

President's Message

By Tamsin Rossiter

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Welcome to a new year! I hope all members and their families have survived our summer of floods and cyclones.

My thoughts are with our Queensland members in particular.

With AMT's Annual General Meeting just around the corner, we are unapologetically focusing on the bigger picture. Holding an AGM is not merely about fulfilling a legal requirement - it is also an opportunity to reflect on our achievements over the past year and look towards an even brighter future for our profession. Part of our strategic plan for 2011 is the completion of policy development for our Standards and Scope of Practice. Our next step is to initiate conversation with government regarding the regulation of our profession.

Proposed national health reform will address health issues that Australia will face over the coming thirty years, in particular our aging population and the resultant burden on health services. This will mean a greater focus on preventative health care. The increasing body of evidence available on the efficacy of massage means we can expect Massage Therapy to play an integral role in the provision of national health care.

The pace of change in our industry has been rapid over the past ten years. With the inexorable march towards professionalism and mainstream medical acceptance, it is sometimes easy to forget what brought us to this point in the first place - the profound and manifold benefits of touch. Nowhere is this more evident than in the extraordinary voluntary work of AMT member and former therapist of the year, Noreen Davern.

Those of you who attended AMT's Melbourne conference in 2008 will recall Noreen's moving presentation of her work in South Africa.

Noreen has since returned there having spent the last few years tirelessly fundraising for the charity organisations with whom she is affiliated. Noreen and her dedicated team of therapists at Mountains Massage volunteer countless hours of massage to fund her work.

Currently, Noreen is living in a tin shed with two of her children who are assisting in her work. She is providing massage for people living with HIV/AIDS, TB and Cerebral Palsy. Much of her work is focused on the provision of palliative care massage. She sees clients with multiple conditions, infections, skin disorders and complex health conditions.

The communities are desperate for health care and pain relief treatment. With physiotherapists only visiting monthly, Noreen is becoming increasingly sought after. She is also working in a number of different orphanages where conditions and hygiene standards are extremely poor and children are touched in an extremely limited way.

Much of Noreen's work comprises the application of therapeutic touch. This is particularly relevant in communities experiencing abject poverty, where there is limited access to health care and minimal or non-existent remedial touch.

There are a myriad of massage therapy applications and modalities, all with their own specific methodologies, goals and objectives. Noreen's work reminds us of the extraordinary capacity of human touch to soothe, love, validate and care for people living in such deprived conditions.

On a final note closer to home, I look forward to seeing as many of you as possible at our AGM. It's a great opportunity to network with our increasingly active Melbourne branch.

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Secretary's Report

by Rebecca Barnett

2011 started with a bang not a whimper, as a series of unfortunate events demanded AMT's attention (not as diverting as the Lemony Snicket kind but I did have brief pause to wonder whether Count Olaf was serving on the Board of WorkCover NSW).

On December 16 last year, WorkCover NSW announced that they had ceased processing new applications for remedial massage provider approval until further notice. This was due to their concerns about the information being provided by applicants seeking approval.

AMT met with WorkCover on January 27 to discuss a new way forward with the processing of provider applications. WorkCover's primary goal is "to establish a reliable and consistent way of ensuring that injured workers continue to have access to high quality remedial massage therapy services". They will be consulting with the associations to determine new provider recognition criteria that meets their quality assurance standards.

This is obviously a great opportunity for AMT to put a strong case forward. Unfortunately, the process is likely to take some time, as the NSW state election will likely mean a change in government and therefore new management at WorkCover. It will probably be around 9 months before the new approval criteria is determined and established. We will keep you informed on the progress via the journal and website.

In the meantime, established WorkCover remedial massage providers will continue to provide services. This current review process has not impacted on their status.

nib's whitecoat search facility

AMT has been involved in ongoing dialogue with nib regarding their proposed whitecoat provider search facility.

Until these negotiations have concluded and we are completely confident that nib has responded to our feedback and concerns about the site, we continue to recommend that you hold off from registering on the whitecoat website. However, if you have already registered on the site, we strongly suggest that you use the feedback facility to alert nib to any of your concerns about Whitecoat.

At this stage, whether you choose to register on the Whitecoat website or not, your provider details will be listed on it. However, during this consultation phase, you can only access your own page when you use the registration code assigned to you. The whole site will not be publicly available until the consultation period is over. nib has an awful lot of feedback to incorporate already.

Since sending our first advice to members via email, nib has provided an association log-in for the whole whitecoat site so that we can assess whether our issues and concerns have been adequately addressed.

nib also convened a meeting on January 27 of all the associations that had raised concerns regarding the website. Dentists, physios, osteos, chiro, optometrists, acupuncturists, herbalists and AMT were all at the same table.

nib are painfully aware of the PR nightmare they created with the rollout of the whitecoat pilot. The mailout to providers clearly caused a firestorm of comment and outrage, both at association and individual provider level. On the positive side, nib is obviously keen to accommodate the feedback. They have realised that the website won't work without the support of the associations and their members.

Not surprisingly, much of the discussion at the meeting centred on the key issue of provider opt-out. It underpinned many of the concerns around nib's two proposed rating systems (the customer advocacy score and the service charge score). At this stage, nib has not made a clear commitment on the issue of opting out. They are seeking legal advice on the matter.

nib has also now responded to AMT's initial letter seeking clarification of key issues. A copy of nib's response is available for download from the home page of AMT's website.

We plan to issue our final advice once we have reassessed the new version of the whitecoat site and met with nib again.

Inter-association Regulatory Forum (IARF)

After attending 4 IARF meetings throughout 2009/10, the AMT Board made the decision late last year to withdraw from the group. This decision was based on a number of crucial factors, the principal one being our strong conviction that a singular regulatory scheme cannot practically encompass the diverse range of professions and modalities represented at the table.

The IARF is still yet to formalise parameters or objects for its operation. The group has recently expanded to include various counselling and psychotherapy bodies. It was unclear to us how much more it would expand and what the implications of this would be for the group's activities.

