



amt

in good hands

the journal of the association of massage therapists ltd

march 2009

President's Report

By Alan Ford

Association of Massage Therapists Ltd

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Hello members and welcome to the Year of the Ox, 2009 and the Obama era. I hope you all enjoyed the festive season with family, friends, and lots of things on the menu that you probably shouldn't have consumed—just like I did.

This year will bring new challenges for our industry and its therapists, with the inevitable consequences of the global economic crisis biting into our incomes. There will no doubt be times when the accumulation of cancelled bookings, fewer walk-ins and the increasing costs of managing a small business will seem endless, but hang in there as things will turn around—it's just a case of sticking it out and waiting for better times to come.

The Board continues to push ahead with reforms which will see all sub-committees working with specific Terms of Reference. Once again, we ask any members who have a particular interest in the areas of Strategic Planning and Marketing, Ethics, Finance, Discipline, or Education and Research, to help out. Your assistance will spread the load in a bid to have completed guidelines by year's end.

This year the Annual Conference returns to Sydney after an absence of three years. It is our intention to host alternate conferences between Sydney and other regions from here on—so make the most of the event when it is being hosted in your region.

Our Annual General Meeting is just around the corner—in fact this copy of *In Good Hands* may well be delivered 'post event'. If so, I would like to congratulate the incoming President on their election to the position, and offer my full support and any advice should they need it in the future. I believe that nominations for positions on the Board are coming in thick and fast, so all the best to those taking up positions in which you will help guide the association in its new-found professional direction.

As your outgoing President, I would like to take this opportunity to thank the office staff for their dedication, professionalism and sheer hard work over the past three years in assisting me with my position. I am also very grateful for the unwavering support of our secretary, Rebecca Barnett, and members of the Board—particularly during the turbulent first few months of my presidency. Without the guidance and direction of senior Board members like Colin Rossie, who has more drive, will, and conviction to a cause, than any other bodyworker I have ever had the pleasure to meet, many of our achievements of the past couple of years would never have been made.

Finally, thanks to you, the members, for your support these past three years. I wish each and every one of you the best for the future. I look forward to catching up with as many of you as possible at the AGM and later in the year at the Conference.



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Secretary's Report

By Rebecca Barnett

Several months ago, the AMT Board endorsed a strategic plan to propel our profession forward for the next decade. At the core of this strategic plan are the twin goals of formal government recognition and public awareness of the health benefits of massage therapy. We have captured this core in a simple vision and objectives statement that will underpin all the activities undertaken within AMT on behalf of members.

Vision

Australians recognise massage therapy as an integral part of health and wellbeing.

Objectives

- The Australian public recognises the benefits of massage therapy and has the information, knowledge and resources to choose a professional therapist.
- The Australian government recognises massage therapy as a legitimate health service.
- Practitioners of massage therapy are adequately skilled and well-educated.
- Practitioners of massage therapy are supported in clinical practice.
- The practice of massage therapy in Australia is supported by a sustainable model for governance and regulation.

Much of the Board's focus over the past year has been on governance reform. In simple terms, governance refers to the place where the mechanics and ethics of an organisation meet: it is the structural, procedural and ethical principles that inform the way an entity does business.

Ongoing governance reform is crucial to the longevity of AMT and to our capacity to advocate effectively on behalf of the membership. It's not particularly sexy or fun. It's even a little gruesome. In fact, it's much like law and sausages—better not to see it being made.

However, without a sound, ethical and professional core to our Association, we cannot promote a sound, ethical and trustworthy profession to the general public, other health professionals and government. To this extent, governance is essentially an organisational expression of personal ethics and conduct.

As part of our governance project, the AMT Board has made a commitment to openness and transparency in the management of the Association's affairs. Inclusiveness and participation are intrinsic to this commitment. As Alan mentioned in his report, we have established five committees in the following key areas:

1. Ethics
2. Education and Research
3. Discipline
4. Finance
5. Strategic Planning and Marketing

Each of these committees has specific Terms of Reference that govern their operation. These are now available for download from the AMT website in the governance subsection.

We invite all members who are interested in a specific committee to consider getting involved. If you are interested, but perhaps need some encouragement or more information, please call me on 0414 732 873. We are particularly keen to recruit members to the Ethics Committee as there is much work to be done in this area.

I'd also like to remind members that the proceedings from executive meetings are available for download inside the AMT forum.

Maternity leave for AMT members

The Strategic Planning and Marketing Committee recently championed an initiative to offer a special maternity leave option for our members.

The special package, which was endorsed at our last Board meeting, involves the following:

- deferral of active AMT membership for up to three years
- a run-out period of three years on the electronic version of the AMT journal.

Members who opt for maternity leave from AMT will not pay annual fees and are, therefore, not eligible as health fund providers. However, they will be retained in the system and will be eligible to reactivate their membership when they return to work. Uninterrupted access to industry news via the AMT journal during this period is intended to keep therapists connected to their peers and in touch with the activities of their professional community.

We believe that this initiative is an excellent way of supporting female members through a career-disruptive phase and hope that it will result in skills being retained in the industry.

Health fund news

The health funds are gearing up for the roll out of the new Private Health Insurance Accreditation Rules on 1 July this year. AMT has already been contacted by several funds requesting confirmation that we comply with the requirements of the new legislation.

The new rules will not affect AMT members in good standing—it's basically business as usual. As long as you maintain the currency of your first-aid and insurance, and are up to date with CEUs, we can continue to forward your name on our monthly health fund lists.

The new rules place the onus on the associations to guarantee transparent admission criteria, ethical standards of practice, and to maintain a formal disciplinary process. From 1 July 2009, therapists who do not belong to an association will no longer be eligible for health fund provider status.

MBF correspondence

Members with current MBF provider status will probably have received a letter from the fund requesting confirmation of their association membership details. This correspondence has been sent out in connection with the impending accreditation rules.

I contacted MBF and asked for clarification as to why AMT members are required to confirm this information directly with the fund when we forward an up-to-date list of eligible MBF providers every month. The fund claims that, in a small number of cases, they are having problems cross-matching the information in their database with the information we send through. It seems highly likely, however, that this is an exercise in blatant officiousness with the rather sinister possibility that it is an attempt to 'lose' a few providers in the 1 July transition.

If you haven't already done so, I strongly recommend that all eligible MBF providers call the provider hotline on (02) 8239 2744 to confirm your AMT membership status. I apologise sincerely for the unnecessary stupidity of this. Rest assured, we continue to provide MBF with a list of providers every single month. What they do with it now seems like a huge conundrum.

MBF / BUPA merger

MBF and BUPA are in the process of aligning their provider eligibility criteria as a result of the merger last year. At this stage, it is not clear whether MBF will adopt BUPA's criteria for remedial massage therapists or vice versa, but we can expect a single system to be in place for all the funds now operating under the auspices of BUPA within the next three months. This means that the same criteria will apply across MBF, NRMA, SGIC, SGIO and all the HBA funds (please refer to the health fund table at the back of the Journal).

Unfortunately, it seems highly likely that BUPA will send out a similar letter to the one I referred to above regarding the new accreditation rules. Apparently, this will be due to problems merging their data with MBF's. The efficiencies of the information age are truly a wonder to behold.

Conference '09

I am pleased to confirm that our 20th Annual Conference will take place in Sydney on 23–25 October. Please make a note of the dates in your diary and look out for the full program in the June issue of the Journal. We expect a bumper turnout since it's now three years since Sydney has hosted the event. Register early—popular breakout sessions are likely to book out this year. I'm looking forward to cutting the rug again at the Saturday night gala dinner.

Welcome to our new Editor

I'd like to close this report by saying a warm welcome to our new Journal Editor, Penny Robertshawe. I look forward to seeing how the Journal develops under her stewardship. I doubt that anyone is more pleased than me to see fresh energy and enthusiasm in the role. Best wishes in the job Penny!

