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President's Message

by Annette Cassar

Welcome to 2015. The year kicked off with intense media speculation around a leaked draft of the National Health and Medical Research Council report into Natural Therapies. *The Australian's* Sean Parnell spearheaded the suggestion that the Federal Health Department would move to axe the government rebates on private health insurance policies covering natural therapies, including massage.

AMT was quick to respond: within days we had launched an online petition to 'Retain the Private Health Insure Rebate for Massage Therapy', and published a media release and position statement clarifying our stance on the issue – that the scope of the review was too narrow and the findings underscore an urgent need for more research into massage therapy. You can access the media release here:

<http://www.amt.org.au/downloads/news-items/AMT-Media-Release-PHI-petition.pdf>

Within one week, the AMT petition had garnered 3000 signatures, with the count (at the time of going to print) now standing at 6686. If you haven't done so already, get on board and sign the petition <http://bit.ly/amtpetition>. You can also download a printable client communiqué, which gives clients various options about how they can support our stand <http://bit.ly/clientcommsPHI>.

Hot on the heels of the NHMRC reportage, *A Current Affair* aired an exposé in late January about "cheap massage clinics popping up around Australia that could be putting your health at risk". The program pointed the finger at some common

problems in these establishments, including communication breakdown and lack of qualifications.

This segment underscored the importance of the work AMT has invested in articulating benchmark professional standards for the safe and ethical practice of massage therapy via the AMT Code of Practice. The Code of Practice is a coherent set of policies that not only informs therapists of their professional and ethical obligations but also informs the public of what they should expect from a qualified therapist. The picture painted by ACA is a million miles away from AMT's Code of Practice.

By committing ourselves to applying benchmark standards, we form a powerful image in the public's mind of what it means to be in the hands of a caring professional. I encourage you to review the Code of Practice if you haven't looked at it for some time and thank you for your ongoing commitment to upholding the highest professional standards.

AMT is also justifiably proud of our members' commitment to continuing professional development. Our continuing education system has been in place for more than 20 years now, having been established long before the advent of health fund recognition criteria. Some of our long-standing members have very fat files, stuffed with CEU records that tell a story of dedication and professionalism. As President of AMT, I am proud to represent these passionate and committed people.

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Association of Massage Therapists Ltd

Office hours:
Monday-Friday 9.30am - 4.00pm

Suite 3.02
22-36 Mountain Street
Ultimo NSW 2007

Postal address:
PO Box 826
Broadway NSW 2007

T: 02 9211 2441
F: 02 9211 2281

info@amt.org.au
www.amt.org.au

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Secretary's Report

by Rebecca Barnett

At a recent industry meeting, I found myself yet again defending the retention of the Certificate IV in Massage Therapy Practice within the Health Training Package.

The massage therapy Cert IV is now utterly unique - it is the only remaining Certificate IV within the complementary health sector. And because it's the last man standing, it has become the object of much scrutiny, debate and sometimes even open derision.

Informed dialogue about appropriate qualification levels for the nascent profession of massage therapy is important and useful. It helps us to reflect on where we've been and to think coherently and strategically about where we need to head, to support the goal of embedding massage into mainstream healthcare delivery.

Given that AMT championed the retention of the Certificate IV in Massage Therapy Practice within the Health Training Package, it's timely to put on public record AMT's reasons for wanting to preserve the Cert IV, especially in the face of the qualification creep that has occurred in all other complementary health disciplines.

The first and primary reason is that we believe there is still a distinct vocational outcome at that qualification level and, in fact, a growing societal need for general health maintenance massage and stress management. In a society suffering from an epidemic of somatic alienation and touch deprivation, the profound benefits of basic massage therapy, delivered by an appropriately qualified practitioner, cannot be overstated. Not every client is remedial. Not every presentation is purely musculoskeletal. Not every appointment is about fixing something. Massage therapists also provide support, a sense of wellbeing and even, God forbid, nurture.

Secondly, AMT sees the Certificate IV operating in a broader healthcare context, not just as a standalone qualification. For example, we see a clear role for healthcare workers who hold dual qualifications in aged care and massage, especially in the context of an aging population. Given the move towards interdisciplinary healthcare teams and at-home services as a more economically sustainable model of care delivery, the Certificate IV takes on a whole new relevance.

AMT also sees a role for the Certificate IV as an adjunct to professions such as registered nursing. AMT is proud to represent many registered nurses who are also qualified massage therapists – in fact, many of those members have moved out of nursing and into massage exclusively.

In essence, AMT sees the retention of the Certificate IV within the Health Training Package as supporting our goal of moving massage therapy into the domain of primary care. Moreover, we believe it fills a distinct and significant niche in terms of healthcare delivery in Australia.

The skills learned at Certificate IV level form the building blocks of everything massage therapists do, regardless of whether they go on to complete Diplomas or Advanced Diplomas. The race to abandon the qualification and disavow the benefits of basic massage in the interests of professionalisation not only sells massage short, it fundamentally undermines our foundations. There is room in the health marketplace - and identifiable healthcare needs - for massage therapists to work at different levels of qualification. When registered nurses moved to a degree level qualification, the nature of their role underwent a permanent shift.

The previous tasks registered nurses performed didn't just magically go away but were filled by enrolled nurses and assistant nurses, qualified at Diploma level and Certificate III level respectively (still healthcare workers nonetheless).

AMT is committed to preserving learning pathways for therapists, including the development of articulation pathways into degree qualification. The Certificate IV is the basic building block of that qualification journey and we shouldn't be too quick to sacrifice it at the altar of professionalisation.

NHMRC review of Natural Therapies

As Annette mentioned in her report, the New Year brought a flurry of media speculation around a leaked draft of the National Health and Medical Research Council's (NHMRC) review of natural therapies. The news reports were grim, suggesting that the federal health department would act to remove the government rebate on natural therapies, including massage, currently covered under private health ancillary packages.

The coverage was essentially characterised by broad misreporting of the NHMRC's findings and unhelpful speculation around the government's likely response. Some commentators even appeared to speak with authority on the NHMRC findings without having seen a copy of the draft report.

The NHMRC review is yet to be publicly released. AMT is aware of the findings but, until the report is officially released, our response has to be somewhat constrained. AMT wrote to the Federal Health Minister, Sussan Ley, to confirm the Department's timetable for its consideration of the NHMRC findings. We continue to await a response.

AMT is writing to the Health Minister again to establish the timetable for consideration of the NHRMC findings. We will keep you informed of developments.

2015 classified research database

Given the NHMRC review of natural therapies and the dominant model of evidence based medicine, the dissemination of massage therapy research has become even more critical. AMT maintains its commitment to making quality research accessible to members via this journal, the AMT website and AMT's social media platform (Facebook and Twitter).

The online release of our 2015 classified research database in January was met with unprecedented engagement. Within three weeks, the database was downloaded from the AMT website more than 3000 times. Our Canadian colleagues at the Registered Massage Therapists Association of British Columbia were quick to light up social media with news of the update's release – in fact, they broke the news before we had notified our own members. Their switched-on librarian had been monitoring the AMT website and jumped on the database link as soon as it was published. It's certainly gratifying to see AMT's work receiving international acclaim. We encourage all members to reap the benefit of this home-grown golden fleece: don't let those cluey Canadians steal all the booty.

The 2015 database includes hyperlinks to a substantial amount of full free text material, so quality research is only a single mouse click away. You'll find the database here:

<http://www.amt.org.au/downloads/practice-resources/AMT-Classified-Research-January-2015.pdf>

AMT member database

Speaking of database launches ...

AMT launched its new member database at the beginning of February. A year in development, the database gives AMT members more control over their information, including adding practice addresses and reporting CEU activity. The new system allows AMT to issue critical reminders to members via text and email, and will substantially automate health fund reporting.