Increasingly, AMT's commitment to the forum was interfering with the critical work that needs to be done for our own constituency. The formal notice we sent to forum members of our withdrawal encapsulates the Board's position on the IARF:

"The AMT Board wishes to give formal notice of the Association's withdrawal from the IARF.

Although the IARF is yet to formalise its objects, we believe that the likely goals of the group are in conflict with AMT's stated objective of establishing and promoting massage therapy as a distinct and discrete profession.

It remains unclear how the interests and needs of the broad groups represented at the forum can be encompassed within a single regulatory framework.

In the absence of clear and agreed objectives for the IARF, we have determined that it is in the best interests of AMT's membership to focus our singular efforts on the constituency we were founded to serve. However, we are happy to cooperate with any requests for information from the IARF wherever practicable.

We wish you all the best in the complex task of carving out a distinct and recognisable identity for the broader natural medicine profession."

BUPA recognises AMT myotherapists and shiatsu practitioners

Good news! BUPA has formally agreed to accept AMT members with myotherapy and shiatsu qualifications that meet their provider recognition criteria. In the case of Myotherapy, the recognised qualification is either the 21920VIC or 21511VIC Advanced Diploma of Remedial Massage. Shiatsu practitioners must hold the HLT 50202/7 Diploma of Shiatsu and Oriental Therapies. Many thanks to Linda for putting in the hard yards on the paperwork to achieve this result.

Please refer to the health fund status table at the back of the journal for the full list of health funds that recognise myotherapists and shiatsu therapists.

Advanced Trainings in Australia

Building on the spectacular success of Art Riggs' visit to Australia last year, I am incredibly pleased to announce that AMT is sponsoring a visit by Larry Kohila and Bethany Ward this year. Larry and Bethany are faculty members of Advanced-Trainings.com, a group of educators who present continuing education seminars internationally. They will kick off their tour down under with presentations at the AMT annual conference. This will be followed by a series of workshops in the Gold Coast, Melbourne and Sydney throughout late October and early November.

AMT members will receive a 20% discount on the registration fee at Larry and Bethany's Australian workshops. Their article on page 14 of this issue on the clinical application of the latest fascia research will give you a good sense of what to expect from their Australian workshop series. Stay tuned for part 2 in the June edition of In Good Hands.

Do we have your current email address?

Results of AMT's 2010 qualitative survey are published on page 8 of this issue of In Good Hands. A handful of our respondents commented that they would really like more contact from AMT.

Over the past two years, we have made increasing use of email notifications to members, especially for issues that require a quick response such as nib's whitecoat facility, but also for distribution of other information and resources such as our Fact Sheets (these are also available for download from the AMT website).

If we don't have a current email address for you on file, you will be missing out on all these important notifications. If you have an active email account and haven't received any of our email notifications over the past month, please call AMT Head Office on 02 9517 9925 and register your email address with us.

Don't forget to send us back a proxy voting form if you can't attend the AMT AGM on the 27th. I look forward to seeing a big crowd of Melbournites in the flesh in a few weeks time!

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DEADLINE

**Deadline for the
June 2011 issue of
In Good Hands is:
1st May, 2011**

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

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php?Page=Members_CEU_1.php](http://www.amt.org.au/index.php?Page=Members_CEU_1.php)

News from the regions



Hunter by Paul Lindsay

On 19 November, Eleshia Venners and I attended the WEA Academy of Complementary Health Awards night and presented a prize to Samantha Reid for being an outstanding student in the Certificate IV Massage Therapy Practice course. We were able to talk informally to many of the students and hope to see some of them swelling the ranks of AMT.



▲ Paul at the WEA Awards Night

Our November meeting featured a presentation on 'Nutritional health for the musculoskeletal system' given by Carolyn Ward, the coordinator of the WEA Academy of Complementary Health. Carolyn's talk focused on the needs of the musculoskeletal system with particular reference to calcium, vitamin D and magnesium, and the symptoms of imbalance that massage therapists need to recognise.

In November, Hunter New-England Health invited Hunter branch to provide voluntary massages at a Staff Health and Wellbeing day, building on the work we did with them in Newcastle in 2009. We were able to provide neck and shoulder massages at the former Wallsend Hospital on 25th November. Coincidentally, a petition to engage a massage therapist on a regular basis at the health centre was circulated on the very same day.



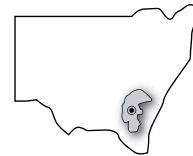
▲ Voluntary massages

We were able to provide recommendations for this proposal, which has now been approved by management, subject to the development of a Service Level of Agreement. We hope that this will be the first of many health sites to include a massage therapist!

Our January meeting was a mini-workshop, where several members demonstrated techniques that could be used on a clothed client, using either a massage chair or a massage table.



▲ Hard days work - massage style!



ACT by Karin Cavanagh

Our last workshop for 2010 was very informative. Gary Odewan's presentation on 'Working with athletes' was a little different from those of our previous sports presenters in the sense that his focus was more on the athlete's perspective rather than the therapist's. Gary gave us a rundown of some of the athletes he has worked with and how he has helped them achieve personal (and national!) bests. He also explained the athlete's usual training scheme using 'Periodisation': endurance training (both general and specific) followed by a taper just before competition. Working in concert with the athlete's training cycle obviously determines whether massage therapy treatments should involve biomechanical correction or simply stretch and strengthen techniques. A big thank you to Gary for stepping in at the last minute in place of our scheduled presenter.

By the time you read this, our excursion to Wollongong Uni for Wet Lab will have taken place. I will report on that in the June issue. Our next meeting will be the AGM on 10th April at 10am. Everyone is welcome - hope to see you all soon.

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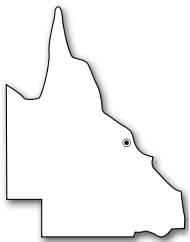
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Sydney South by Kelly Walker

Our final meeting for 2010 was a social gathering at The Ritz Hotel, Hurstville. We combined a Christmas Party with a little regional business. We discussed speakers for the following year, future directions for our meetings, and generally encouraged ideas and input from within our group. It was a pleasant and relaxed evening, giving us a rare opportunity to learn more about each other's practices and views on particular massage-related subjects.