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Need CEUs?

Journal question -
March edition

Name one clinical test that should always be undertaken when assessing for sciatica.

Please write your answer in the space provided on your CEU record sheet and retain it until you submit the form with your annual renewal. Blank CEU forms can be downloaded from:
http://www.amt-ltd.org.au/index.php?Page=Members_CEU_1.php

DEADLINE

**Deadline for the
June 2009 issue of
In Good Hands is:
1st MAY, 2009**

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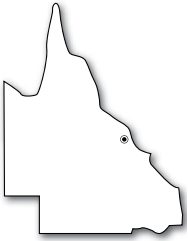
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All health funds now require
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Please post or fax a copy of your
First Aid Certificate to Head Office
so your name remains current on
the Health Funds lists.

News from the regions



Mackay by Annie Caruana-Kirchner

Our guest speaker at the November AGM was Barbara Whitfield, nationally accredited instructor with the Queensland Keep Fit Association. Barb talked about the benefits of her specialised aqua fitness and yoga classes. These classes cater for people of all ages with varied ailments such as fibromyalgia, diabetes, arthritis and cardiac conditions.

Our local office bearers were also elected:

Chairperson	Annie Caruana-Kirchner
Secretary	Claire Kemp
Treasurer	Liz Sharpe
Librarian	Diane Sant

Two of our Mackay members received awards at the Carers Queensland Carer Friendly Business Awards. The awards aim to recognise businesses that have demonstrated an understanding of the particular needs of unpaid family carers. This is done by implementing employment, service policies and procedures that help make life a little easier for carers. Both Diane Sant and Cathy Lee were nominated for the Great Service Award.

Thanks also go to Linda Danvers for instigating this program at the beginning of 2006. Linda proposed that Mackay AMT therapists provide one free massage per month for a carer. Eight of our local therapists will be participating in the program in 2009. The carers are given vouchers to receive four complimentary massages per year. The concept has worked fabulously and we encourage therapists in other regions to consider adopting the program.



Sydney South by Rene Goschnik

Another good year as our branch meetings came to an end. It was a year of many interesting discussions and presentations, with between ten and fifteen fellow therapists attending each meeting. Our last meeting in December featured a presentation about the AMT conference in Melbourne from our own Jenny Della Torre and John Eades. After the presentation, we all went out for a Christmas dinner at the Ritz Hotel in Hurstville.



Jenny Della Torre presenting at the South Sydney meeting in December

Also discussed at the December meeting was the idea of inviting guest speakers from various medical and health professions. We are still looking for an enthusiastic person to fill the position as our Secretary. This position will be put to the vote at our AGM on 1 April 2009.

We would love to see more therapists coming along to our meetings. It is a great way to network with other therapists in the area. I wish you all a successful and healthy 2009.



Hunter by Paul Lindsay

Hunter Branch travelled a rocky road last year with the resignations for personal reasons initially from the Secretary, then the Chairperson. To bring some stability to the group, I have moved into the position of acting Secretary while Dan Robinson has moved into my former position as Treasurer. The position of Chairperson is currently unfilled.

Our September meeting's theme was 'Show and Tell', when members brought along favourite items that they used in their practice. There were reference books, anatomy models, a frame for showing clients their posture, a model spine that (unusually) showed progressive deterioration in the vertebral disks and, most popular, a personal massager—not for the clients, but for the therapist's hands and arms after a hard day's work!

Our January meeting was a discussion of the best and worst incidents from members' experiences. Discussing the worst incidents highlighted potential problems and enabled a variety of solutions to be offered while the best incidents reminded us all why we work in this profession.

Our next meeting will be on 15 March 2009 and a guest speaker is planned.

News from the regions (continued on page 6)

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News from the regions (cont...)



**Mid North Coast
by Jan Crombie**

A happy and a prosperous New Year to all from the Mid North Coast Branch. At our last meeting for 2008 we discussed the upcoming member's day in Sydney. I gave a presentation on the workshop 'Tricks of the Trade' by Jeff Murray who was at our National Conference in Melbourne.

The Australian Ironman Triathlon is fast approaching on 5 April 2009 and we are again looking for volunteer therapists. If anyone is interested in volunteering, could they please email messageim@aapt.net.au.

Our meetings are held at 1 pm on the third Saturday of every second month (the next one is on 18 April 2009) so if you are passing through or on holidays, please drop in to the Nikki Adams Room, Senior Citizens Building, Munster Street, Port Macquarie.

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Unravelling the Mystery of Unwinding

by Budiman Minasny

I can't tell you how it works. I know that the intention of the therapist has a lot to do with it. Also the less guarded the patient is, the quicker it will work.

John E. Upledger, 1987

What is unwinding?

To unwind usually means to relax, become less tense, rest, or to take it easy. 'Unwind your body' is a commonly touted phrase used to promote relaxation bodywork. However, fascial or myofascial unwinding is a specific type of bodywork that is used to release fascial restriction by encouraging the body or parts of the body to move into areas of ease. Unwinding in this sense typically involves a therapist inducing the unwinding process in a client. This process is usually followed by a spontaneous reaction: parts of the body bend, rotate, twitch or twist—sometimes in a rhythmic pattern.

Unwinding is a gentle and non-invasive treatment that facilitates the body's own physical release potential without forcing the tissue in any way. It is a therapy that needs to be experienced so that it can be appreciated. This article looks at some aspects of physical unwinding, and also presents some of the theories about why and how it occurs.

The unwinding technique is usually offered in classes in myofascial release—particularly those that follow the approaches of John Barnes^{1,2}. Unwinding can be thought of as an expression of inner movement. Sometimes, just a gentle touch with a clear intention of restoring balance whilst being aware of a client's body can stimulate unwinding. Unwinding can also happen automatically when a therapist is working on a client's soft tissues. The client generally moves in response to the therapist's touch and energy.

The movement can be large or small, involving one or more parts of the body. It is essential for the client to feel safe in the hands of the therapist as it is this trust that allows the expression of movement.

In some cases, emotional release can also occur during unwinding and therefore it is important to distinguish between pure physical unwinding and emotional release. This discussion is limited to physical unwinding which has a profound therapeutic benefit in releasing chronic musculoskeletal pain.

Unwinding may have originated in osteopathic methods—Dr. Viola Frymann, an osteopathic physician, is credited with developing the unwinding techniques and also coining the term 'unwinding' in 1963. However, according to Robert C. Ward³, the osteopathic origins are unclear, even though unwinding procedures have been described for decades by many osteopathic practitioners.

Most indirect manipulative techniques are based on a common concept that the role of the therapist is to encourage the activity of inherent corrective or homeostatic physiological mechanisms. The phenomenon of unwinding, where parts of the body move spontaneously and involuntarily, can sometimes appear mystical; however, its therapeutic effect is known clinically. Ward³ recognised that the seemingly random movements reflect a variety of interacting electromechanical events affecting central, peripheral, autonomic, and even physiologic functions. He added that, 'amid much speculation, satisfactory scientific descriptions for the events are lacking.'

How do you unwind?

Descriptions for inducing unwinding can be found in books on craniosacral therapy such as those written by Upledger and Vredevoogd⁴, and Milne⁵.

To induce the process, the therapist must be centred, grounded, and have a respect for the client's innate healing wisdom. During the treatment, the therapist acts as a catalyst or facilitator by placing the client's body in certain configurations that allow it to unwind and release. The release is set in motion with the therapist's touch but the client soon takes control.