Your personal login will enable you to:

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AMT is in the process of transitioning all reports from the old system to the new. For this reason, data integrity is critical. If you haven't accessed your personal member portal, could you please assist us by logging in as soon as possible to check that your details are correct and up to date? You can access the site from here:

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Just click on the link that says "Didn't receive confirmation instructions" and you will receive a new link to activate your personal account. If you require assistance, please don't hesitate to call Head Office on 02 9211 2441.

2015 AGM

The Annual General Meeting will be held on March 15 in Adamstown, Newcastle. It will be followed by a workshop presented by Ron Phelan, "The Essential TMJ". Attendance at the workshop will attract 35 CEUs. The meeting and workshop will attract 50 CEUs. I hope to see you on the day.

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DEADLINE

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Fibromyalgia: Continued Perspectives for the Manual-Massage Therapist - Part One

Steven Goldstein

B.A. Education 1984, B.H.Sc. Musculoskeletal Therapy 2007

This is Part One of a three-part series of theoretical, pathophysiological presentations and practical applications for treating fibromyalgia. Part One focuses on the historical context of fibromyalgia and the difficulty clinicians have had with identifying the clinical diagnosis for fibromyalgia.

Introduction: Historical Context

A good deal of information and advice continues to be written regarding the treatment and management of this difficult syndrome. If you are new to treating fibromyalgia, it will appear complicated by virtue of its presenting symptoms and difficult to manage and treat. Imagine a person who is in considerable pain but no physician can identify why the pain is occurring and often cannot find anything specifically wrong with the person. Until 1990, when the American College of Rheumatology, following the work of Dr. Fredrick Wolfe, set criteria that described the syndrome; it was mismanaged, misdiagnosed and misrepresented.⁽¹⁾

For many years, lack of a unifying etiology and a universal terminology hindered the understanding and recognition of fibromyalgia. An Edinburgh physician, William Balfour, suggested that an inflammatory process that affected connective tissue was responsible for the occurrence of pain in what was then called muscular rheumatism that involved fatigue, stiffness, aches, pains and disturbed sleep.⁽²⁾ In 1880, a US psychologist named Beard wrote about a collection of symptoms consisting of fatigue, widespread pain, and psychological disturbances. He called it 'neurasthenia' and attributed the problems to the stress of modern life.⁽³⁾ In 1904, a pathologist, Ralph Stockman, reported (erroneously) that he had discovered evidence of inflammatory changes occurring in the fibrous, intramuscular septa of biopsies from afflicted patients.⁽⁴⁾

This led Sir William Gowers (1904) to introduce the term "fibrositis" to describe the condition, believing - again erroneously - that inflammation was a key feature of 'muscular rheumatism'.⁽⁵⁾ Numerous subsequent studies of similar biopsies failed to replicate the inflammatory changes found by Stockman and the term "fibrositis" is no longer considered an accurate descriptor for the pathology.

Many studies have been done since these early studies and among the most important are those of Lewis and Kellgren who, in the 1930s, investigated referred pain.⁽⁶⁾⁽⁷⁾ It was that work, and the research of Smythe, a rheumatologist, and Moldofsky, a psychiatrist in Toronto, Canada, who conducted electroencephalographic studies on a group of patients suffering generalised muscle pain and disturbed sleep, that finally determined the etiology of fibromyalgia.⁽⁸⁾⁽⁹⁾

Studies by Robert M. Bennett, Frederick Wolfe, and Muhammad B. Yunus have also been critical in categorising symptoms and tender points.⁽¹⁰⁾⁽¹¹⁾⁽¹²⁾⁽¹³⁾

Hench was the first to document the term fibromyalgia in the early 1970s.⁽¹⁴⁾

Hench noted that muscle as well as ligamentous and tendinous connective tissues are usually subjectively involved. Later, in the 1980s, Yunus proposed a unified classification system, and the first diagnostic criteria.⁽¹⁵⁾⁽¹⁶⁾ As mentioned above, in 1990 the American College of Rheumatology first established criteria for the classification and diagnosis of the disease.

Nonetheless, the 1990 ACR classification which follows is fraught with inconsistencies and controversy: Fredrick Wolfe's 'criteria' was originally intended as a diagnostic tool, and is not necessarily 'diagnostic criteria'.

Wolfe's 'diagnostic tool' was differentiated from 'diagnostic criteria', when in 1990, for the first time, the clinicians performing studies, Wolfe, Yunus, et. Al., noticed that the 'tender point' count was significantly greater in FM sufferers than any healthy control group.⁽¹⁷⁾

The ACR criteria for fibromyalgia (FM) require that patients have a history of chronic pain for ≥ 3 months and pain in ≥ 11 of 18 tender point sites on digital palpation.⁽¹⁸⁾



Figure 1. The 18 tender points of fibromyalgia.

Confusion arises when clinicians and physicians who want to simplify use tender point criteria as a tool to differentiate FM. Wolfe felt the inconsistencies in tender point count could not allow it to be consistent as 'criteria'.

Yet another important problem beset fibromyalgia diagnosis. Patients who improved or whose symptoms and tender points decreased would not fall within the ACR's 1990 classification criteria. It was not clear how to categorise or assess these patients.

In addition, the ACR classification criteria set such a high bar for a diagnosis of FM that there was little variation in symptoms among fibromyalgia patients. These two considerations suggested the need for the development and use of a broad-based severity scale that could differentiate among patients according to the level of fibromyalgia symptoms.⁽¹⁹⁾

One of the consistent problems with FM is the plethora of presenting symptoms that, for massage therapists, can make assessment difficult.

For instance, Wolfe's recent study states: "We also asked patients to indicate which of the following symptoms they experienced in the last three months: blurred vision or problems focusing; dry eyes; ringing in ears; hearing difficulties; mouth sores; dry mouth; loss of or change in taste; headache; dizziness; fever; chest pain; shortness of breath; wheezing (asthma); loss of appetite; nausea; heartburn; indigestion or belching; pain or discomfort in the upper abdomen (stomach); liver problems; pain or cramps in the lower abdomen (colon); diarrhea (frequent, explosive watery bowel movements, severe); constipation; black or tarry stools (not from iron); vomiting; joint pain; joint swelling; low back pain; muscle pain; neck pain; weakness of muscles; tiredness (fatigue); depression; insomnia; nervousness (anxiety); seizures or convulsions; trouble thinking or remembering; easy bruising; hives or welts; itching; rash; loss of hair; red, white, and blue skin color changes in fingers on exposure to cold or with emotional upset; sun sensitivity (unusual skin reaction, not sunburn); yellow skin or eyes (jaundice); fluid-filled blisters; numbness/tingling/burning; swelling of the hands, legs, feet, or ankles (not due to arthritis); irritable bowel syndrome; faintness; frequent urination; painful urination; pain, fullness, or discomfort in the bladder region; sensitivity to bright lights, loud noises, or odors; fatigue severe enough to limit daily activity; tender lymph nodes; or frequent sore throats. We summed the positive replies to create a 0–56 count of somatic symptoms scale."⁽²⁰⁾

Given the great number and wide variety of accompanying conditions, is it any wonder fibromyalgia was so difficult to diagnose and treat for physicians or allied health care professionals? Hailed with great relief, a new ACR classification came into effect in 2010.⁽²¹⁾

New 2010 ACR Classification for Fibromyalgia

Prior to the publication of the 2010 American College of Rheumatology preliminary fibromyalgia diagnostic criteria, diagnosis was straightforward as long as the examiner ignored the temptation of analysing the accompanying conditions as indicators of the problem and applied the tender point examination. The examiner simply identified that the patient was experiencing widespread pain and then performed a 60-second examination of tender points as described by the 1990 ACR Classification Criteria.

The 2010 ACR Diagnostic Criteria has eliminated the tender point examination and made diagnosis more difficult by requiring evaluation of symptoms. The 2010 criteria altered the case definition of fibromyalgia by recognising that **symptoms were a central part of the syndrome**. In so doing, the new criteria imposed a special burden on the examiner: the necessity to interview the patient in detail sufficient to identify the extent and severity of the symptoms. The ACR 2010 criteria provided rules for categorising symptom severity in order to make a diagnosis, but didn't precisely define how symptom severity was to be ascertained, leaving this to the clinician. The ACR criteria committee was purposeful about this: clinicians now were provided with symptom guidelines, but they could use ascertainment methods that were appropriate for their clinical setting and manner of practice. In general, the committee felt that a comprehensive patient interview and a physical examination are required to provide the requisite diagnostic information.