We are looking forward to another productive year ahead.



Mackay by Rod Legge

Mackay meetings are reasonably well attended.

The branch convened a special meeting in August for a presentation by James Walsh while he was in the region. James later presented a 2-day workshop with about 12 in attendance, including members from other associations. The workshop opened our eyes to new approaches to postural assessment. We now heed the way people walk and breathe, and what minor corrections can alter poor habits.

We are still hoping to obtain a second opinion by an osteopath on the problems associated with the sacrum, following on from the presentation by a chiropractor.



Northern Rivers by Keryn Rose

The last 2 years have proven to be financially trying, with some local members reporting that business has been down by almost 50 percent. Quiet times can provide much needed rest for our busy bodies and give us space to reflect on our professional practice methods.

We are in for a treat on Sunday 6 March at our Members' Day in Lismore where local member Lynne Stebbing will present a session on 'Safe hand and body positioning'. This will be an opportunity to gain new insights into the way you use your greatest asset, plus an opportunity to swap a treatment with your peers. Look forward to seeing you there.



Melbourne by Kerry Hage

AMT's Melbourne branch met for the first time this year despite the best attempts of the floods to thwart us! With a slightly leaner attendance than our last few meetings, it was nevertheless a productive meeting. Alys Cavanagh, a Remedial Massage Therapist, spoke about the work she has been doing in her local area with homeless people. She also talked about the new volunteer-run clinic she has established to help those who have little or no access to healthcare, let alone food and a roof over their heads. Alys' presentation was informative and fascinating, and we were all moved by the stories she shared.

For the rest of the meeting, we took the first step towards building a Melbourne branch library, with the purchase of our first book and establishment of the borrowing procedure. We also started putting together a local strategic plan to help us get the region active and maximise the benefits to our Melbourne members.

We followed proceedings with a separate Peer Review treatment swap session, taking advantage of the meeting quorum to get to know each other's treatment style and gain a few extra CEUs into the bargain!

Our next meeting on May 15 is set to be full of fun, incredibly informative and interactive. We can't wait! I hope to see lots of Melbourne members at AMT's AGM on March 27 too.



Riverina by Jodee Shead

Our first meeting for 2011 was well attended despite the heavy rain and storms. Our 'newest' recruit to the region, Kay Fredericks, presented a session on Structural Assessment. Kay has been in the industry since 1978 and we feel blessed that she has moved to the Riverina, where we have already benefited from her relaxed but professional presentation style.

Kay is booked to speak again at our next meeting.

The branch has decided to take part in a Natural Health expo on the 16-17 April. Andrew Hendy, Nicole McKenzie Roslyn Keech, Siebren DeBoer and Alison Hunter have volunteered to man our stand. Nicole and Siebren have also volunteered to give a 20-minute talk on the benefits of massage therapy and of being a member of a professional association. Our aim is to increase public awareness of the fact that we are a profession with special qualifications and skills.

Riverina members who wish to promote their business at the Expo should send business cards to:

Siebren DeBoer
2090 McBain Rd
Koyuga 3622

Our next meeting will be held on Friday 13 May. Kay Fredericks will be presenting a session on psoas and walking assessments. Please RSVP to Jodee Shead via email, moweld@bigpond.com

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That's what I like about you - Results of AMT's qualitative survey

by Rebecca Barnett

Feedback from the qualitative survey that AMT conducted last year has been pivotal in structuring our soon-to-be released 2011-2016 Strategic Plan.

The survey was originally sent out to 1474 AMT members via the June 2010 journal. It was subsequently sent via email on 14 September 2010.

We received 162 responses, giving a return rate of 9%. Thirty-two surveys were received via mail, 96 via email and 32 via fax. Emailed responses constitute 60% of returns.

The data has been grouped into major themes under the three broad questions that were asked. Many survey respondents included multiple areas of comment under each question. The results have been tabulated to reflect this.

So, here is what you had to say ...

What do you like about AMT?

Response	# of responses	% of respondents
Head office service/staff	108	67
The AMT journal	66	41
Information supplied / communication	30	18.5
Conferences/regional meetings/networking	49	30
Single modality association	11	6

Obviously, the big bouquets go to our Head Office staff and the AMT journal, with a staggering 67% of respondents praising Head Office and 41% singling out the AMT journal. This is an extremely gratifying result on both counts.

The AMT conference and regional meetings are also a significant part of AMT's suite of member services, with 30% of respondents mentioning them. A small percentage (6%) like the fact that AMT is a single-modality association.

What you said:

"I really appreciate those that take the time to give us so much information. It is invaluable to me. Thank you"

"General meetings are always informative and relaxed, and there's an opportunity for all to say their piece"

"The workshops organised by AMT are fun, educational and interactive"

"I love the AMT journal, packed with information and articles. I read it from cover to cover."

"The thing I like most about AMT is the Journal, as it keeps me informed about what is happening in the industry"

"I love the fact that every AMT gathering feels like a family reunion, the quality of the lectures are second to none and questions from participants are encouraged rather than dismissed as off-topic or irrelevant"

"I like the brains behind the operation! I feel there is a real energy and drive in the team to strive for the benefit of the profession, the therapists, our clients ... and, let's face it, mankind in general."

"I really love the notifications you send me when my insurance or senior first aid is nearly due"

"AMT has worked tirelessly to help increase public awareness of massage as a valid complementary therapy".

"I like the way that things get handled promptly and that I feel like I am known rather than just being lost in the crowd"

"I like AMT's professionalism and integrity, its commitment to regional branches and its focus on member participation"

"I like the fact that AMT seems to attract members who are at the leading edge of professional practice"

"I was taken aback by the high standard when I joined AMT, with the welcome pack and journals, how quickly emails are answered, and with ongoing training like CEUs"

"I like the security of being involved with an association. I also like the regular updates and information provided by AMT. I appreciate the personalised service and affordable membership rates as well. There seems to be plenty of options to meet CEU requirements."

What do you not like about AMT?