Motion is usually induced in the body by lifting and holding certain body parts in order to remove the influence of gravity—a technique often used when working with the limbs. The sense of weightlessness in the body can initiate movement that is usually thought to be impossible to achieve. According to Kern⁶, when the effect of gravity is removed, any strain patterns held in the tissues become more easily clarified. An alternative method is for the therapist to add compression to the joints in the area, or to hold a part of the body in a relaxed position.

The unwinding process can either be carried out on the body as a whole, or on specific body parts such as arms, legs, the neck and even the jaw. For example, in arm and shoulder unwinding, the client lies supine while the therapist lifts an arm. The arm is then supported under the therapist's elbow and wrist and a light compression towards the shoulder joint can be added. After a while, the therapist will sense movements around the shoulder joint.

For hip joint unwinding, the client lies supine with knees bent. The therapist lifts both legs by the knees so that the thighs form a ninety degree angle with the hip. A gentle compression of the knees towards the hip joint is introduced then released. In this case, the movement will be sensed around the hip joint and in the legs.

To unwind the neck, the client sits on a chair while the therapist stands behind. The therapist puts one hand on top of the client's head and the other hand on a shoulder; then introduces a gentle compression to the head before releasing. After some time, the therapist will sense movement in the neck and follow it. Neck unwinding can also happen spontaneously when performing myofascial techniques such as suboccipital decompression, or whilst stretching neck flexors with the neck extended and rotated.



During leg unwinding, the client lies supine and the therapist stands at the end of the table holding the client's legs in full extension at the ankles. The therapist feels for the restriction over the whole leg up to the hip and applies either traction or compression. Again the therapist follows the inherent movement.



It is imperative that the therapist senses and follows the intrinsic motion arising from the client's body—it must not be directed by the therapist but rather followed as the body unwinds. Sensitivity and fine palpation skills are required to carry out this process. Unwinding will not occur if the client does not feel that he or she is in a safe place.

In clinical practice, the unwinding patterns are unpredictable. Body repositioning can begin with muscles twitching and gentle movements such as the head rocking from side to side. If allowed to build momentum, movements can get stronger and all the therapist needs to do is to hold the body lightly or let the client's body go while the movements continue. Sometimes unwinding can get quite vigorous and aggressive involving the whole body. The pattern of movement can be rhythmic, but at other times, it can be random. After a period of time, the movement ceases and the unwinding is said to have reached a still point.

In some cases, unwinding happens spontaneously while the therapist is using other techniques on the client's connective tissues. Clients usually unwind when they feel supported. If the client suddenly starts to unwind without the therapist's intention, it is best for them to support the client and stay out of the way. In cases where the body starts unwinding vigorously, it can take over the session—it is important at these times for the therapist to refrain from analysing or judging what is happening. Remember that this is a natural process and that it should be allowed to flow. Taking a seminar on unwinding would certainly be helpful in learning how to manage this process.

Upledger and Vredevoogd⁴ suggest that, after unwinding, the client will ultimately return to the body posture in which their original injury occurred. When the process of unwinding begins, the client usually assumes that the therapist is guiding their movements. Sometimes, when they are made aware that this is not the case, clients can stop the movement because it feels strange to them that their body is moving unconsciously.

Benefits of unwinding

Unwinding techniques can be used in conjunction with other modalities to release pain or movement restriction. Barnes² suggested that myofascial release and unwinding are most beneficial for anyone with acute injuries, 'spasms will lessen, pain will diminish and range of motion will return.'

The process is always gentle, following the body's own demands. It is usually experienced as a very relaxing, soothing, and pleasant event. Even in painful neck or frozen shoulder conditions, the gentle process of unwinding can be carried out to encourage and rediscover pain-free mobility to the area.

Barret Dorko⁷ characterised unwinding as having four attributes: effortlessness, warmth, muscular softening, and surprise. The muscular softening is attributed to the full expression of muscles, and the warmth to an increase in blood flow. The effortless and surprising qualities of this motion are both characteristic of instinctive and unconscious motivated movement.

McCarthy et al.⁸ documented the use of unwinding in the treatment of a patient with chronic neck pain. They evaluated the outcome of short-term pain and disability in a patient with chronic neck and shoulder girdle pain treated solely with unwinding. The results showed a reduction in pain intensity and perceived disability.

Tissue memory

One of the metaphors used to describe fascial unwinding is untangling telephone wires or twisted rubber bands. The most common explanation for its effects is that our tissues hold memories of past traumas and unwinding allows the client's body to move into self-correction. Fascia may become short and tight due to trauma, poor posture, and physical stress.

Upledger and Vredevoogd⁴ described unwinding as follows: 'When an injuring force occurs, the tissue which receives the force changes. Perhaps it retains the energy of the impact. A level of increased kinetic activity or higher entropy is set up in the impaired area. The human body either dissipates that energy and returns to normal; or the body somehow localises the impact of the energy and walls it off'. This localised energy can be referred to as energy cysts: 'These energy cysts are areas in which kinetic energy is now stored as potential energy in the connective tissue matrix. Unwinding attempts to free this stored energy⁹'.

There are also various theories suggesting that memories of traumatic events may be encoded differently from other events. One theory refers to state-dependent memory which stems from the observation that memory in one state of consciousness cannot be recalled until the person returns to that same state¹⁰. Another theory, put forward by Sigmund Freud, proposed that unwanted memories can be excluded from awareness—a process called repression. Moreover, recent studies show that a biological mechanism exists in the human brain to block unwanted memories¹¹.

Neurobiological fascia theory

Robert Schleip^{12,13} presented a comprehensive review on the neurobiology of fascia and provided a theory on how myofascial release works: 'Fascia and the autonomic nervous system appear to be intimately connected. Fascia is densely innervated by mechanoreceptors which are responsive to manual pressure. Myofascial manipulation involves a stimulation of intrafascial mechanoreceptors which are then processed by the central nervous system and autonomic nervous system. The response of the central nervous system changes the tonus of some related striated muscle fibres. The autonomic nervous system response includes an altered global muscle tonus, a change in local vasodilation and tissue viscosity, and a lowered tonus of intrafascial smooth muscle cells.'

Gentler types of myofascial stretching and cranial techniques also have been shown to affect the autonomic nervous system. Clinical observations show that gentle myofascial techniques can stimulate clients' involuntary motor reactions such as rapid eye movements or muscle twitching. Zullow and Reisman¹⁴ indicated that parasympathetic activity increased as a result of compression to the fourth intracranial ventricle (CV4) and sacral holds as measured by heart rate variability.

Fernandez Perez et al.¹⁵ examined the effect of introducing three myofascial induction or craniosacral techniques on physiologic changes.

The three techniques tested were suboccipital muscle decompression, CV4, and deep cervical fascia stretching (with client supine, head off the table, neck supported and under extension). Additionally, anxiety levels significantly decreased after the application of the three techniques, and heart rate and systolic blood pressure were lowered. The effects were observed up to twenty minutes after intervention. These myofascial induction techniques are also known clinically to trigger unwinding of the neck.

Unwinding as an ideomotor action

Dorko⁷ suggested that fascial unwinding can be explained as an ideomotor movement—muscles can be involuntarily activated by thoughts. Involuntary muscle movement can manifest in various ways, for example, asking a subject to think of an activity is enough to set the muscles required for that activity into action. In 1852, psychologist/physiologist William B. Carpenter defined ideomotor movement as the 'influence of suggestion in modifying and directing muscular movement, independently of volition'. Carpenter used ideomotor action as an explanation for various phenomena that were being credited to new physical forces, spiritual intervention, or other supernatural causes. Later, in 1890, William James proposed a wider meaning for ideomotor activity as being the basic process underlying all volitional behaviour.

According to ideomotor theory, the typical reason for performing a movement is to produce an effect in the environment. The ideomotor principle is based on two conditions. Firstly, movements and their ensuing effects must become associated, making it possible to predict an effect or consequence of a given movement. Secondly, this association works in both ways so that the anticipation of the required movement directly triggers the actions that have been learned to produce that movement.