The new criteria indicates two distinct but combined diagnostic pathways using a scoring system that clients subjectively indicate in respect of, first, a WPI Widespread Pain Index and, second, a SS Symptom Severity scale.

The WPI Widespread Pain Index charts 19 areas of the body where the patient might feel pain: shoulder girdle, hip, jaw, upper arm, upper leg, lower arm, and lower leg on each side of the body, as well as upper back, lower back, chest, neck, and abdomen over the past week, with each painful or tender region scoring 1 point.

The first part of SS Symptom Severity scale scoring is broken into three sections: fatigue, waking unrefreshed and cognitive symptoms suffered by the client during the previous week. Each section is scored: 0 - no problem; 1 - slight or mild problems: generally mild or intermittent; 2 - moderate: considerable problems, often present and/or at a moderate level; 3 - severe: pervasive, continuous life-disturbing problems. The section yields a 0 to 12 score. The second part of the SS Symptom Severity scale is calculated using a checklist of 41 associated symptoms.

A patient is diagnosed with FM if:

1. The WPI is at least 7 and the SS scale score is at least 5 or the WPI ranges between 3 to 6 and the SS scale score is at least 9.
2. The symptoms have been present at a similar level for at least three months.
3. The patient does not have another disorder that otherwise explains his or her pain.

The differential diagnosis of widespread pain is broad and includes numerous psychological, hematologic, endocrinologic, autoimmune, infectious, and neurologic disorders; cancer; and vitamin and mineral deficiencies.

The Fibromyalgia Client

The next article in this series – Fibromyalgia Syndrome: The Causative Factors - will examine the causes of fibromyalgia syndrome and the confusing client presentations a practitioner may encounter.

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Steven Goldstein holds a BA Education, and a B HSc Musculoskeletal Therapy. He has been a massage educator since 1992, instructing in direct myofascial release, indirect osteopathic releasing methods and somatic approaches known as Integrative Soft Tissue Release (ISTR). For more information, visit www.fascialrelease.com

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Absence of Evidence is not Evidence of Absence: The use of validated outcome measures for practice success and data collection

by Andrew Shepherd

The recent media attention surrounding The Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies is a hot topic within our industry.

According to media reports, a leaked version of a government review – which was conducted by the National Health and Medical Research Council (NHMRC) – found no conclusive evidence to show natural therapies work. It was reported, however, that there was low to moderate evidence that massage may improve certain health outcomes for a limited number of clinical conditions.

If the government decides to remove the rebate, it could mean that many members of the Australian public who currently access our services because the rebate makes them affordable may cease to do so. This would seriously affect AMT members' businesses and livelihoods.

The AMT has been collating a national database of evidence based on reputable research studies about the benefits of remedial massage, however, more evidence is needed.

So how can we positively affect the government's decision about its rebate policy? Signing petitions and getting the message out there to our clients and the general public is a worthwhile endeavour. After all, campaigns run by GetUp! and Change.org have been proven to work in terms of mobilising public pressure on government entities.

But our efforts should go deeper than this. We all know in our hearts that massage works. But how can we prove it? Or rather, how can we acquire compelling evidence that shows that it is extremely unlikely that no health

benefits flow from massage therapy?

From a scientific point of view, evidence must demonstrate that the likelihood or chance of a hypothesis being wrong is very low. Or another way of putting it is: instead of showing proof for a hypothesis, you must show enough good evidence that there is only a small chance (usually < 5% per cent) that a hypothesis is wrong.

Let's change direction for a moment. In your own practice, how do you measure your success with clients? Do you just treat them until they say they feel better? How do you measure a client's statement that they are feeling better? Or perhaps the question should be: why should you measure client outcomes?

Why take the time to measure and record your successes?

The simple answer is that measuring your outcomes shows you what treatment worked over a given timeframe and why. This is important in terms of learning which techniques and treatment protocols are effective, allowing you to reliably apply them in relevant circumstances. It is also a good way of showing your client how you chose the particular treatment that has achieved a beneficial outcome.

Your measurement of past successful treatment is a powerful tool that enables you to demonstrate to your clients how and why massage is effective. The accumulation of such evidence means you can justify a series of treatments, for instance, rather than rely on the hit-and-miss approach of "see how you go and give me a call". Such evidence will also enable you to demonstrate to other health professionals that what you do works, and could give them the confidence to refer their clients to you.

How to collect and measure your evidence

Collecting evidence starts with conducting a thorough history and physical examination at a level appropriate to your training. The general consensus within mainstream medicine is that eighty per cent of your working diagnosis flows from the information you carefully obtain from the client's history. This is the basis on which you form a clinical opinion about the possible causes of the client's complaint, which then drives the direction of your examination. Remember, however, that if you are in doubt about the nature and treatment of a client's complaint, simply refer him or her to a primary health care practitioner.

Here's a simple example: Mary comes into your practice complaining of lower back pain after an afternoon of gardening two days ago. She has no real prior history of back pain, no major past medical issues and is otherwise fit and healthy. The pain is a dull, localised ache around the lower lumbar, which gets better with heat and stretching and becomes worse with immobility. She denies the presence of referred pain or neurological symptoms.

By obtaining this simple history of the client's problem, along with her medical history, you are in a position to diagnose a simple muscular lumbar strain.

This diagnosis means that you can limit your examination to a simple structural analysis, range of motion (ROM) testing and palpation, using a visual analogue scale (VAS) or a one-to-ten pain scale to measure pain levels.

By recording this data, you are establishing a pre-treatment baseline; these same variables can be measured again after treatment.

For example, if Mary experienced only 50 per cent of normal lumbar flexion and reported a VAS of 7/10 pre-treatment and experienced 75 per cent of normal lumbar flexion and reported a VAS of 4/10 post-treatment, these figures quantifiably and qualitatively measure your treatment's success. By converting these figures into percentages, you can show your clients a measurable degree of success.

So, for the client who might get up from the table after an hour of massage and says, "Yes, it's a little better but I can still feel it", you can now say: "Well, Mary, pre-treatment my measurements indicate that you had only 50 per cent of normal lumbar flexion; now you have 75 per cent. That's an improvement of 25 per cent. Also your pain levels were 70 per cent of maximum and now they are 40 per cent, an improvement of 30 per cent."

A client's response, based on my own experience of 20 years, is almost always, "WOW!"

So how does all of this relate to research and evidence for the efficacy of massage therapy?

How this evidence will help us

The example above illustrates the collection of data - quantifiable data using outcome measures (ROM and VAS) - that are valid across the medical profession.

If enough massage therapists

1. collected data pre- and post-treatment for, say
 - a. six treatments per client for ten clients
 - b. regarding commonly seen complaints (such as lower back pain (LBP) and shoulder/neck pain (SNP))
 - c. using widely accepted outcome measures (ROM and VAS) and
 - d. widely accepted treatment protocols (such as myofascial release, trigger point therapy, deep friction, Swedish massage)
2. recorded this data and
3. entered the figures into a database capable of statistical analysis (several online apps can do this)

the massage therapy profession would thereby create a huge data sample collected from case studies. Now it has to be said that case studies are not the gold standard for collecting evidence concerning a given hypothesis; rather, a double-blinded, randomised control trial constitutes that standard.

But the collection of a large enough sample size, using simple data variables and valid assessment protocols (VAS and ROM) means that, despite bias, sufficient data can be generated on which to perform a robust statistical analysis to see if what massage therapists do really works.