Response	# of responses	% of respondents
The CEU system (cost, variety)	66	41
Access to regional groups/networking	25	15
Lack of lobbying with government	4	2

The CEU system copped a bit of a battering, with 41% of respondents singling it out for criticism. On the positive but possibly frustrating side, many of the comments relate to things that AMT has almost no control over, like the cost and location of accredited workshops (unless it is an AMT event, of course).

Obviously, there is still room for us to establish more regional networking groups, with 15% of respondents commenting on access issues. Establishing more regional branches should, in turn, help to address the issue of cost of the CEU participation since established regional networks give us the capacity to run more subsidised member events.

Since the survey was released, work has already proceeded in this direction with the establishment of regional branches in Melbourne and Perth. These new branches will provide much-needed support for local members, enhancing their access to CEU activities and quality networking.

AMT is keen to continue fostering and supporting new regional networks. If you would like to start up a group in your area, please contact Head Office on 02 9517 9925.

A small percentage of respondents (2%) mentioned lack of lobbying with government. This is an area we plan to address with our 2011-16 Strategic Plan.

Phase 1 of this project is articulating national Standards of Practice for the massage therapy profession. We will be entering into a consultation phase with the newly-drafted standards in April and plan to launch the complete Standards of Practice at the AMT conference in October.

What you said:

"As I live in rural Western Australia, I feel a bit left out over here. We need a representative to assist the many WA therapists with courses"

"The local branch is too difficult to get to"

"As a part-time practitioner, I find it difficult to meet the CEU quota"

What would you change about AMT?

Response	# of responses	% of respondents
The CEU system	54	33
Regional networking - more groups/locations	22	13.5
More information/contact from AMT	8	5
More lobbying with government	10	6

Not surprisingly, results in this area mirrored the dislikes. The largest number of responses refers back to the CEU system, with a third of respondents mentioning this. The focus of many of the comments in relation to CEUs is cost, variety and access. A planned review of the CEU system will hopefully address much of this feedback.

Six percent of respondents asked for more lobbying with government. Several respondents also said that they would like AMT to have a greater public profile.

What you said:

"AMT's public profile is not as large or recognisable or well known as ATMS"

"I would like to see AMT have a high public profile"

"I would like more of a presence in Brisbane/Sunshine Coast in regards to AMT accredited courses"

"Get more WA members to be proactive in forming a committee"

"More seminars/courses in Melbourne"

"The AMT journal should include more specific professional articles or case studies on treatment of various conditions. The current magazine is very much focused on policy and admin."

"I would like to see strong alliances with other health professionals, such as physiotherapists and exercise physiologists"

"It would be great if there was more training in regional areas"

Conclusions

Taken overall, the results of the survey were overwhelmingly positive. There was a mass of respondents who said they had no dislikes and were happy with the services that AMT provides.

We have been working hard to address the issues that were raised, specifically the critical issue of access to ongoing professional education and networking. Access and equity will always be a challenge in a country the size of Australia but leveraging the benefits of regional groups is a key tactic that AMT employs to ameliorate this difficulty.

I'd like to thank all of those who participated in the survey and provided us with much-needed feedback to guide the continuous improvement of our suite of member services and benefits.

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Massage Therapy in a Palliative Care Setting

by Hayley Moeller

I have been involved with palliative care for the last 4 years and wanted to share some insights into the challenging and rewarding nature of the work.

Let's start from the beginning and look at the definition of palliative care. If you are anything like me, it may come as a surprise - I had always assumed that palliative care meant working with the elderly.

Palliative Care is caring for patients with an advancing illness who are no longer responding to curative treatment.

This does not necessarily mean that the end of life is imminent - a patient could be in palliative care for many years! The definition applies to anyone at any age facing a terminal illness with no hope of a cure. Sadly, I have lost many patients who are younger than me ... and I am only 41.

The majority of patients I work with are between the ages of 40 and 60. Their illnesses are varied – predominantly cancer but also Motor Neurone Disease, brain tumours and Multiple Sclerosis.

Once a patient is on the Palliative Care program, they have access to specialised doctors, nurses, occupational therapists, physiotherapists, counsellors and, of course, massage therapists. These specialists work together to ensure that the patient's journey is as peaceful and pain free as possible.

"You matter until the last moment of your life, and we will do all we can not only to help you to die peacefully but also to live until you die"

**Dame Cicely Saunders,
Modern Day Hospice movement and
St Christopher's Hospice in England**

Reaping the benefits of massage therapy

Each week I witness the amazing relief that massage brings to patients. Many of the people I work with cannot wait to see me again after their treatments. They frequently comment that massage is the only thing that brings them pain relief. Some patients also comment that it is not only the treatment that brings them joy but the company. When you consider that these people are usually being poked, prodded or jabbed by medical staff, it is not surprising that they look forward to the experience of a comforting treatment just for them.

Included in a palliative care program, massage therapy can help to lower anxiety and pain, improve energy, decrease nausea, improve sleep and can provide a sense of wellbeing and calm. A recent study of 1290 cancer patients at the Memorial Sloan-Kettering Cancer Center in the US found that patients who received massage as part of their treatment compared to those who didn't experienced a 50% decrease in symptoms of pain, fatigue, stress/anxiety, nausea and depression.¹

"All through my cancer diagnosis and treatment, the only time someone touched me and it didn't hurt was on the massage table"

(From Gayle MacDonald's book, Medicine Hands)

Adjusting to a palliative setting

Palliative care work is vastly different from normal clinic work. You need to be extremely adaptable, often treating in weird and wonderful positions. You are usually surrounded by lots of devices and other things that get in the way, like oxygen tubes and pipes, medical equipment, medicine drivers and vomit bowls. There are often quite unpleasant smells.

The patient's room may be full of family members, other visitors and lots of emotion.

The bodies you work with are often quite compromised by skin deterioration, lesions and ulcers. The work can be unpredictable too: patients may not feel up to a treatment when you arrive or they may tire during a treatment and ask you to stop. They may cancel a treatment the morning of their booking or die on the day of a proposed treatment.

"After the poking and prodding during my treatment, the gentleness of the massage made me feel human again"

(From Gayle MacDonald's book, Medicine Hands)

However, not all of the work takes place in a hospital setting. Many patients and their family's opt for home care and treatment. These patients are visited by doctors and nursed at home. I also do some home visits in my palliative care work.