This is the difference between normal sensorimotor and ideomotor learning.

For example, when playing the piano, both types of learning may be present, but sensorimotor mapping would associate the finger movement to the sight of the musical note, whereas ideomotor learning would associate the finger movement to the hearing of the tone. In unwinding, when it is initiated, movement is guided and associated by the stretching sensation to find pain-free areas where there is ease of movement. Meanwhile, in stretching, the movement is guided by the therapist's hand or cue.

Dorko⁷ hypothesised the mechanism of unwinding as follows: 'Muscular pain can arise from mechanical deformation of various tissues. If the movement required for reducing that injury is not permitted because of cultural norms, the body would respond with an array of isometric contraction of muscular activity.'

Dorko further surmised that this muscular activity is commonly misinterpreted as a lack of appropriate relaxation, and is therefore subjected to various forms of stretching, manipulation or exercise. Manual techniques that elicit ideomotor activity such as unwinding allow full expression of the muscles and encourage the body to complete the motor response for which the contraction was activated. The therapist's touch is gentle and non-coercive, with a goal to make the client aware of internal motor activity and then to get out of the way of that activity.

Consciousness theory

Halligan and Oakley¹⁶ suggested that all the thoughts, activities, ideas, feelings, attitudes and beliefs that have been traditionally considered as the contents of consciousness, are produced by unconscious processes—just like actions and perceptions. It is only later that we become aware of them as outputs when they enter our consciousness.

In their model, all of the brain's information processing activities sent to unconscious parts of the brain are referred to as Level 2. Within this level, there must be some kind of decision-making device—a central executive structure. This structure identifies the most important task the brain is carrying out at any moment and selects the information that best describes the current state of the brain in relation to the chosen task.

Only this selected information is allowed to enter Level 1 to produce a conscious experience.

In a hypnosis trial, Haggard et al.¹⁷ showed that an ideomotor response produced by suggestion is generated via normal voluntary motor control systems but experienced as involuntary, resulting in a conscious experience close to that of a passive movement. Unwinding or ideomotor process thus represents dissociation between voluntary action and conscious experience.

A hypothetical model

The author proposes a hypothetical model employing the neurobiological and ideomotor action theories to explain the process of unwinding. In the first stage, the induction process, the therapist working on a client introduces gentle touch or stretching onto the tissue. When the client feels safe and supported, the process is initiated. The touch stimulates mechanoreceptors of fascia and, in turn, arouses parasympathetic nervous system response. The result is that the client is in a state of relaxation and calm, which is sometimes followed with rapid eye movement, twitching or deep breathing. The stimulation also influences the central nervous system, which responds to the introduction of stretching or movement to areas of ease. This occurs in the unconscious state and the client remains unaware, indicating dissociation between voluntary action and conscious experience. The stretching sensation also stimulates a response in the tissue, providing feedback to the central nervous

system as outlined by the theory of ideomotor action. The process is repeated until the client is relaxed or has reached a still point.

In conclusion

Unwinding is a gentle form of therapy which can be incorporated with other forms of bodywork. It is a non-invasive treatment which responds to the body's inner demands to release—never imposing any stress on the tissues. It is generally painless and brings about a much appreciated sense of relief, ease and relaxation, as well as the more profound therapeutic release of underlying chronic conditions.

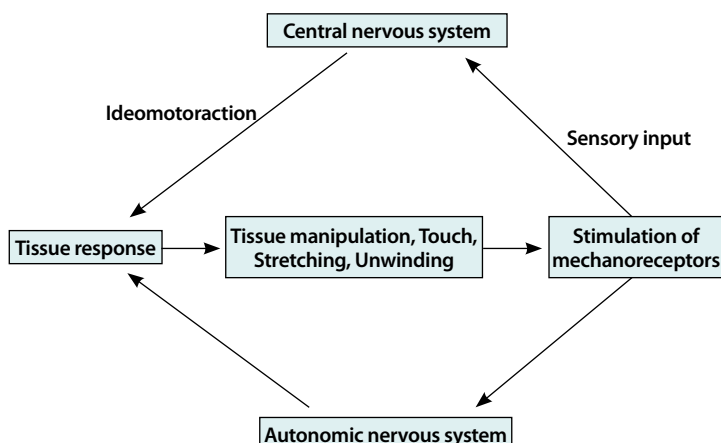
The effects of myofascial manipulation have been studied at cellular, tissue and whole body levels. These studies showed that it is impossible to generate immediate and permanent lengthening or unwinding of the fascia with mechanical means. Creating such changes requires substantial force and longer durations of stretching. Stimulation of mechanoreceptors is the most likely trigger of such release¹³.

As bodyworkers, we can view unwinding as an application of the neurobiological concept employing the self-regulation dynamic system¹³. The therapist works as a facilitator to induce the parasympathetic nervous system. By paying attention to the state of the autonomic nervous system, unusual sensations are created with subtle stimulation, including immediate feedback and active macro-movements.

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A hypothetical model for fascial unwinding (based on Schleip¹³)

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Interview with Alan Downes

by Penny Robertshawe

Alan Downes has travelled the globe as a sports massage therapist working with some of the world's best athletes. His career in massage therapy began in 1982 as a part-time pursuit while still holding down a full-time job in local government. At 50, an age when a many of us are thinking about slowing down, Alan Downes retired from his work in local government to take up full-time sports massage therapy. Thirteen years after 'retirement', he's still going strong. Here, he talks to Penny Robertshawe about his journey into the world of high-level sportspeople.

Could we start with a bit of a background to your career to see what brought you to where you are today?

In general terms, my background has been in athletics and rugby league where I used to do a lot of coaching. But when my kids got to school age at the end of the '70s, I realised I had to spend more time with them and so I gave the coaching away. Then, in 1981, I saw an advertisement for a massage course which incorporated sports massage. Of course, that long ago there was no such thing as sports medicine as we know it today and certainly not the development in massage therapy. Anyway, I did that course and I guess I've been doing courses ever since because you never stop learning.

Did you begin working with athletes straight away?

No. I mainly worked with football players. I was still working in local government at the time—that was my real job so to speak. And in about 1987, my son got involved with cycling and I used to go along and watch him ride. My first actual massage appointment was to the Commonwealth Bank Cycling Classic in 1988.

How did you get that job? Through your son's cycling contacts?

It was a consequence of doing sports training courses at New England University in Armidale.

One of the lecturers up there was responsible for putting together a twelve-person massage team for the 1988 Commonwealth Bank Cycle Classic. That was the bicentennial year and you'll understand that they wanted to make it a special event.

So you just stuck your hand up?

I saw an advertisement in *Sports Health* to join the massage team and I applied for it. When the lecturer knew that I was applying, he told the people involved that he wanted me on the team. So starting from there, I had twelve years working on the Commonwealth Bank Cycle Classic. And in the last three years, I became its medical coordinator.

After a couple of years of working with the Cycle Classic, I got to know some of the Queensland officials and they asked me if I would like to look after the Queensland team for the 1990 National Titles. So I've been doing the Queensland team ever since—to this very day.

When did you begin travelling overseas?

As a consequence of working with the Queensland team, I started to be recognised by some of the Australian officials. And then, in 1991, I was invited to go along to my first overseas trip which was a tour of New Zealand.

My first World Championships were in Sicily. I think that was back in 1994. I've done World Championships in Denmark as well. And I worked under Jeff Murray at the Sydney 2000 Olympic Games's sports medicine centre. And then I suppose my recent big one was the World Championships in Bordeaux, France last year with the Paralympic side.

So you went from working with able-bodied sportspeople to Paralympians?

Yes that's a consequence of meeting one of Australia's renowned cycling coaches, James Victor.