Collecting such data should not take much effort in practice. Of course, AMT members would have to adhere to strict guidelines regarding outcome measurements, treatment protocols and data collection when generating the relevant data. Those figures would then be entered into a national database for analysis. A huge amount of data could be created and analysed very quickly and relatively cheaply.

Massage therapy would then be in a position to rely on a statistically significant number of recorded cases to justify a claim that "we have enough good anecdotal and empirical evidence to show that what we do as a profession works."

That is, provided that the numbers we have generated and subsequently crunched actually show this, which I am sure they will.

■ amt



Andrew Shepherd has worked in the allied health industry since graduating from Loftus TAFE in 1994 with an Associate Diploma of Health Science (Massage Therapy). For the past six years, he has worked as a registered chiropractor, and is the owner of Mosman Chiropractic and Massage.

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Practitioner Profile: Amina Dargan

How did you get started as a massage therapist?

After leaving high school I worked in the property industry for six years, however, I always had an interest in natural therapies. A college was offering a Certificate IV in Massage one day a week, which just happened to land on my day off, so I jumped at the opportunity. I completed the course in 12 months and graduated from the Australasian College of Natural Therapies in 2004. In 2012, I completed my diploma at Australian School of Remedial Therapies.

What is your favourite part of the job?

Hands down, it would be guiding clients to a healthier pain free lifestyle.

Do you have a particular interest or specialisation within the field?

Headaches. I cannot believe how long people will put up with headaches before seeking some help to at least alleviate the pain. I have been successful in assisting clients with eliminating their ongoing headaches by releasing neck and shoulder muscles and giving advice on stretches and breathing to aid in relaxation.

Name one highlight of your career as a massage therapist.

For the past two years I was Treasurer of the Blue Mountains AMT branch, and this year, I have stepped into the role of Secretary. Being a part of the branch, networking with other therapists, and organising AMT Branch meetings and workshops has been deeply rewarding.

What are the most rewarding aspects of the job?

Getting positive feedback from clients and knowing that the treatment I am providing has improved a client physically and/or mentally.

What are the most challenging aspects of the job?

At times I find the job physically challenging however, in the past - before I injured my wrist - I managed this by maintaining my strength, stretching, exercising and eating well.

One of the workshops you organised for the Blue Mountains AMT branch was about self-care with a focus on 'the wrist'. Can you share some of that advice?

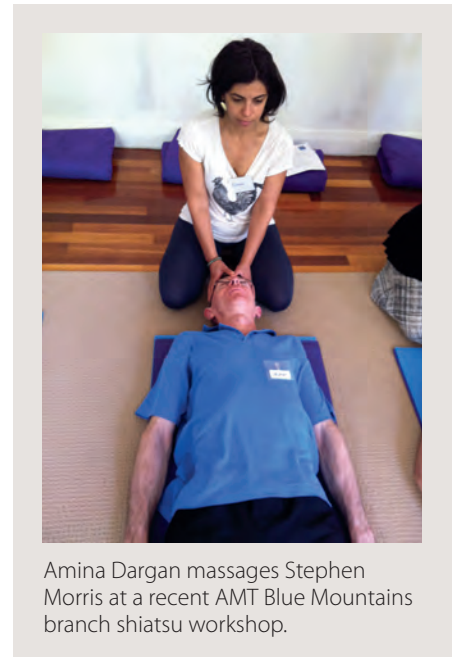
Talking from personal experience, it is important for massage therapists to be aware of how they use their wrists both inside and outside of the clinic environment. Working around the house using a shovel and sledge hammer triggered my injury. Being mindful of the mechanics of how you use your wrists, not overusing them, including a regular stretching routine for the wrists, arms and hands, and most importantly, self massage to the arms is the key to longevity in the field of manual therapies.

Do you have any future study plans?

I begin studying a Bachelor of Health and Rehabilitation Science this year. Rehabilitation has always been something that I have had a passion for. Working as a massage therapist, I have felt limited in the service I can provide for my clients. I am interested in gaining extra skills to help increase a client's movement and assist in their pain management. I will also gain skills in how to plan and coordinate health programs to individuals or community groups, which is something that I am really looking forward to.

What would you like to be doing five years from now?

I hope to be in my last year of study and working in the rehabilitation service.



Amina Dargan massages Stephen Morris at a recent AMT Blue Mountains branch shiatsu workshop.

What changes would you like to see in the massage therapy profession?

There needs to be a change in the public perception of massage therapy as a 'luxury' or merely as a way of winding down. I would like to see the health benefits of remedial massage taken seriously.

What advice would you give someone considering massage therapy as a career?

Taking care of your health and wellbeing is essential. It is best to ease into the industry, for example, when just starting out, it is better to massage part-time. A good idea is to have two jobs: work half the week in massage and the other half in something that is not so physically straining. Slowly building up your stamina and strength can help you to avoid burn out or injury. ■amt

Client Perspectives: the movement towards patient-centred evidence gathering

by **Rebecca Barnett**

In the middle of the eighteenth century, naval surgeon James Lind conducted the first randomised controlled trial (RCT), testing 12 randomly assigned sailors to six treatments for scurvy. Fast forward to 1948 and the first published RCT appeared in the British Medical Journal, a trial testing streptomycin as a treatment for tuberculosis. Ironically, the epidemiologist who conducted the trial, Sir A Bradford Hill, chose randomisation of subjects as a strategy to prevent doctors from maneuvering their patients into the streptomycin arm of the study - not because he believed it was the best design for the trial but rather because the drug was in short supply at the time.

The RCT rapidly became the centerpiece of biomedical research and, to this day, is still considered to be the gold standard for experimental design and, therefore, the strongest evidence for the effectiveness of a given intervention.

As evidence-based medicine (EBM) rose to prominence in the 1990s, RCTs and systematic reviews gradually became the dominant force in health policy-making. The establishment of the Cochrane Collaboration and the Cochrane Library (an online database of systematic reviews) is axiomatic of the dominance of systematic reviews in the efficacy discourse.

Closer to home, the recent NHMRC review of natural therapies is a case in point of the significance of systematic reviews in policy making - the NHMRC only considered evidence at systematic review level in its report.

The current paradigm of evidence-based medicine has enjoyed 25 years of dominance. It is perhaps not surprising, then, that academics, researchers and commentators are increasingly testing its limitations and weaknesses, and positing ways to enhance its relevance in healthcare delivery and policy-making.

One of the key areas of concern with EBM is its reliance on experimental evidence at the expense of patient experience. In its eagerness to embrace the RCT and systematic reviews as objective, disinterested science, EBM systematically edged real patients with subjective experiences of their health out of the frame. While RCTs are great for testing the efficacy of a particular drug, they are not terribly good at evaluating complex, real world interventions like massage therapy and GP consultations, where multiple factors are at play and the context in which treatment occurs has a significant influence over the outcome.

In July last year, Trisha Greenhalgh, Professor of Primary Health Care at Queen Mary University of London, launched the "Campaign for real evidence-based medicine". At the core of this campaign was the desire to put patient care at the centre of evidence-based medicine.

Professor Greenhalgh's campaign coincided with an announcement by the British Medical Journal about significant changes to its editorial policy, aimed at embedding patient perspectives in study design and reporting. The BMJ's editorial panel now includes patients.

These are potentially seismic shifts in the way we think about medical research and efficacy, away from the monolith of objective quantitative analysis towards a qualitative, sociological perspective that encompasses subjective patient experience and patient narratives as evidence of efficacy. (For the post-modernists in our ranks, it's an attempt to take down the violent hierarchy inherent in the binary opposition of subjective/objective.)

AMT is excited about this movement towards patient-centred evidence gathering and the potential it will unlock for investigating complex interventions like massage therapy.

For this reason, it's my pleasure to introduce AMT's first Client Perspectives feature. We are committed to publishing clients' stories of their experiences of massage therapy in coming issues of *In Good Hands*, in support of the emerging paradigm of real evidence-based medicine.

The new Client Perspectives column is underpinned by the conviction that the therapeutic interaction is a two-way conversation and there is much we can learn from our clients to help us deliver better, more responsive care. We're looking forward to sharing some powerful narratives with you. ■ **amt**

DID YOU KNOW?