Many adjustments may need to be made to your usual way of working. These include:

- letting go of the intention to 'fix' the client in favour of just 'being'
- decreasing your pressure
- slowing the speed of your strokes
- handling the body with great mindfulness
- being aware of site restrictions and challenging positioning requirements.

I am fortunate to be part of a wonderful team at Clare Holland House in Canberra, where massage therapy is embraced wholeheartedly. I am one of a team of four contract massage therapists. We are paid for our work but it is provided complementary to the patients and their carers. It is a very popular program, with massage requested regularly.

It is incredibly heartening to be treating a patient and have their doctor enter the room and say, "Oh, I'll come back later. What you are doing there is far more important!"

"The most precious gift we can offer others is our presence"

Thich Nhat Hanh

Working in palliative care makes you examine your own mortality, which can be difficult and confronting. In our society, many of us fear death and tend to shy away from it. However, dying is one of the few certainties we have in life's journey, so I believe we need to be more open to it.

When I was first approached about working in this area, I was not sure whether I could cope. I have experienced death in my life, including the loss of my mother when I was only 10 years old, so I was not certain if I could work effectively with palliative care patients and their families.

Strangely enough, it has helped with my own healing and I feel privileged to be involved with people at such a vulnerable stage in their lives.

I encourage any therapist who is eager to explore a different way of working to consider training in this field. It is incredibly rewarding and challenging, and has enhanced my massage therapy career more than I could possibly have imagined. In 2009, I was awarded the Margaret Corden Scholarship from the ACT Palliative Care Society to further my studies in both Oncology Massage and Lymphatic Drainage. This scholarship is thanks to the bequest of Margaret Corden, a former volunteer at the Hospice.

1. Cassileth, B.R. and Vickers, A.J., "Massage Therapy for Symptom Control: Outcome Study at a Major Cancer Center", *Journal of Pain and Symptom Management*, 2004;28:244-249.

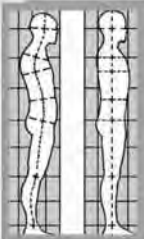
Hayley Moeller has been a member of AMT since she graduated with the Diploma of Remedial Massage in 2004. She has since undertaken extensive post-graduate studies in Oncology Massage and Lymphoedema Management, and has been involved in Palliative Care since 2007.

Hayley runs her own successful massage business in Canberra and also contracts to ACT Palliative Care, providing massage therapy to patients and their carers at the ACT Hospice (Clare Holland House) and in patients' homes.

*Further resources:
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Translating fascia research into techniques you can use

by Bethany Ward and Larry Koliha,
Certified Advanced Rolfers

Which therapist is more effective - one who knows the science underlying our work or one who has a well-developed intuition, and is able to sense and respond to subtle, possibly unquantifiable cues? We've noticed that many practitioners proudly lean to one side or other of this fence but we maintain that, not only do you **not** have to choose between scientific knowledge and intuition, it is actually ideal if you don't. Incorporating scientific input and developing a deeper 'knowing' are highly complementary pursuits.

This is the first of a two-part article. We'll be discussing some of the latest fascia research that applies to manual therapies and demonstrate how you can use this information to select techniques that target a variety of soft tissue changes. In particular, fascia plays a critical role in low back pain so we have focused on techniques that address this common issue.

What is fascia - really?

Until recently, this form of connective tissue has been the poor stepchild of the scientific and medical communities. When considered at all, fascia has generally been dealt with in fragmented parts - as ligaments, tendons or, occasionally, as wrappings of muscles in compartmental syndromes. For the most part, Western medicine has treated fascia as inert packing material that fills in the places between the 'important' parts such as muscles, bones and organs. This outlook is evident in the dearth of research devoted to the subject, at least until recently.

In the last three decades, fascia research has increased more than six-fold. So much so, that two noted Rolfer™ practitioners, Thomas Findley (MD, PhD) and Robert Schleip (PhD) convened the first Fascia Research Congress on the Harvard University campus in 2007.

The objective was to bring together fascia scientists and clinicians to inform each other's work. The congress was only intended to be a one off but it was so successful that a second was held in Amsterdam in 2009. Future meetings are to be held every three years, with the next congress planned for March 28-30, 2012 in Vancouver, Canada.

How do we change fascia?

Therapists who work with fascia witness therapeutic changes every day. We know we're affecting the connective tissue and we have ideas about the mechanisms. But the truth is that, until we started working with researchers, a lot of our understanding was educated guesswork.

Research presented at the Second International Fascia Congress suggests that there are three main ways that our work may be most effective in changing fascia:

- 1) Focusing on areas that cause tension in fascia (for example, adhesions, fibroses and scars)
- 2) Taking a global view of the body in our assessments, touch and treatment
- 3) Choosing interventions based on the type of mechanoreceptors in the area you are working and your intended outcomes.

Let's look at these a bit more closely.

Targeting areas that cause tension in fascia

A study examining the effects of stretch on areolar or 'loose' connective tissue found significant remodeling of the fibroblast cells, which make up fascia, in response to only 20 minutes of tension (Langevin, 2009). Based on this work, we can extrapolate that areas that put constant tension in the fascial web are remodeling the tissue and creating significant changes in its structure.

Therefore, it makes sense to direct our therapeutic efforts at areas of scarring, fibrosis and inflammation to rebalance areas of chronic tension in fascia.

Areolar connective tissue is the most widespread connective tissue in the body. In addition to filling the spaces between organs and surrounding and supporting blood vessels, this tissue attaches the skin to underlying tissue. As such, fibrosis can cause strain patterns in the body the same way a seam changes the pull through a piece of cloth.

After appropriate preparation, you should address fibroses and scar tissue early in your sessions, leaving time to integrate these changes throughout the system. How do you know if you've accomplished your goal? Test before and after your interventions. Improved range of motion, smoother function or increased comfort are good indicators that you are creating more balance in the fascial matrix.