He was the successful coach of the Australian Women's Cycling Team that won the gold medal in Athens. He decided it was time to give away the national women's team and he came back to take on the Queensland Academy of Sports cycling unit. And then shortly after that, he took on the head coaching role for the Paralympic unit in Adelaide. He asked me if I would like to join the team.



What was the difference for you in working with able-bodied people and Paralympians?

Well, particularly with the sprinters, you're dealing with a very large animal so to speak. The male sprinter is a very very big man. And after doing a session with say four or five members of the sprinting team, you really exhaust yourself. It really takes it out of you because of their size. You've got to really work hard on them.

With the Paralympic people you don't get as big a person bodywise. My first episode of having a one-legged athlete on the table was a bit daunting. But you overcome these little problems. You talk about how they got their injuries and how they lost limbs and so on. And just by having regular conversations with them it breaks the ice, and you forget that they're disabled.

But in general terms, I found that their temperament is not as fiery as the able-bodied sprinters. I don't know why that is but they're a great bunch of people to work with. They're really dedicated to their task.

Do they have different sorts of problems to the able-bodied people?

You need to differentiate between those people with cerebral palsy, those who have suffered brain damage in motor vehicle accidents, people who are born with limb deformities, and people who have lost limbs through either illness or motor vehicle injuries. So the spectrum of disabilities and their causes is widespread. You've got to be aware of their needs. And sometimes they're still carrying niggly phantom pains and you need to be aware of those. But in the main, you treat them just like an ordinary person. They wouldn't want to have it any different.

You worked with the Paralympic team in Beijing. Was the routine very structured there?

It was more structured than in Sydney when we were responsible to Jeff. And there's certainly a hierarchy. With the Olympic team particularly, you have the chief medical officer, you have your physiotherapy staff, you have your psychology staff, you have your recovery staff and of course, you have your massage team.

Although I was attached to the cycle unit, I was officially a member of the Beijing medical team and I was under their direction at all times. I couldn't do any work with the athletes in their rooms—all massage had to be done at the medical centre. And the beauty of that, of course, was that I was dealing with other professionals and I was getting a different aspect on sporting injuries and new techniques of recovery and that sort of thing. Working with a broad range of medical professionals in a situation like that was very rewarding and educational.

When you're working on the road, what are some of the advantages and disadvantages?

When you're doing the track championships you either work from your motel room, or you work at the track. So your hours are quite long.

You're doing general massage through the day and then you're working at the track in between events doing recovery massage. So it's a fairly long day. My days would start from say 9 o'clock in the morning and finish at 11 o'clock at night.

That must be exhausting.

It is exhausting and you know by the time you get home you're pleased to see the end of it.

How many days would you keep that up for?

Five days. And sometimes we'd go down a little bit earlier for pre-event practice. We'd go three days beforehand while the cyclists are getting used to the track and we would massage in those three days as well. When you're doing a road team, in road racing, you're living out of a suitcase, so it becomes more tiring because your hours are different. You've got to get up early for an early morning start in the race and when they've finished you've got to put all their gear and what have you in the hotel rooms. Then you do your massage, then you have dinner and then you do massage again after dinner. And then you've got to prepare their morning feeds that they carry on their bike.

That's doing a road race. It's different than the velodrome. Doing a road race takes a lot more out of you I guess in terms of your overall responsibilities compared to the track. And it is very tiring, I can tell you that.

Do you ever work with other types of athletes?

Sometimes I drift from cycling to other sports through the Queensland Academy of Sport where I have a contract. I got a phone call last year asking if I'd like to attend a pre-Olympic training camp for the Australian rowing team at Murwillumbah. So I did that and it was great. You're working on different parts of the body with rowing of course so there's a bit of variation. One of the joys I got out of that was seeing one of the crews that I was working on get a gold medal.

Do you have any advice for massage therapists who are interested in working with sports teams and athletes?

Well, with your local towns, you'll find teams that would love to have a massage therapist on board.



And the only difficulty is that you might have to compromise and reduce your fees and or even do some pro bono massage. But say, for arguments sake, you get in with your local swimming club and you do massage with them, it could lead to a state team and eventually on to an Australian team. It's just a matter of being at the right place at the right time and being recognised for the work you do.

If you have a passion for a sport, get in with that sport—it might be basketball, it could be netball, it could be anything. Before I got involved with cycling, I was doing some of the local triathlon events up here [in Brisbane]. But you've got to be careful and let people know that you won't do massage for nothing all the time—you've got to draw the line somewhere.

Are you planning to keep going with sports massage Alan?

Well I'm getting to an age where I think I might have to call it quits one of these days. But I'm still physically active. I race bicycles myself. I'm still quite fit. So while I'm still fit, I'll keep going.

It's been a most rewarding career. I know that I'm putting back into sport what we didn't have when we were playing sport and that in itself is rewarding. Even in general practice, when you are able to see people walking out in a more comfortable condition than when they came in—that's also rewarding.

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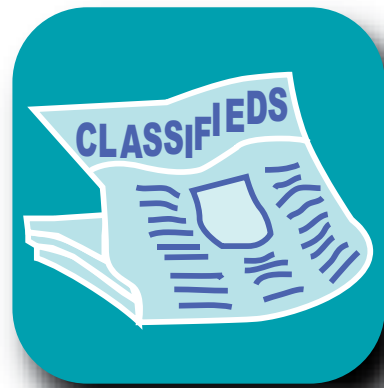


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Superficial Blood Clots: A Contraindication to Massage

by **Kristin Osborn**

As a practitioner of lymphology and remedial massage, a new contraindication to massage has recently come to my attention. I have had several clients showing up at my clinic who have been referred by other remedial massage therapists. The clients had presented to these other clinics complaining of pain in their legs and had been given remedial massage treatments.

Although leg pain is not an unusual complaint for the remedial massage therapist, the reason that these particular clients were suffering turned out to be due to superficial blood clots. All of them had some form of either lymphoedema or lipoedema in their legs.

Clients with lymphoedema or lipoedemas must not have any form of remedial, deep tissue, trigger point or vigorous massage on their oedematous limbs because it can potentially cause superficial blood clots. If the condition is left untreated, the clots can travel into the deep veins. So how can we tell if the limbs are oedematous or not?

Take a history

You cannot rely on clients telling you that they have lymphoedema or lipoedema as they may not know. Ask clients if they have had any form of cancer, now or in the past. Most clients develop their lymphoedema after having cancer nodes removed and radiation therapy. This usually occurs three to eight years after the event.

Even if their surgery or radiation therapy is recent and there are no signs of oedema, they may still have the beginnings of lymphoedema. Ninety two per cent of patients that have had node removal or radiation will get lymphoedema. There are 8,000 new cases reported every year in Victoria alone.¹

Lipoedema is a women's genetic disorder. One of the basic signs of this disease is when a woman's top half of her torso is a size 8 and her bottom half is a size 14.

First signs of oedema

Lymphoedema is recognisable by the following characteristics: puffiness, stiffness, discomfort, heaviness, tightness, heat, pain, (bursting, shooting, joint), numbness, and difficulties in putting on jewellery, shoes or doing up trousers. There is also usually a weight increase for no apparent reason, an increase in skin temperature, fibrosis, and a tendency to bruise easily. These signs and symptoms can be found in both arms and legs.²

Other conditions associated with lymphoedema

The following conditions may also coexist: high blood pressure, heart conditions, arterial and venous conditions (thrombosis and varicose veins), diabetes, thyroid conditions, inflammation, infections, autoimmune disease, hormonal conditions and pregnancy.

If you are in doubt as to whether or not your client suffers from lymphoedema or lipoedema, inform them of your suspicions and leave the affected limbs out of your treatment session. Using gentle, rhythmic effleurage is fine if you keep the direction moving from distal to proximal. Clients should be advised to consult a professional lymphologist for a correct diagnosis.