Use of the Cochrane Library is notably high in Australia. Thanks to funding from the Australian government, the Library has been free to access since 2002 and Australians have become the highest per capita users in the world. It would seem we're an unusually research literate bunch! In 2011, the most downloaded reviews were models of care for child-bearing women, preventing falls in older people living in the community and zinc for the common cold! (<https://acc.cochrane.org/cochrane-library>)

Client perspectives – Lisa Vaughan

Massage therapy has been a part of Blue Mountains resident Lisa Vaughan's healthcare for more than 30 years. Initially, Lisa sought remedial massage for relief from pain caused from a back injury. Six years ago, however, massage therapy became more than just about muscles after the 51-year-old was diagnosed with cancer. Lisa shares her story ...

It had been too long between massage appointments. Lisa felt stressed and her body ached. She had been diagnosed with cancer, and it was starting to take its toll on her health and wellbeing. At this point, now about six years ago, Lisa began monthly massage sessions from an oncology-trained therapist. She soon found it was the one thing that made her cancer treatments bearable.

"I was desperate to be able to have massage again. I'd probably had a break for a while and my body was just in an appalling state," says Lisa.

Choosing an appropriate therapist was a big part of Lisa's journey with massage. Specialist training and continuity of care were imperative to her treatments.

"I now have massage as an adjunctive treatment to my cancer treatments with an oncology-trained massage therapist. She knows where not to massage me - I've had lymph nodes removed and she knows what to do with that system.

"She has been on the scene for a long time. If you are seeing a regular massage therapist, you get that continuity of care."

Lisa says she values the approach of her massage therapist, which is very different from her other healthcare professionals.

"My massage therapist knows me really intimately - knows my body really well - and she will comment each week now about what different part of my body might be needing attention.

She seems to know even more than I do at times - and I love that.

"With other healthcare professionals that I see, there is less of a personal relationship. I am the one who needs to tell them what's going on."

Initially, a back injury was Lisa's primary reason for seeking massage therapy. But Lisa found that the benefits she gained from her treatments extended far beyond her muscles. In fact, she says doesn't know what she would do without massage therapy.

"I knew that that (the massage) treatment I was getting that day was going to be something that I came back feeling really positive and rejuvenated from ..."

"Through my cancer treatment while I was having chemotherapy and radiotherapy it would be the focal point of the week or the fortnight. I knew that that (the massage) treatment I was getting that day was going to be something that I came back feeling really positive and rejuvenated from, whereas the chemo and radiotherapy were something that I didn't look forward to. They were something that I had to just endure.

"The massage therapy just makes it totally bearable. I don't really know how people can go through that treatment without having massage therapy as an adjunct to it because massage truly is a wonderful therapy that helps your whole being. I find massage so relaxing and it's so good for me - I feel energised from it."

Just being able to relax and drift off into her own private thoughts is an important aspect of Lisa's massage therapy sessions. For this to happen, conditions must be right.

"Because my therapist knows me, I'm able to just float off. I take myself into different visualisations: I go off into a rainforest and off into a deep pool where there are mermaids and fish ... the music that she plays really enhances that experience.

"I also absolutely love when she uses the hot rocks. It relieves the tension and I can relax really quickly. She'll do that at the beginning of the massage and I always come out of there feeling just fantastic, ready to dive into the day.

"I'm there being treated just absolutely beautifully and I can relax, which allows me to get on with my life, which can be quite a stressful life."

There are a few key elements that enhance Lisa's treatments.

"I love having the oil left on. I know (massage therapists) are trained to just wipe the oil away at times but I say to them "Leave it on" because it soaks into your skin and it just makes your skin beautiful the next day.

"I also think it is important for therapists to take their cues from the client as to whether to have a conversation or not. At times, when I have had different therapists, they have wanted to talk and it just leads me away from my visualisation. I find it is much better for my mind to be taking me to the places where it needs to go rather than just conversations about daily life."

Lisa says there is only one downside to her massage treatments:

"I'd love to be able to stay there longer than an hour. That seems to be the general amount of time that you are given and that's fair enough, I guess I'm just being greedy.

"I really don't know how you people do it all day. I'm so grateful that you can though. It is such a giving out profession. I am hoping you find somewhere to get your own massage from."

■amt

Therapist Self-care: Finding your centre of gravity

In this installment of our self-care series, *In Good Hands* chats to Certified Rolfer, Colin Rossie about the important of working posture ...

Human beings are unique in that we stand upright in gravity. Our body's ability to maintain itself in a balanced state depends on the musculoskeletal system's ability to maintain balance – in other words, to not fall.

Dr Ida Rolf, the founder of Rolfing, characterised a human being “as a ‘something’ organised around a vertical line.”⁽¹⁾ The upright human being is subject to the laws of physics: the body must contend with the force of gravity and does so by organising itself, as best it can, around this vertical line.

“We stand upright – we walk with alternate bipedal gait and we have unique adaptations from an evolutionary perspective. Humans are different to other animals: our centre of gravity passes from our perineum through to the crown of our head,” Certified Advanced Rolfer Colin Rossie said.

The idea of a ‘centre of gravity’ is by no means new; in fact, many cultures embrace similar concepts.

“Traditional folk cultures always have nice names for what, in Western biomechanics, we call ‘G’, which is the body’s true centre of gravity. The Chinese call it the dantien, the Japanese call it the hara, and in yoga it is the second chakra,” Colin said.

“Projecting Ki – something that is often talked about in shiatsu – is really just a sense of projecting out from your centre of gravity. We all have these images that we use in our work – a shiatsu practitioner thinks of Ki, someone doing tuina will think of qi, a Rolfer will think of body in relation to centre of gravity.”

The major weight bearing segments of the body: the head and neck, shoulders and arms, torso, lumbar spine, pelvis, thighs, legs and feet have an ongoing balancing act with the field of gravity, according to Paul Zimmerman, a student of Dr. Rolf. Zimmerman said an ideally organised body, when viewed from a profile, would be characterised by an imaginary vertical line bisecting the ear, shoulder, hip, knee, and ankle. This alignment would be accompanied by an aesthetic symmetry between the front half and the back half of the body.⁽²⁾

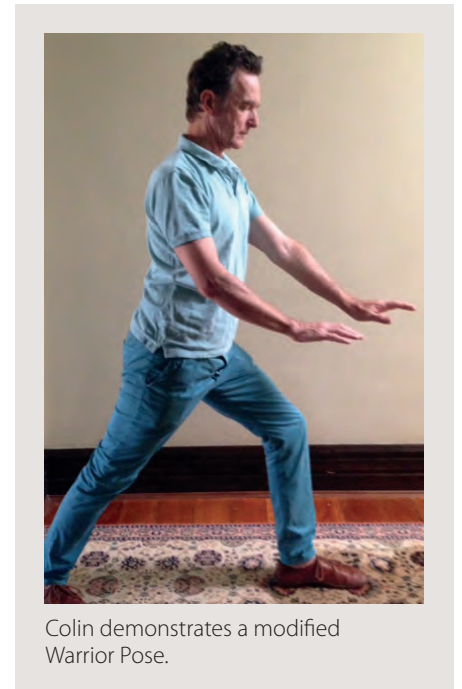
Most of us fall short of this ideally organised body, and the result can be pain and dysfunction. According to Zimmerman, the average body is at odds with gravity and continually struggling via chronic physical tension and ongoing background pain, to maintain its verticality.⁽³⁾

“Having an awareness of your centre of gravity, and relating from your centre of gravity down into the ground through your feet and then out into the world through your hands is an important part of self care – and not just for practitioners but for every person on the planet,” Colin said.

“Many problems we see in our clinics, for example, a lot of lower back pain and a lot of neck pain stems from people not having a good relationship to their centre of gravity.”

For massage therapists, developing a dynamic awareness of the centre of gravity can help to avoid injury and increase working longevity.