Include a global view in assessments, touch and treatment

Although a global view of fascia is a novel addition to conventional thinking, it has long been a favoured approach among many holistic therapists. Perhaps one of the reasons connective tissue has been misunderstood is because it doesn't lend itself to reductionism, in either dissection or classification. There are almost no discrete ligaments in the body: all but two have to be 'created' by the dissector's scalpel (van der Wal, 2009). Although researchers distinguish between a dozen types of fascia (Langevin & Huijing, 2009), the fascial system is actually composed of a single piece which wraps, permeates and envelopes all other structures under the skin. So, as a myofascial therapist, you need to be feeling through the body to assess and monitor how forces are transmitted.

The research is showing that, not only can fascia not be separated into parts, but also that its function is inseparable from the function of muscle. A study of muscles in the lower leg found that, when a muscle contracts, its tendons actually lengthen and store energy that is released when the muscle relaxes, making gait more efficient (Kawakami, 2009). It is highly likely that this relationship occurs in other parts of the body, making the interplay between fascia and muscle important in energy transfer between tissues. We are just beginning to understand this relationship but it appears that, when we move in ways that create smoother, more graceful movements, we are training this elastic recoil property in our fascia.

Choosing interventions based on mechanoreceptors and intended outcomes

A particularly interesting area of fascia research has to do with mechanoreceptors, the sensory receptors that respond to mechanical pressure or distortion. Robert Schleip has been researching the relationship between mechanoreceptors and fascial tonicity. He is a leader in the field of addressing sensory receptors via bodywork to affect tissue tone, body awareness and deeply established movement patterns. We are extremely indebted to Dr Schleip for his generous sharing of research and ideas.

Because fascia research has been very limited in the past, we are still learning basic information about its properties and composition. Researchers' discoveries are opening up new methods for creating long-term change in clients' structures. Manipulation of mechanoreceptors in the fascia is an extremely valuable tool that can significantly inform the way we work.

The rest of this article and the one that follows will be devoted to discussing four types of mechanoreceptors found in fascia (Golgi, Paccini, Ruffini and Interstitial receptors); their locations; the effects they can produce in the body; and the kinds of touch required to achieve these outcomes.

We also demonstrate a technique for each receptor type, using the example of back pain as a common presenting condition, to underscore the practical applications of the research in hands-on treatment.

Choosing techniques to stimulate receptor types

When selecting techniques for a session, remember to first prepare the client and the area to be worked then follow up with more targeted techniques that differentiate tissue and, lastly, leave time at the end of the session for integration techniques that help the client to incorporate and embody any shifts that have taken place.

This article will cover Paccini and Golgi receptors and associated techniques. The next instalment will address Interstitial and Ruffini receptors.

Paccini Receptors: Vertebral Mobility Technique

Work with Paccini receptors can increase local proprioceptive attention and self-regulation. These receptors are inherent to your clients' experience of inhabiting their bodies so techniques that stimulate them are appropriate for both preparing and integrating phases of your work. Located in deep capsular layers, spinal ligaments and myotendinous junctions, Paccini receptors respond to the high velocity adjustments of chiropractic; the sudden pressure release techniques common to osteopaths; and to vibratory tools, rocking, shaking and rhythmic joint compression.



▲ **Image 1:** In the Vertebral Mobility technique, gently grip the spinous process between fingers and thumbs. Image courtesy ActionPotential, Inc.

Although high velocity adjustments are not in the scope of practice of massage therapy, there are many other options available to target these receptors.

Your purpose is to wake up the Paccini receptors and techniques that provide fairly quick, unpredictable movements deep inside the joint capsule are most effective. Keep your intention open and inquisitive, rather than directed and expectant. Your aim is to help the client's nervous system 'look around' and get reacquainted with areas where awareness may have become reduced.

Because people tend to reinforce movement patterns that are often focused on the space directly in front of them (for example, computer work, rushing to the next appointment, conversing with others), proprioception in areas of the spine and back often becomes diminished. This can introduce imbalanced body use and create self-perpetuating movement patterns that contribute to chronic back pain. Stimulating Paccini receptors can help your clients reset these sensors to provide more accurate information and new movement options.

The technique

To perform the Vertebral Mobility technique, start with the client prone and lightly grip (don't squeeze) a spinous process between your thumbs and fingers (Image 1). With your feet well-grounded and knees unlocked, gently rock the vertebra fairly perpendicularly to the spine (Image 2). Initially, you're observing if the vertebrae rotates right or left. If there isn't balanced movement in both directions, keep rocking in varying directions and notice if it releases.

After you've felt a response, move to an adjacent vertebra and repeat. Although you can use this technique along the length of the spine, in terms of stimulating Paccini receptors it is probably most effective to work sections of vertebrae that have become undifferentiated in the client's awareness. Look for sections of vertebrae that appear 'quiet' during gait or areas your client doesn't move through during normal activities. These still areas are common in clients suffering with back pain.



▲ **Image 2:** With feet well-grounded, rock the spinous process and observe its movement.
Image courtesy ActionPotential, Inc.

Paccini receptors become desensitised to repeated movements so change the direction of your input every two or three repetitions. You are talking to the client's nervous system at a very deep level. Your unspoken intention is to reacquaint the client with parts of the body they may not have visited recently. Keep a sense of curiosity: How does this vertebra like to move? What is it doing now?

Paccini techniques are subtle but can profoundly impact local proprioception and long-held movement patterns. Draw the nervous system's attention to an area and let it determine if it is ready to reintroduce this feedback.

Golgi Receptors: Quadratus Lumborum Technique

Stimulating Golgi receptors is a powerful tool for improving proprioception and decreasing muscular tonus. We all have clients who have muscles that seem to have forgotten how to relax. Even when they consciously relax an area, the muscle is still firing at some level. If this is the case, go for the Golgi.

Golgi receptors are abundant at myotendinous junctions, aponeurosis attachments, peripheral joint ligaments and joint capsules, so these are locations to target. These receptors respond to slow, deep, stretching techniques performed close to attachment sites.

Golgi tendon organs have been shown to be unresponsive to passive stretching (Jami 1992) so eliciting slow active client movements during manipulation will increase the relaxation of local muscle tone.

