6770	85

Please view the Calendar of Events on the AMT website for the complete 2008 listing: www.amt-ltd.org.au

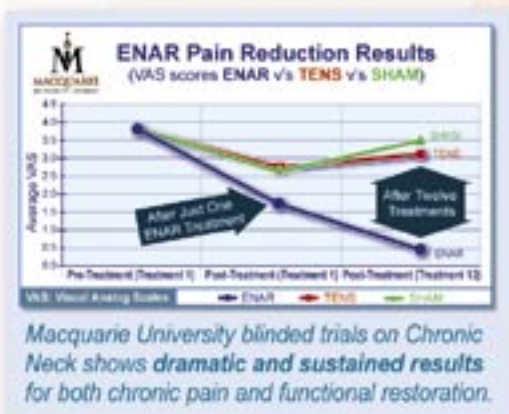
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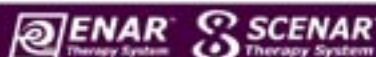
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AMT Members' Day and Annual General Meeting

ABN 32 001 859 285

WHEN: Sunday, 20 April 2008	REWARD: 40 CEUs for attendance (workshop and AGM)
TIME: 10.00am to 4.30pm (Registration 9.45am)	COST: \$60 AMT members \$90 non-AMT members Lunch and afternoon tea will be provided
WHERE: Ryde-Eastwood Leagues Club 117 Ryedale Road West Ryde	PLEASE BRING: your own massage table if possible

MEMBERS' DAY – TENSION HEADACHE

10.00am "My Head is Killing Me"

Keynote address by Natalie Hitchens

Natalie obtained her medical degree from UNSW in 1988 then went on to train in Internal Medicine and Neurology at RNSH, Monash Medical Centre (Melbourne) and St George Hospital. She works as a consultant Neurologist in her private practice in Strathfield as well as being a visiting consultant at Bankstown Hospital. She also has abundant personal experience of both migraines and tension headaches!

Natalie will discuss the different types of headache, paying particular attention to the more sinister causes such as tumours, meningitis, haemorrhages and arteritis and how to judge which patients should be sent off to their doctor or hospital urgently. She will also briefly discuss migraine, tension headache, cluster and other benign types of headache.

11.30am **Treatment of Trigger Points**

Presented by Colin Rossie

Colin will do a brief, general review of trigger points and then demonstrate treatment protocols for the most common trigger points responsible for the referred pain of headaches of cervicogenic origin.

1.15pm **Lunch**

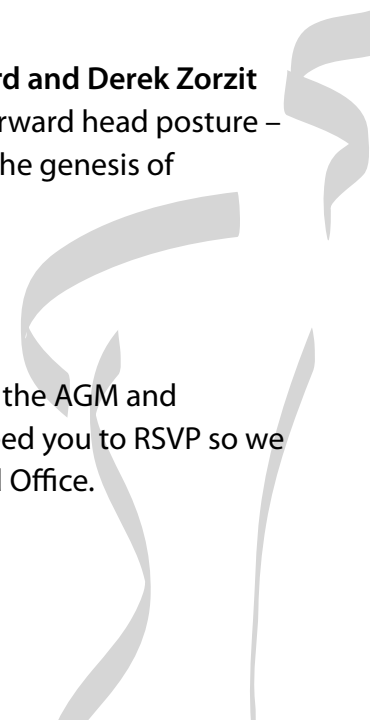
2.00pm **Addressing the postural dimensions** **Presented by Alan Ford and Derek Zorzit**

Alan and Derek will lead a session on stretching and strengthening to address forward head posture – a major contributor to soft tissue dysfunction in the shoulders and neck, and to the genesis of tension headache.

3.00pm **2008 Annual General Meeting**

4.00pm **Afternoon tea**

Members who do not wish to attend the whole day are warmly invited to attend the AGM and afternoon tea. There is no fee to attend this portion of the program but we do need you to RSVP so we can cater appropriately. Please return the registration form overleaf to AMT Head Office.





AMT Members' Day and Annual General Meeting

ABN 32 001 859 285

Please find enclosed: \$60.00 AMT members
 \$90.00 non-members

TOTAL \$ _____

Cheque or Money Order (made out to AMT)
EFT (see payment details below)
Or please debit my visa/mastercard

AMT Membership number: _____

Please indicate if you can bring a massage table: Yes / No

I will only be attending the Annual General Meeting and Afternoon Tea

*** NON-MEMBERS, PLEASE SUPPLY ADDRESS & PHONE CONTACT DETAILS**

First name: _____ Surname: _____

Address: _____

Phone number: _____

Cardholder's Name: _____

Card Number:

Cardholder's Signature: _____ Expiry Date: _____ / _____

AMT REFUND POLICY
• Cancellation up to 4 weeks prior – **full refund**
• Cancellation less than 4 weeks but more than 2 weeks – **less 15%**
• Cancellation less than 2 weeks but more than 1 week – **less 25%**
• Cancellation less than 1 week – **less 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 Ltd, PO Box 792
Newtown NSW 2042
or fax 02 9517 9952





ABN 32 001 859 285

2008 Annual General Meeting Agenda

Sunday 20 April, commencing at 3.00pm
Ryde-Eastwood Leagues Club,
117 Ryedale Road, West Ryde

- Item 1** Apologies and declaration of proxies
- Item 2** Minutes of 2007 Annual General Meeting
- Item 3** Business arising
- Item 4** President's report
- Item 5** Secretary/Treasurer's report
- Item 6** **Motion – Acceptance of financial statements**
"That the financial statements be accepted"
- Item 7** Report on the election of Office Bearers
- Item 8** Other business
- Item 9** Close of meeting





2008 Annual General Meeting Proxy Form

ABN 32 001 859 285

If you are a financial practitioner level member and would like to vote but are unable to attend the AGM, please forward your proxy to the Secretary or an attending Member.

Please send your proxy form to:
AMT Ltd, PO Box 792, Newtown NSW 2042

Proxy Voting Form for AGM 2008

I, (name) _____

of (address) _____

being a financial member of the Association hereby appoint the Company Secretary) or (name)*

as my proxy to vote on my behalf at the AGM to be held on 20 April 2008.

Signature _____ Date: _____

* Delete as appropriate.

**ALL PROXY VOTES MUST BE RECEIVED 24 HOURS PRIOR TO THE
ANNUAL GENERAL MEETING BEING HELD**