“Most injuries that happen to massage therapists generally occur because of a poor relationship to their centre of gravity,” Colin said. “Many therapists put a lot of effort into what they are doing with their hands and their elbows. As a result they tend to push their humerus up into



Colin demonstrates a modified Warrior Pose.

their glenoid, crowding the acromioclavicular joint and the clavicular space at the scalene triangle.”

Relating the upper limb to the centre of gravity can help massage therapists avoid wrist and hand injuries, Colin said.

“Dynamically, our centre of gravity it is about reaching down into the ground and out with our hands. We reach out, grab something, and bring it towards us, or reach out with tools and work into an object.

“As massage therapists, our tool is our hands. Injuries happen if we are pushing into our hands rather than reaching out from them. When we push into our hands, we tend to be jamming things like our wrist bones and we end up forcing one thing into the other.”

In his workshops, Colin teaches students to work using a position he refers to as a modified version of the Warrior Pose in yoga.

“Once you have found your centre of gravity, something like the horse stance, which is what is commonly taught in a lot of massage schools, becomes difficult because you are basically bowing your centre of gravity. Instead, I recommend a partial Warrior Pose.” (See image p17)

The next step in working with your centre of gravity, Colin said, is to “take it for a walk”.

“Finding your centre of gravity is not a static thing: we are not statues, we don’t just stand still all the time, we move,” he said.

“When we are working around a table or with a client, if we find our centre of gravity and relate from that centre line in our body out into our feet, it gives us our base of support.”

And from there, Colin said, we can transmit our centre of gravity to our client.

“As a Rolfer, that is the prime thing I am doing, trying to transmit a relationship of the body to its centre of gravity.” ■amt

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How to find your centre of gravity: “The Line” Meditation

by Colin Rossie

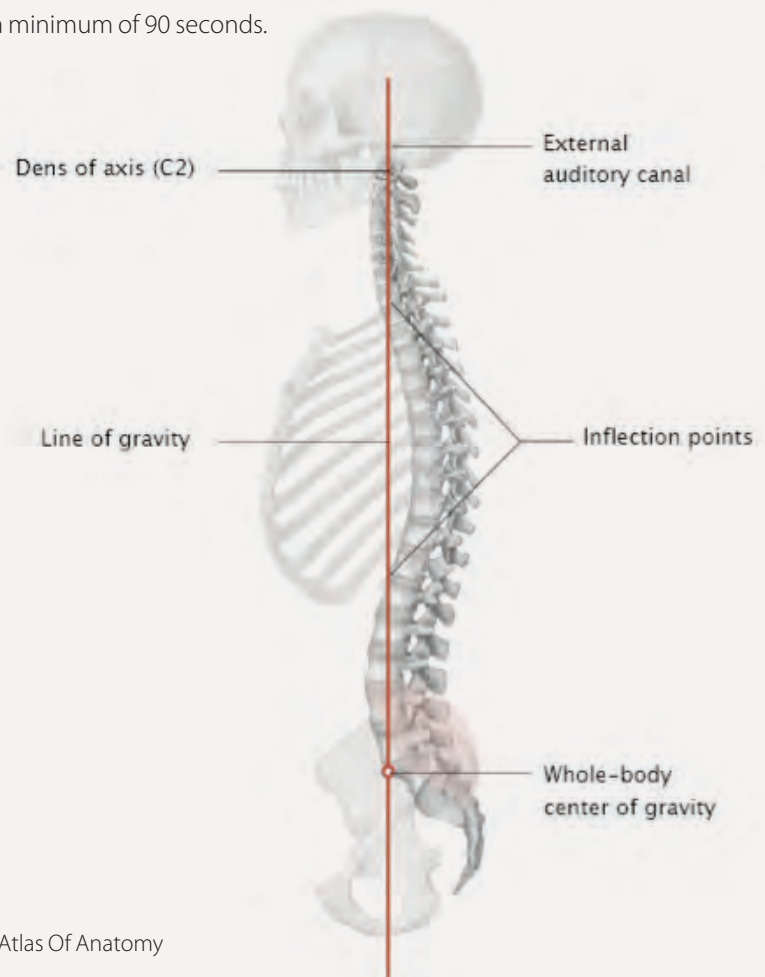
Stand with feet parallel, knees under the hip joint, ankles under the knees (so the legs are under the pelvis.) The feet should be quite close together but still slightly apart, with the inside of the feet parallel to each other.

Close your eyes.

Imagine a line that runs up the middle of your body, from your perineum through to the top of the skull. This line passes between the coccyx and the pubic bone, continues up the spine, just slightly touching the front of your lumbar vertebrae, continuing up so that in the thorax it is 3 cm or an inch in front of the middle (6th) thoracic vertebrae (the one that is most posterior, in the middle of the rib cage), continuing on up to the cervical (neck) vertebrae, touching the front of your lower cervical vertebrae, from there going through the middle of your upper cervical vertebrae, on through the hole in the base of your skull (the foramen magnum, where the spinal cord exits the skull)) and on through the centre of the head to your crown, the highest point in the skull.

Treat visualizing this line as a meditation: not in the spiritual sense, but in a very real, physical sense. With your eyes closed, keep your focus on the line: if the focus is disturbed always bring it back to that line; if the mind starts to wander bring your focus back to the line.

Hold for a minimum of 90 seconds.



Relaxation, Telomeres and Health

by Dr Judy Lovas

Ground breaking research into telomeres – special molecules of DNA that affect how cells age – has demonstrated the effects of relaxation on health. This has implications for the relaxing influence of massage therapy, which may have a positive impact on telomeres and their influence in ageing, cardiovascular disease and some forms of cancer.

Telomeres are caps located at the end of each strand of DNA that protect our chromosomes from damage, very similar to how plastic tips protect shoelaces. Eventually, telomeres get too short to do their job, causing cells to age and stop functioning properly. Stress is known to influence the rate of telomere shortening (Epel et al, 2009).

According to the research, stress and distress have a negative impact on telomeres, which can result in a range of conditions and dysfunction. Lifestyle factors that promote cancer and cardiovascular disease can adversely affect telomerase function. Telomere shortening is also linked to: ageing; disease risk and progression of cardiovascular conditions; and premature mortality from many types of cancer, including breast, prostate, colorectal, bladder, head and neck, lung, and renal cell (Ornish et al, 2008).

It is now understood that telomere length is affected by the interplay among genetics, life experiences and psychosocial and behavioural factors. Resilience to stress and the presence of healthy lifestyle factors such as relaxation, meditation and social connections are associated with longer telomere length and may protect individuals from stress-induced telomere shortening (Epel et al, 2009).

Recent evidence shows that telomere shortening is counteracted by telomerase, a cellular enzyme.

Comprehensive lifestyle changes significantly increased telomerase activity and the capacity to maintain telomere length in specific immune cells (Ornish et al, 2008). Thirty men with low-risk prostate cancer made intensive lifestyle changes for three months. Telomerase enzymatic activity per viable cell was significantly increased after three months compared to the baseline measures. Furthermore, a follow up study demonstrated increased telomere length after five years, compared with controls (Ornish et al, 2013).

In a study of family dementia caregivers who suffered depressive symptoms, increased telomerase activity was demonstrated in family members who meditated compared to no meditation. The meditation group had a significant (43 per cent) improvement in telomerase activity compared with 3.7 per cent in the control group, which suggests improvement in stress-induced cellular ageing (Lavretsky et al, 2013). Another study investigated the effect of a mindfulness-based intervention on stress-related eating and examined changes in telomerase activity from pre- to post-intervention (Daubenmier et al, 2012). Correlations were found between improvements in psychological distress, eating behaviour, and metabolic health and increased telomerase activity. These findings suggest that telomerase activity may be regulated by both psychological and metabolic stress.

The sophistication of research into relaxation has developed from a generic 'systems' approach to one that examines highly specific, cellular and molecular changes. Whether incorporating relaxing massage techniques or teaching clients to take diaphragmatic breaths, massage therapists will benefit from understanding the psychological and physiological advantages of relaxation.