The technique

For clients with low back pain, addressing iliac crest attachments is key. In this side-lying technique, it is important to position the client so the shoulders and hips are stacked vertically (not rolling forward or back). Bent knees can act like a kickstand, allowing the client to stabilise and relax into the position.



▲ **Image 3:** To release the quadratus lumborum, contact the edge of the iliac crest and slowly lean to apply pressure in a medial caudal direction.
Image courtesy ActionPotential, Inc.

With a soft fist (relax your hand as much as possible), use the edge of your knuckles to make contact with the superior attachments of the iliac crest (Image 3). Apply pressure in a medial and caudal direction by gradually leaning into the attachments until you meet resistance. Your intention is to create length and softening of these tissues so using your other hand to create traction will facilitate this. Keep your pressure in a caudal direction so as not to press the spine anteriorly.

You want to gently challenge the tissue in a firm, controlled manner and wait for release. Check in with the client: Is the pressure okay?

To enhance the effect on the Golgi receptors, ask your client to raise his or her top knee towards the chest. If the client 'hip-hikes' or shortens in the waist, coach them to stay long through the mid back and lumbar as the knee 'floats' towards the chest. Clients will tend to initiate movement too quickly so remember to cue slower, more controlled movements to facilitate the Golgi response and inhibit muscle tone.



▲ **Image 4:** Using an elbow to stimulate quadratus lumborum attachments provides firm, controlled weight and may be easier on your body.
Image courtesy ActionPotential, Inc.

Variations on this technique include using your elbow (Image 4) and positioning the client's upper leg to reduce or enhance lumbar curve. If the client has a significant lordosis, keep both legs bent to help lengthen and decompress the curve. In the case of flat lumbar, try straightening the client's upper leg, which you can then position posteriorly to increase lumbar curve.

Conclusion

The world of fascia research is introducing new considerations for massage therapists and bodyworkers. In addition to verifying and informing our work with adhesions, it is bringing much more clarity to ways we can use mechanoreceptors to create profound structural changes.

Rather than replacing intuition, scientific inquiry challenges our assumptions, often prompting our own informal experimentation and uncovering unexpected connections which expand our awareness. Scientific knowledge and intuition can be mutually reinforcing.

In the second part of this article, we will continue our discussion of ways to address mechanoreceptors via bodywork, hopefully stimulating your mind as well as mechanoreceptors in the process!

Bethany Ward and Larry Koliha split their time between teaching and private practice. Faculty members of Advanced-Trainings.com, which offers continuing education seminars internationally, Ward and Koliha also teach at the Rolf Institute® of Structural Integration. Ward is President of the Ida P. Rolf Research Foundation, a non-profit that supports Structural Integration research and stewards the International Fascia Research Congress. AMT is proud to be sponsoring Bethany and Larry's visit to Australia in October. After presenting at the 2011 Annual Conference, they will be teaching Advanced Myofascial Techniques workshops in the Gold Coast, Melbourne and Sydney. AMT members will receive a 20% discount on the registration fees. To learn about classes and dates, go to www.advanced-trainings.com

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RESOURCES

DVDs (in alphabetical order):

- *Advanced Myofascial Techniques DVD series*
www.advanced-trainings.com
Five volumes of hands-on techniques for bodyworkers and manual therapists, with Til Luchau, Certified Advanced Rolfer and Director, Advanced-Trainings.com Faculty.
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- *International Fascia Research Congress DVDs & Proceedings Books (2007 & 2009)*
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- *The Nature of Fascia*
www.terrarosa.com.au
Dr. Robert Schleip discusses mechanoreceptors and fascia in depth.
- *Strolling Under the Skin*
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Websites

- Access fascia research articles at Dr. Schleip's website:
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Clinical Perspectives: Tension Headache

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

A Myotherapist's Approach by Jodie Goode

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If there is substantial jaw tension implicated in the headaches.

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

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

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

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

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

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

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

Looking outside the box - a structural approach by Jeff Murray

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

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

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

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

Other important aspects of scapular deviation to look out for are winging of the medial border and tipping of the inferior angle, or a combination of both.

Winging without protraction would indicate a weak serratus anterior muscle. Winging with protraction could indicate weak medial trapezius and serratus anterior muscles. Tipping would indicate a tight pectoralis minor muscle.

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

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

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

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

On palpation, you will obviously feel a tight upper trapezius. However, it is not necessarily the upper trapezius muscle that needs to be released but rather the concentrically loaded triceps brachii.

Once triceps brachii has been relaxed, it will allow the scapula to return to neutral which in turn will take the eccentric load off the upper trapezius. Once triceps brachii has been released, I would recommend addressing any trigger points in the upper trapezius.

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.

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Retention of Client Files

by Rebecca Barnett

The AMT Board will release a consultation draft of the Standards of Practice at the upcoming Annual General Meeting on March 27. With the impending release of this significant document, we thought it would be timely to revisit as issue that was posted on the AMT forum in relation to retention of client records. The soon-to-be released draft of the Standards of Practice will include a comprehensive policy on Record Keeping.

The AMT forum is a valuable resource for members to share information, and seek guidance, advice and support from their peers. Members who have registered for the forum receive 10 CEUs per year for participation. www.amt.org.au/forum

After being in business for 11 years I need to decrease the weight of my filing cabinet! Does anyone know if there is a legal restriction on how many years a confidential client file must be kept? I have memories from TAFE's Law and Ethics subject that 7 years is appropriate but is that more for the accounting side of business? On a more solemn note, does the same apply to the file of a client who has passed away (not during a massage!)? Thanks.

Michelle

Hi Michelle,

Surprisingly, this is a much greyer area than you might think. Given the increasing litigiousness of society, there are some groups of health professionals who retain their client/ patient records for life, in spite of the recommendations made by their various governing bodies that they only need to retain them for 7, 15, 25 years or whatever.

In our practice and procedures guidelines, AMT recommends that you retain client records for a minimum of 7 years.

This obviously falls into line with the statute of limitations on other significant business documents that you have alluded to, like tax records etc, so it's a pretty logical cut off. But it's also enshrined in the Health Records and Information Privacy Act (2002), which we are subject to as massage therapists.