Only three per cent of doctors know how to correctly diagnose lymphoedema and even fewer understand lipoedema.¹ Much of my work this year will involve trying to rectify this situation. If you have any questions, please email me on newlymphclinic@bigpond.com.

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Massage Towels and Fire Danger

by Jess Threlfo

Jess Threlfo works in a busy sports massage clinic in the heart of Sydney's CBD. Here she tells of her first-hand experience with massage towels and their potential as a fire hazard.

At our clinic we know the dangers of poorly washed massage towels. About 18 months ago, we contracted a laundromat to wash our clinic's massage towels. The service was cheap and the laundromat was conveniently located. The service included washing, drying and folding the towels then placing them into a big laundry sack. The laundry workers would pick up and drop off the towels a few times a week.

One Friday morning, the laundry workers dropped off our towels as usual. The towels sat in their sack for a few hours ready to be put away. Most of the clinic's therapists had gone to lunch when someone smelt something unusual. Then one of our therapists untied the laundry sack and a big rush of smoke filled the air. The smell that emitted is hard to describe: smoky, burning material mixed with rancid oil. Because the towels had been folded straight from the dryer while they were still very hot, and then been left to slowly smoulder over several hours, when the oxygen hit them, they began to ignite.

You can imagine the fire alarms and evacuations that followed. The other people working on all twelve floors of the building were not impressed. Thankfully, there was only one client in the clinic at the time but unfortunately, she was brand new to the practice that day. Our new client had to quickly dress and follow everyone else out of the building (she received a free treatment as compensation).

That hectic afternoon resulted in us losing over 30 towels. The two therapists who were working at the time were left coughing and suffering smoke inhalation. Their eyes were badly bloodshot too. We were very fortunate, however, it could have been so much worse—if we had left the towels overnight we might have had a full-on fire.

After that day, we defiantly changed to a much more diligent and experienced laundromat that is used to dealing with massage, spa and physiotherapy clinic towels. Even so, about three months ago we experienced a similar problem. As before, the towels were delivered still very warm and fresh from the dryer. Two of us started folding the towels from the sack and again smoke began to flow from the large pile. As we had seen this before, we quickly poured a nearby bottle of water over the smouldering spots before too much oxygen got to it. We then dragged the pile of towels out of our clinic and onto the floor's shared kitchen area. We hosed all the towels off and threw them into the bin—it was the only way to stop them smouldering and catching alight.

That time the fire alarms didn't go off, thanks to our quick thinking. But I was coughing all afternoon and I think I must have burnt the inside of my throat a little. I could smell that oily, smoky, burning towel stench on my clothes and in my hair all afternoon, so could my clients. We lost about 20 towels that time. And over the whole office floor, an unusual smell hung in the air for a few days afterwards, puzzling the people working in other offices.

Later we discovered that the laundromat's washing machines were playing up by not releasing washing powder into the machines—our towels were literally still full of oil when they hit the dryer.

We learned a lot from these experiences. We now have a fire extinguisher on hand and we check the towels as soon as they are delivered.

I suspect that the use of low-grade unprocessed oils, especially those purchased in the supermarket, increased the risk of a fire occurring. Some of the therapists I work with use these cheaper and more accessible oils. I prefer to use water-dispersible grape seed oil, and now more of the therapists at our clinic do too. Our towels come back much cleaner these days—not as greasy as they were in the past.

We learned our lesson the hard way—I hope you don't have to. My advice is look out for the distinctive smell of burning, rancid towels and research your laundry service. Make sure the laundry workers know they are washing towels full of massage oils. Also, get a fire extinguisher.

If you are washing your own towels, don't set your dryer heat too high and let the towels cool before folding them. I find that, for my own towels and oil-soaked clothes, a little dishwashing liquid or eucalyptus oil in the washing machine helps to clean out the oil—it acts as a degreaser. Does anyone else have other great home remedy suggestions?

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Sciatica: Three Clinical Perspectives

We continue in this issue with looking at how different therapists view and treat a particular condition. This time our subject is sciatica. Three therapists, Kerry Hage, Alan Ford and Jeff Murray generously share their approach and treatment protocols for this common problem.

A Myotherapist's Approach by Kerry Hage

Often the term sciatica is associated with pain in the buttocks and/or radiating down the leg due to a neurological injury. In fact, the term sciatica more accurately describes the symptom of pain radiating from the buttock into the posterior or lateral leg¹ which may be, but is not limited to, a neurological cause.

In my experience as a myotherapist, I have found that sciatic pain more commonly occurs as a result of muscular dysfunction through the pelvis. Regardless of this, it is important to treat every case individually with a thorough case history to determine the mode of injury or commencement of painful symptoms, followed by screening for disc injury and neurological involvement using clinical testing.

The clinical tests I most often use to rule out disc or nerve root involvement are the slump test, straight leg raise, and the Valsalva manoeuvre. If the outcomes of these tests are positive, a more thorough investigation should be conducted. When the outcome of such an investigation indicates a serious disc or neurological injury, it is my practice to refer the patient to their GP or another physical therapist such as a physiotherapist or an osteopath, for further investigation. This would usually involve diagnostic imaging of some description.

My belief is that knowing when to refer a patient on is just as important as having the right skills and ability to perform an effective treatment.

If the initial testing process shows negative results for serious nerve involvement or disc injury, then the treatment can commence.

For the first session I usually treat the client very generally with deep tissue massage, trigger point therapy and heat through the gluteal muscles (minimus, medius and maximus), piriformis, hamstrings, lumbar erector spinae and quadratus lumborum. If the client's pain is more lateral than posterior down the leg, I will focus more around the hip joint and at gluteus minimus.

After the first treatment, the expectation is that the symptoms become more centralised towards the main aggravation or dysfunction. From this point, treatment is focused upon the dysfunctional muscles, which may be shortened or weakened, as identified by their known pain referral patterns or indicated by postural assessment.

For treatment of the gluteal and piriformis muscles, I have found myofascial dry needling and active myofascial release techniques to be particularly effective for the resolution of trigger points. A longer period of pain relief is also experienced by the client, though the latter modality tends to be more painful for the client during the treatment.

After the second treatment, or once there is a significant reduction in pain experienced by the client, stretching and strengthening of the gluteal muscles and other involved muscle groups is advised. Often it is appropriate for the client to partake in yoga or Pilates classes at this stage of rehabilitation. Correction of any postural dysfunction will also need to be addressed, which may involve specific gait analysis or orthotic therapy as indicated by a podiatrist. Obesity may also be an issue requiring specific guidance and support from a trained dietician.

Additionally, client education about the cause of pain and effective ways to maintain back health should be established. This may range from teaching correct posture and lifting procedures, explaining or advising the client on appropriate time frames for certain

household activities like cleaning or gardening, establishing a maintenance-based stretching regime as opposed to a rehabilitation-based schedule, and advice on whether to use heat or ice after vigorous activity, sport or during a flare up.

Often sciatica can be aggravated by an activity that the client finds difficult to pinpoint like sleeping in a different bed, placing a wallet in their back pocket and subsequently sitting on it, or lifting and holding a small child on a hip. Whatever the cause, sciatica can be a recurring issue if the aggravating factors are not identified and corrected. This, coupled with regular maintenance treatment appropriate to the severity and intensity of the client's symptoms, as well as active participation in stretching and a suitable exercise regime, should see the client having fewer recurrences of their symptoms.

Reference

1. Travell JG, Simons DG. Myofascial pain and dysfunction: the trigger point manual: volume 2, the lower extremities. Lippincott, Williams & Wilkins, 1999.