■ amt

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Dr Judy Lovas began working as a massage therapist in the 1980s and was involved in the establishment of TAFE NSW's Associate Diploma in Health Science (Massage Therapy). Judy has conducted research into the effects of massage therapy on immune responses and examining the effects of massage therapy on secondary conditions of people with spinal cord injury. She currently teaches psychology at Australian Catholic University and conducts seminars for health professionals in the physiological and psychological benefits of relaxation therapy.

For more information on Judy's seminars please visit: www.artandscienceofrelaxation.com

RESEARCH

Chronic musculoskeletal disorders contribute to lost years of life

Chronic musculoskeletal disorders can contribute to lost years of life, according to recent Australian research.

A new report from the Australian Institute of Health and Welfare (AIHW) looks at years of life lost due to premature death, and the leading causes of these deaths.

The report, *Australian Burden of Disease Study: Fatal burden of disease 2010*, showed that there were around 143,500 deaths in Australia in 2010, resulting in 2.25 million years of life lost.

“The term ‘fatal burden’ refers to years of life lost, using the measure YLL (years of life lost). One YLL represents one year of healthy life lost due to premature death,” said AIHW spokesperson Dr Lynelle Moon.

When it comes to chronic musculoskeletal diseases, the data showed that females were almost twice as likely as males to die of an early death in this disease group. (See table 1)

The report also showed that five disease groups accounted for 81 per cent of fatal burden in 2010, with two groups accounting for more than half (58 per cent) of the total fatal burden.

Cancers were the largest contributor of fatal burden in 2010, accounting for 35 per cent of the total, while cardiovascular diseases accounted for a further 23 per cent.

These were followed by injuries (13 per cent), neurological conditions (6 per cent) and respiratory diseases (5 per cent).

Males accounted for more (59 per cent) of the total fatal burden than females. This was largely due to the high number of years of lost life in males due to injuries.

Injuries were the leading cause of fatal burden in those aged under 45, after which cancers and cardiovascular diseases were most prominent.

This report is the first in a series of publications from the Australian Burden of Disease Study 2011. The full report of this study will update and extend this report with estimates of fatal and non-fatal burden.

Full publication:

Australian Burden of Disease Study: Fatal burden of disease 2010



Disease group	Males				Females				Persons			
	Deaths		YLL		Deaths		YLL		Deaths		YLL	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Infections	1,583	2.2	25,265	1.9	1,795	2.6	19,611	2.1	3,378	2.4	44,897	2.0
Infant and congenital conditions	778	1.1	59,491	4.5	599	0.9	44,189	4.7	1,378	1.0	103,680	4.6
Cancer and other neoplasms	25,116	34.1	439,041	33.3	19,275	27.6	339,294	36.3	44,391	30.9	776,335	34.5
Cardiovascular diseases	21,764	29.6	304,868	23.1	23,533	33.7	213,698	22.9	45,298	31.6	516,566	23.0
Respiratory diseases	4,674	6.3	61,951	4.7	4,007	5.7	49,185	5.3	8,681	6.0	111,136	4.9
Gastrointestinal diseases	2,745	3.7	51,810	3.9	2,794	4.0	35,169	3.8	5,539	3.9	86,979	3.9
Neurological conditions	5,155	7.0	64,068	4.9	7,960	11.4	70,822	7.6	13,115	9.1	134,910	6.0
Mental illnesses and behavioural disorders	776	1.1	25,511	1.9	422	0.6	9,809	1	1,198	0.8	35,320	1.6
Endocrine disorders	2,201	3.0	32,488	2.5	2,265	3.2	25,373	2.7	4,465	3.1	57,861	2.6
Kidney and urinary diseases	1,692	2.3	19,276	1.5	2,052	2.9	19,239	2.1	3,744	2.6	38,515	1.7
Chronic musculoskeletal disorders	400	0.5	5,754	0.4	862	1.2	9,863	1.1	1,262	0.9	15,617	0.7
Skin disorders	189	0.3	2,310	0.2	313	0.4	2,669	0.3	502	0.3	5,179	0.2
Blood and metabolic disorders	794	1.1	15,776	1.2	847	1.2	13,265	1.4	1,641	1.1	29,041	1.3
Injuries	5,744	7.8	210,845	16.0	3,140	4.5	81,161	8.7	8,884	6.2	292,006	13.0
All other disease groups	22	< 0.1	296	< 0.1	40	0.1	957	0.1	61	< 0.1	1,254	0.1
All diseases	73,633	100.0	1,318,810	100.0	69,894	100.0	934,506	100.0	143,527	100.0	2,253,316	100.0

Notes

1. Number of deaths and YLL for 2010 are the annual average of 2009–2011. The numbers may not add to total for all diseases due to rounding.
2. All other disease groups comprise reproductive and maternal conditions, sense organ disorders and oral disorders.
3. Analysis excludes 6 deaths due to missing age.

Source: AIHW analysis of the AIHW National Mortality Database.

AIHW 2015. Australian Burden of Disease Study: Fatal burden of disease 2010. Australian Burden of Disease Study series no. 1. Cat. no. BOD 1. Canberra: AIHW.

Table 1: Number and per cent of deaths and YLL by disease group and sex, 2010

“Enough Said” and the Ethics of Touch A review

by Kat Boehring

Picture this scenario: Eva is a massage therapist. Like many massage therapists, Eva deals with common day-to-day issues: clients with bad breath, the challenge of relaxing over-talkative clients, and as a mobile massage therapist, the chore of lugging a heavy table up and down flights of stairs.

Eva meets Marianne at a party. Marianne has a sore shoulder, so Eva hands her a business card and Marianne soon becomes Eva's regular client. More than that, the pair hit it off, and it even feels quite natural when they start exchanging stories about their personal lives during massage treatments. Marianne particularly enjoys denigrating her ex-husband, Albert.

One day, as Eva is packing up her table after a treatment, Marianne asks her: “Do you think it would be weird if we just hung out as friends?”

Have you ever found yourself in a situation like this? How would you reply to this question?

Our therapist, Eva, has no qualms and says (quickly and with enthusiasm): “I would love that.” And so Eva starts hanging out socially with Marianne, while continuing to work as her massage therapist.

Things run quite smoothly for a while ... until Eva discovers that Marianne's ex-husband is actually Eva's new boyfriend.

This is not a real-life example, rather, is the premise of director Nicole Holofcener's new flick, *Enough Said*.

While a bit like a cringe-worthy comedy of errors, the film also feels, at times, uncomfortably close to the bone.

As massage therapists, we are all challenged with ethical issues in our personal and professional lives. Most of us have an understanding of professional conduct and an inner sense of ‘right’ and ‘wrong’. But sometimes, applying these concepts to real life situations is not as easy as you might imagine.

Let's go back to the film: at this point in the plot, Eva (Julia Louis-Dreyfus) decides to keep this revelation a secret from both Marianne (Catherine Keener) and Albert (James Gandolfini). Worse than that, she allows Marianne's revelations to colour her perception of Albert. Events soon start spiraling out of control, Marianne and Albert eventually find out the truth, trust is broken, and relationships damaged.

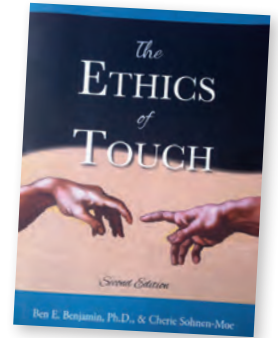
An extremely hurt and heart-broken Albert confronts Eva about her deception. Her defense is: “I didn't know what to do”, to which Albert replies: “You knew what to do, you just didn't do it.”

Both Eva and Albert have a point. Sometimes, when we are faced with these real-life dilemmas, although we may intrinsically know what is right, we may not have the tools or the words at our ready disposal to do the right thing. And as a consequence, we might make very bad choices.