If a client has died from a non massage related cause, you still need to retain their file until 7 years after their last visit.

The only thing I would suggest you do is to have a quick look at the Health Records and Information Privacy Act for guidance on how to destroy records. Full text of the Act is available here:

http://www.austlii.edu.au/au/legis/nsw/consol_act/hraipa2002370/

Here's a cut and paste of a few relevant bits:

How long are you required to retain health records?

You are required to destroy or permanently de-identify health information once it is no longer needed for further uses or disclosures authorised by the HRIP Act. However, this requirement is not absolute. If other legislation requires you to retain records for a minimum period, then this must be followed.

Private sector health service providers must retain health information relating to the person as follows:

In the case of health information collected while the person was an adult – for 7 years from the last occasion on which you provided the person with a health service.

In the case of health information collected while the person was under the age of 18 years – until the person has attained the age of 25 years.

Disposing of health information, or transferring health information to another organisation.

You are required to dispose of health information securely.

When private sector health service providers delete or dispose of a person's health information they must keep a record of:

- the name of the person
- the period covered by the health information
- the date on which it was deleted or disposed of.

When private sector health service providers transfer a person's health information to another organisation (and do not continue to hold a record of that information) they must keep a record of the name and address of the organisation to which they transferred the health information.

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Health Fund Status

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

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

Members with pre-HLT qualifications will only retain their provider status by maintaining the currency of their first aid and insurance without interruption, and by achieving a minimum of 100 CEUs per year. Members are responsible for providing all supporting documentation to Head Office.

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

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

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

Calendar of Events

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

March 2011		CEUs
1-3	Anatomy Trains and Body Reading. Presented by Tom Myers. Sydney. Ph: 02 9542 8277	105
3-7	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley and Shirley Gabriel. Cairns. Ph: 03 9576 1787	175
4-6	Soft Tissue Master Class - Head, Neck and Thorax. Presented by Tom Myers. Sydney. Ph: 02 9542 8277	105
4-6	Practitioner Assessment Skills. Presented by Ron Phelan. Black Rock. Ph: 03 5255 5229	105
5-8	Akupunkt Massage According to Penzel Course A. Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
5-6	Functional Fascial Taping Upper and Lower Body. Presented by Ron Alexander. Brisbane. Ph: 03 9481 6724	90
6	Northern Rivers Branch Meeting. Lismore. Ph: 02 6622 1053	15
9-11	Anatomy Trains and Body Reading. Presented by Tom Myers. Melbourne. Ph: 02 9542 8277	105
10-14	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Perth. Ph: 03 5255 5229	175
12-13	Soft Tissue Master Class - Intrinsic Pelvis. Presented by Tom Myers. Melbourne. Ph: 02 9542 8277	70
12-13	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Brisbane. Ph: 03 9576 1787	80
19-20	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Melbourne. Ph: 03 9576 1787	80
20	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
20	Your Vision - Your Success. Presented by Jeff Shearer. Melbourne. Ph: 1800 088 545	15
21-25	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	140
25-27	Functional Assessments and Corrections of the Lower body (Onsen Vol.2). Presented by Jeff Murray. Tweed Heads. Ph: 07 5599 2514	105
25-29	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Black Rock. Ph: 03 5255 5229	175
25-27	Infant Massage Training. Presented by IMIS. Perth. Contact 1300 558 608	120
26-27	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne. Ph: 03 9532 8144	60
26-27	Ortho-Bionomy Fundamentals (Phase 4). Presented by Anthony Swan. Canberra. Ph: 0412 286 385	70
27	AMT Members' Day and Annual General Meeting. Heidelberg, Melbourne. Ph: 02 9517 9925	40
29	Illawarra Branch Meeting. Presentation. Corrimal. Ph: 0417 671 007	15
April 2011		CEUs
1-3	Infant Massage Training. Presented by IMIS. Sydney. Ph: 1300 558 608	120
2-3	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	56
6	South Sydney Branch Meeting. Hurstville. Ph: 0411 039 819	15
8-11	Neurostructural Integration Technique Advanced. Presented by Ron Phelan. Ocean Grove. Ph: 03 5255 5229	140
14-18	Somatic CST 1. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	160
16-17	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	56
17	Curly Customers: Muscles that Confound. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
17	Your Vision - Your Success. Presented by Jeff Shearer. Sydney. Ph: 1800 088 545	15
26	Illawarra Branch Meeting. Formal. Corrimal. Ph: 0417 671 007	15
29-1	Structural Assessments and Corrections of the Cervical and Thoracic Spinal Regions (Onsen Vol.3). Presented by Jeff Murray. Tweed Heads. Ph: 07 5599 2514	105
May 2011		CEUs
5-6	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Cairns. Ph: 03 9532 8144	60
7	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	28
13-15	Practitioner Assessment Skills. Presented by Ron Phelan. England. Ph: 03 5255 5229	175
13-17	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley and Shirley Gabriel. Sydney. Ph: 03 9576 1787	175
13-15	Infant Massage Training. Presented by IMIS. Gold Coast. Ph: 1300 558 608	120
15	Melbourne Branch Meeting. Mt Waverley. Ph: 0401 256 015	15
21-22	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Perth. Ph: 03 9532 8144	60
21-22	Neurostructural Integration Technique Introduction. Presented by Marianne Grainger. Perth. Ph: 08 9490 3906	70
21-22	Myofascial Cupping. Presented by David Sheehan. Gold Coast. Ph: 03 9481 6724	70
23-27	Somatic CST 3. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	175
25-29	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley and Shirley Gabriel. Darwin. Ph: 03 9576 1787	175
27-29	Functional Assessments and Corrections of the Upper body (Onsen Vol.4). Presented by Jeff Murray. Tweed Heads. Ph: 07 5599 2514	105
28-29	Chi-Acupressure Massage. Presented by Master Zhang Hao. Strathfield. Ph: 02 9629 1688	75
29	Arm and Hand Pain. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
31	Illawarra Branch Meeting. Presentation. Corrimal. Ph: Linda White 0417 671 007	15

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