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

An Onsen Therapist's Approach by Alan Ford

As an Onsen-trained sports and remedial massage therapist, I look for the cause of sciatica coming from the lower back and pelvic regions.

As with all neural symptomatic pain, sciatica can vary from a dull ache radiating from the gluteal region to the back of the knee through to the hamstrings; from deep hip piriformis through to the TFL/ITB laterally to superior peroneal and sometimes continuing to the ankle; or, it can even present as a deep groin ache that traverses through the quadriceps to the distal attachment of the sartorius.

All of these can be described as sciatic-type discomfort, even though we know that the sciatic nerve only travels posteriorly through the gluteals and the leg.

The first requirement for an Onsen therapist in relation to this condition is to take a thorough client case history—particularly if this is the first occasion of sciatica symptoms. If it is the first time the client has experienced sciatica symptoms, I need to know if those symptoms were felt as a sudden onset or as a gradual increase in discomfort which has eventually brought them into the clinic for treatment.

In the former case, I seek specific information about whether the client recently completed a lift and twist action that may have triggered the current onset of sciatica. If not, there may have been an incident in which the client jolted or jarred their lower back and pelvis and thereby caused some impingement of the lumbar discs or spasm through the lower back or gluteals. In the latter case, I look at specific postural and alignment imbalances that could have slowly worked towards the onset of the symptoms.

A posture and structural alignment assessment, as well as specific clinical tests such as the straight leg raise or slump test, are of paramount importance in the case of sciatica. The information gathered from these simple tests and assessments will best guide the therapist on the next step in the treatment plan.

Where the client has increased pain indicators throughout testing, and there is a possibility of disc injury or neurological dysfunction beyond my level of training, I refer the client immediately to their GP for further investigation. If, on the other hand, I believe I can offer assistance for their condition, I use accurate assessment measurements to guide me in developing my treatment plan for the specific case at hand.

In all, there are eight possibilities of variant structural imbalances to consider in the case of sciatica travelling down one leg:

- High hip, excessive anterior pelvic tilt and inflare
- High hip, excessive anterior pelvic tilt and outflare
- High hip, posterior pelvic tilt and inflare

- High hip, posterior pelvic tilt and outflare
- Low hip, excessive anterior pelvic tilt and inflare
- Low hip, excessive anterior pelvic tilt and outflare
- Low hip, posterior pelvic tilt and inflare
- Low hip, posterior pelvic tilt and outflare

Each of these imbalances gives the therapist a multitude of treatment protocols to consider. Generally speaking, the rule of thumb applied in almost all cases with Onsen therapy is to treat the compressive stressed musculature—muscles and tendons that are in a shortened state. This involves using a combination of trigger point therapy to release muscles in spasm or those holding trigger points; transverse friction massage to break up any fibrosis or scar tissue within the region; myofascial release to fascia and muscles to increase blood flow and mobility of the trapped nerves; and isometric stretching to regain lost length within the muscle and improve range of movement in the affected joints.

Muscles and tendons that are being held in tensile stress (stretched beyond their normal length) often carry trigger points which will also need to be released with trigger point therapy. However, these muscles would not be stretched on completion of this action because they are already in a state of tensile stress. I would also apply compression under passive and active engagement to encourage increased blood flow into the region. I would then give the client a set of inner-range strengthening exercises to deliberately shorten and strengthen the stressed musculo-tendon structure and bring it into a normal range.

The most important point to remember is to treat the cause of the sciatic symptom—not just the pathway of pain and discomfort.

For instance, in a case where sciatic pain is being felt in the posterior right leg, and the client has a high right hip, excessive anterior pelvic tilt and a right hip inflare, the areas needing trigger point therapy, myofascial release and isometric stretching would be the lumbar erectors, right quadratus lumborum, and medial rotators of the hip—these are the muscles and tendons in compressive stress.

At the same time, the gluteals, piriformis, lateral rotators of the right hip and hamstrings are all in tensile stress, and therefore need to be activated and strengthened to stop the neural burn of the sciatic nerve that is being held within these muscles in an overstretched state.

In the case of a low right hip, posterior rotation of the pelvis and a right hip outflare, the opposite approach to the above will apply. That is, the lumbar erectors, right quadratus lumborum and medial rotators of the hip will need strengthening, while the gluteals, piriformis, lateral rotators of the hip and the hamstrings will need to be released and stretched.

Since practising Onsen therapy over the past 14 years, I have found these principles to be invaluable and extremely successful in treating sciatic pain and discomfort.

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

A Sports Massage Therapist's Approach by Jeff Murray

As discussed previously by Kerry Hage and Alan Ford, it is most important that we as therapists conduct a thorough assessment in order to determine if it is appropriate to refer or not to refer.

For the purpose of this article, I am going to assume that we have not had any positive findings in our assessments indicating a contraindication to further massage treatment. With no positive findings, I like to conduct a clearing of the hips protocol—the core to Onsen muscle therapy as discussed by Alan Ford—to determine passive and active ranges of motion, strength, weakness and fatigue issues.

We hear so much about the piriformis and most of us have experienced the discomfort associated with having someone's elbow thrust into that particular muscle. I would like to caution and bring awareness to the dangers of releasing the very muscle that may be either the only, or one of the few, muscles responsible for stabilising an unstable sacrum.

This was discussed in my presentation at the 2008 AMT Conference in Melbourne, and followed up in the December 2008 *In Good Hands* conference postscript titled 'Sacroiliac Joint (SIJ) Closure'¹.

According to Trish Wisbey-Roth, sports and Olympic physiotherapist, sensory motor amnesia to one group of muscles can create over-activity in other stabilising muscles². Paul Hodges, a physiotherapist at the University of Queensland, has written extensive reports on sensory motor amnesia and the effects it can have on other muscles. A recent report from Hodges revealed that a non-firing gluteus minimus/medius can have a dramatic effect on the sacroiliac joint; which in turn directly affects the neural loop associated with the pelvic floor, transverse abdominus, multifidus and diaphragmatic breathing³.

Keeping this issue in mind, my second round of assessments identifies whether there is a positive Trendelenberg as this has a direct affect on pelvic stability, sacral nutation and loading on the piriformis and gemellus. Both Wisbey-Roth and Hodges discuss forced closure of the SIJ—if the gluteus minimus/medius and TFL complex are not functioning properly, the proprioceptive information created from forced closure is lost and, as a result, the client suffers from an unstable SIJ.

Getting back to sciatic problems, we have now identified that we have a client with a positive Trendelenberg—insufficient closure of the SIJ. As a consequence of the sensory motor amnesia, the body calls upon the piriformis to act as the controller of the unstable sacrum. As highlighted by Alan Ford, extensive assessments of the pelvic and sacral regions are required in this situation. During these assessments, the therapist may notice a deep sacral sulcus (nutation) if there is instability of the pelvic region as well as a positive Trendelenberg. In this case, I would suggest that the piriformis is responsible for sacral dysfunction.

As therapists, we are all aware that the sciatic nerve either travels under or out of the piriformis muscle; however, what is not so widely known, according to DeLee and Drez⁴, is that about 7 per cent of the sciatic nerve branches travel across the top of piriformis, while approximately 10–15 per cent run through, and 71–79 per cent run under.

With this in mind, we can see how the sciatic nerve is directly affected by tension within the piriformis.

So now we are left with a dilemma—do we release the piriformis? My suggestion is no, and this is supported by the findings of Hodges and Wisbey-Roth. In this situation, we need to release gluteus minimus/medius and TFL because they will be tight; however, they are also weak—this weakness would have been discovered during a fatigue and strength test. Massaging, releasing trigger points or myofascial dry needling are my preferred protocols for treating these muscles depending on my client's preference (myofascial dry needling is my treatment of choice).