That's where books like *The Ethics of Touch* come in.

Some therapists will be familiar with Benjamin and Sohnen-Moe's classic *The Ethics of Touch*. The first edition – considered a groundbreaking text in the field of bodywork bioethics - was published 12 years ago and more than 240 schools now require it as a course text.

A second – and significantly revised - edition of this book was released last year, which includes expanded chapters and two new chapters.



Benjamin and Sohnen-Moe are leaders in their fields. Ben Benjamin is the founder and president of the Muscular Therapy Institute, Cambridge, MA. He was also the initiator and chairperson of the AMTA Council of Schools Professional and Sexual Ethics Task Force for four years and is considered an authority on ethics and boundaries in the body therapy field. Cherie Sohnen-Moe is an author, business coach, international workshop leader, and practising massage therapist.

This book tackles some of the more difficult and confusing dilemmas faced in bodywork practice. It examines some of the ‘curly’ questions: To which level do I as a practitioner have to tolerate client behaviour or demands? What can be done if the client or I am uncomfortable? How do I deal with falling in love/lust for a client? Or if a client falls for me? What should I do if my touch is misunderstood by the client?

In the second edition, chapters include: Ethical Foundations; Boundaries; Dual and Sequential Relationships; The Dynamics of Effectual Communication; Communication Techniques and Strategies; Sex, Touch and Intimacy; Practice Management; The Team Approach; Business Ethics; Support Systems; and Working with Trauma Survivors.



In Chapter two, the authors explain what boundaries are, the types of boundaries, how they develop, what boundary crossings and violations are, why they occur and how to establish, maintain and change boundaries.

The Dynamics of Effective Communication discusses setting boundaries, interactive and reflective listening, managing conflicts and self-evaluation.

Professionalism, informed consent, tips, bartering and taxes are covered in Ethical Practice Management and Business Ethics. If you've ever been faced with the dilemma of finding appropriate ways to refuse to work with a potential client, then this section is a must. In the second edition, Business Ethics is expanded and relevant for today's professional environment and includes marketing techniques, insurance billing, social media communications, and non-traditional payment methods.

Special Considerations in Cases of Trauma is about understanding the emotional needs of people who have experienced unresolved trauma or lived through sexual, physical and emotional abuse. Considering 1 in 5 women and 1 in 20 men have experienced sexual violence since the age of 15 years (Australian Bureau of Statistics Personal Safety Survey, 2006), this knowledge is fundamental to a safe, ethical practice.

In Supervision, the authors highlight an aspect of professional practice that has long been of primary importance to the mental health professions, and is fast becoming essential to massage therapy training and practice: mentoring.

I will admit, when reading this book, there were times when I found myself saying, "Yeah, yeah, I know that." However, the challenge came when applying the knowledge to the exercises at the end of the chapters, which are taken straight from treatment rooms, or to some complex examples from my own clinic.

This book belongs in the office of every bodywork practitioner and in the classrooms of every professional training school. It is an excellent resource for developing critical thinking skills around the subject of ethics.

And although I'm not a big fan of RomComs, I also recommend picking up a copy of *Enough Said* (available on DVD). I found the film sensitive and clever, and as a massage therapist, appreciated much of the humour. (Not to mention, one of my favourite Australian actors, Toni Collette cameos in the film.) But more importantly, it explores a myriad of moral dilemmas that massage therapists face in day-to-day practice.

Title:

The Ethics of Touch, Second Edition

Authors:

Ben Benjamin, PhD, and
Cherie Sohnen-Moe

Publisher: Sohnen-Moe Associates, Inc.

Publication date: 2012

Length: 390 pages



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

Calendar of Events

March 2015		CEUs
14-15	Neurostructural Integration Technique Introduction. Presented by Wendy Eyles. Sydney, NSW. Contact 012 417 719. Email: harmony4massage@gmail.com	70
14-16	Oncology Massage Module One. Presented by Amy Tyler. Castle Hill, NSW. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
15	AMT Annual General Meeting and Workshop. Adamstown (Newcastle), NSW. Contact 02 9211 2441 or info@amt.org.au To register please download the registration form Here.	50
17-18	Modern Cupping Therapy. Presented by Bruce Bentley. Hobart, TAS. Contact 03 9576 1787 www.healthtraditions.com.au	70
20-22	Oncology Massage Module One. Presented by Deb Hart. Hillier, SA. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
21-22	Hot Stone Massage Therapy. Presented by Master Zhang Hao. Strathfield, NSW. Contact 0416 286 899 www.chihealing.com.au	70
21-22	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330. Email: info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	70
21-22	Myofascial Cupping. Presented by David Sheehan. Melbourne, VIC. Contact 03 9481 6724. Email: info@comphs.com.au Register online www.comphs.com.au	70
21-25	NurtureLife® Pregnancy Massage Practitioner. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au (5 day course includes Certificate of Pregnancy Massage) www.pregnancymassageaustralia.com.au	175
21-22	Functional Fascial Taping Upper and Lower Bodies. Presented by Ron Alexander. Melbourne, VIC. Contact Budiman 0402 059 570. Email: terrarosa@gmail.com Register at www.terrarosa.com.au	70
23-25	NurtureLife® Pregnancy Massage Practitioner. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au (3 Day Upgrade to Practitioner from Certificate) www.pregnancymassageaustralia.com.au	105
27-31	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Coolup, WA. Contact 0419 380 443. Email: bowenst@iprimus.com.au	175
27-29	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Brisbane, QLD. Contact 03 9576 1787. www.healthtraditions.com.au	105
27-31	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley. Brisbane, QLD. Contact 03 9576 1787 www.healthtraditions.com.au	175
28-29	Functional Fascial Taping Upper and Lower Bodies. Presented by Ron Alexander. Wodonga, VIC. Contact Budiman 0402 059 570. Email: terrarosa@gmail.com Register at www.terrarosa.com.au	70
28-29	Myofascial Cupping. Presented by David Sheehan. Gold Coast, QLD. Contact 03 9481 6724. Email: info@comphs.com.au Register online www.comphs.com.au	70
29	Shoulder Pain and Scapula Stability. Presented by John Bragg. Wollongong, NSW. Contact 0410 434 092 www.johnbragg.com.au	35
30-31	Modern Cupping Therapy. Presented by Bruce Bentley. Brisbane, QLD. Contact 03 9576 1787. www.healthtraditions.com.au	70
31	The Shoulder Online Workshop. Developed by Bradley Collins. Contact info@thetherapyweb.com www.thetherapyweb.com This course can be started anytime throughout the year and can be completed at your own pace	25
April 2015		CEUs
4-5	Functional Fascial Taping Upper and Lower Bodies. Presented by Ron Alexander. Sydney, NSW. Contact Budiman 0402 059 570. Email: terrarosa@gmail.com Register at www.terrarosa.com.au	70
9-11	Oncology Massage Module One. Presented by Kate Butler. Northcote, VIC. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
11-12	Neurostructural Integration Technique Introduction. Presented by Shayne Sullivan. Geelong, VIC. Contact 0417 011 192 Email: shanyesullivan1@gmail.com	70
11-13	Oncology Massage Module One. Presented by Tania Shaw. Townsville, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
17-19	Oncology Massage Module One. Presented by Bronwyn Sutton. Wagga Wagga, NSW. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
17-18	Onsen Volume III Structural Assessment and Correction for the cervical and upper thoracic. Presented by Jeff Murray Sydney, NSW. Contact 0427 310 510. Email: info@beyondmassage.com.au www.beyondmassage.com.au	70
18-20	Oncology Massage Module Two. Presented by Tania Shaw. Buderim, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
18-19	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Sydney, NSW. Contact 03 9571 6330. Email: info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	70
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21-23	Oncology Massage Module One. Presented by Hayley Moeller. Launceston, TAS. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
24-28	Neurostructural Integration Technique Basic. Presented by Robert Monro. Brisbane, QLD. Contact 0448 428 020 Email: nstqld@gmail.com	175

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