Once the gluteus minimus/medius and TFL muscles have been released of tension, I start my client on an open-chain exercise in order to bring some proprioception to these muscles—understand that open-chain exercises do not create strengthening, but provide a pathway for neural stimulation. During the exercise routine, I am mindful about correct postural control and awareness. The client must develop this awareness before progressing to any closed-chain exercises. Vladimir Janda claimed that the body will always recruit strength over stability—hence piriformis becomes strong at the lack of stability from gluteus minimus/medius and TFL⁵. Janda also said that most people who go into rehabilitation end up worse after about six weeks due to an emphasis being placed on strength and not stability.

Therefore, once clients can perform an open-chain side-lying clam shell exercise, and extended leg abduction to horizontal without anterior or posterior pelvic rotation, I introduce them to mediball and closed-chain strengthening exercises.

One such closed-chain exercise is a single leg stand: the client stands on the positive Trendelenberg leg, keeping the opposite hip up and not allowing it to drop. The client then conducts a mild single-leg squat. This exercise is specifically designed to strengthen the affected muscles.

The rationale behind this protocol is to strengthen the unstable weak muscles which, in turn, creates forced closure of the SIJ and stabilises the sacrum.

Once stability has been re-established, the piriformis can relax and, as a result, remove the compression on the sciatic nerve and relieve sciatic symptoms.

References

1. Conference postscript: sacroiliac joint (SIJ) closure. In *Good Hands* 2008;(12):11.
2. Wisbey-Roth T. Grading and progressing a dysfunctional specific core stability program, proceedings of the National Sports Medicine Australia Conference Perth, 2001.
3. Hodges P. Dealing with the challenges of spinal stability. The mechanism of motor control of the trunk. Abstract 37 KP Singer (Ed). Abstracts of the 7th Scientific Conference of the IFOMT. University of Western Australia, 2000.
4. DeLee JC, Drez Jr D. DeLee & Drez's orthopaedic sports medicine, principles and practice, 2nd ed. Philadelphia: Saunders, 2003.
5. Janda V. On the concept of postural muscles and posture in man. *Australian Journal of Physiotherapy* 1983;29(3):83–84.

Jeff Murray originally studied massage therapy at Hunter College of Massage in 1990. After many years of post-graduate study, he is now the only Onsen Therapy instructor in Australia. In 1998 he was appointed the Director of Sports Massage for the Sydney 2000 Olympic and Paralympic Games. He has a busy practice in Tweed Heads and lectures at Kingscliff TAFE.

■ amt

The next time we run this column we will be covering carpal tunnel syndrome. We invite all of you to make suggestions for other conditions that could be covered and encourage any therapists to contribute. If you would like to make a suggestion or find out more about writing for this column, please email Penny Robertshawe at journal@amt-ltd.org.au.

Health Fund Status

HEALTH FUNDS AND SOCIETIES

CRITERIA

Commonwealth Bank Health Society
Manchester Unity

These funds recognise all AMT practitioner levels.

A.C.A Health Benefits Fund
Cessnock District Health Benefits Fund
CUA Health Limited
Defence 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
Reserve Bank Health Society
Railway & Transport Health Fund Ltd
St. Luke's Health
Teachers Federation Health
Teachers Union Health
Transport Health
United Ancient Order of Druids Friendly Society
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 Health Management Group
Australian Unity
Government Employees Health Fund (AHMG)
Grand United Friendly Society
HCF
NIB
Victorian WorkCover Authority

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

MBF
NRMA
SGIC (MBF Alliances)
SGIO (MBF Alliances)

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 and Two providers remain eligible.

Medibank Private
HBF

Medibank Private recognises Senior Level One, and Two 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)
CSR Health Plan (HBA)
HBA (formerly AXA)
HealthCover Direct (HBA)
Mutual Community (HBA)
Overseas Student Health Cover (HBA)
St George Protect (HBA)
VSP Health Scheme (HBA)

HBA require a nationally-recognised, diploma level qualification from a Registered Training Organisation. Existing Senior Level One and Two 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 2009		CEUs
1-2	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	80
5-9	Neurostructural Integration. Presented by Ron Phelan. Perth. Ph: 0419 380 443	175
6	Workcover Outcomes Training Course for Remedial Massage Therapists. Cronulla. Ph: 1800 801 905	20
8	Members' Day/Annual General Meeting. Lumbopelvic Pain Workshop. Presented by Trish Wisbey-Roth and Jeff Murray. Ryde-Eastwood Leagues Club, Sydney. Ph: 02 9517 9925	40
14-15	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Brisbane. Ph: 03 9576 1787	80
15	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
21-22	Contemporary Cupping Concepts. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	80
21	Muscles and Pelvic Alignment. Presented by John Bragg. Mackay. Ph: 0438 773 333	35
22	Sciatica, Piriformis Syndrome and Hip Pain. Presented by John Bragg. Mackay. Ph: 0438 773 333	35
27-29	Treatment of Pain (Onsen Technique) Vol II. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
31	Illawarra Branch Meeting. Presentation. Corrimal. Ph: 0417 671 007	15

April		CEUs
1	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
5	Massage for Breathing Pattern Disorders. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
18	Mid North Coast Meeting. Port Macquarie. Ph: 02 6584 6661	15
28	Illawarra Branch Meeting. Formal Meeting. Corrimal. Ph: 0417 671 007	15

May		CEUs
8-10	Onsen Technique. Presented by Jeff Murray. Echuca. Ph: Jodee Shead 0419 575 037	105
9-13	Akupunkt-Massage according to Penzel (Course A). Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
16-17	Chi Acupressure Workshop. Presented by Master Zhang Hao. Strathfield. Ph: 02 96299 1688	70
17	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
17	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
21	Mackay Branch Meeting. Mt Pleasant. Ph: 07 4942 8481	15
22	Riverina Branch Meeting. Cobram. Ph: Jodee Shead 0419 617 007	15
24	Muscles and Pelvic Alignment. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
26	Illawarra Branch Meeting. Presentation. Corrimal. Ph: Linda White 0417 671 007	15
29-31	Treatment of Pain (Onsen Technique) Vol III. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
30-31	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	80

June		CEUs
6	Workcover Outcomes Training Course for Remedial Massage Therapists. Newcastle. Ph: 1800 801 905	20
13	Posture Beyond the Plumbline (Different ways of looking and working with the body). Mackay. Presented by Colin Rossie. Ph: 02 9517 9925	35
14	Scoliosis - Soft Tissue Protocols & Techniques influenced by Rolfing. Mackay. Presented by Colin Rossie. Ph: 02 9517 9925	35
13-14	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	80
20	Mid North Coast Meeting. Port Macquarie. Ph: 02 6584 6661	15
20	A Fascial Approach to Shoulder Problems. Presented by John Bragg. Mackay. Ph: 0438 733 333	35
20-21	Traditional Cupping- Western Tradition. Presented by Bruce Bentley. Brisbane. Ph: 03 9576 1787	80
21	Neck and Headache Pain. Presented by John Bragg. Mackay. Ph: 0438 773 333	35
21-25	Neurostructural Integration. Presented by Ron Phelan. Sunshine Coast. Ph: 0419 380 443	175
26-28	Treatment of Pain (Onsen Technique) Vol IV. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
30	Illawarra Branch Meeting. Formal Meeting. Corrimal. Ph: 0417 671 007	15

Please view the Calendar of Events on the AMT website for the complete 2009 listing: www.amt-ltd.org.au

20th Annual AMT Conference

23-25 October

@ The Novotel

Brighton le Sands, Sydney

Look for the full program in the next issue of *In Good Hands*.

**Last year's delegates
can't be wrong ...**

Loved it!

**We needed
longer - about
3 weeks**

**Enthralling
and
inspiring**

**I still have
chocolate fondue
stains on my
AMT T-shirt**



in good hands