

President's Message

by Annette Cassar

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Welcome 2016. I hope all members had a Merry Christmas and a Happy New Year.

New Year is time to take stock and review our business operations, to reset goals and look at our CEU's. In view of this, I have taken a hard look at where my business is going and my work/life balance. I know I have to make some changes. As therapists we need to look after ourselves. Those in our profession are very giving and we can easily burn out.

At AMT the New Year is time to think about what needs to be done to support our current members, whilst growing membership numbers.

2016 is our 50th Birthday year and we've lots to celebrate. The massage profession has come a long way in that time. Massage is no longer looked at as a luxury but a necessary part of maintaining our busy lifestyles.

We kick off 2016 with our AGM which is being held on Sunday 13th March at Q Academy - Brisbane Campus. The AGM Agenda can be found on the AMT website. In particular note *Item 7: Special Resolution for Consideration*. I'm looking forward to seeing a record number of members supporting AMT and attending the AGM.

The AGM will be followed by a workshop presented by Jeff Murray: *Tricks of the Trade*. The focus of the workshop is on breaking the pain cycle and will cover the ankle, shin splints, knee, SIJ, wrist, elbow, shoulder and thoracic pain. Jeff will be incorporating some of the techniques he learned from Kenzo Kase, the inventor of Kinesio® Taping.

The New Year has brought with it a new look for AMT with our new logo/branding. The board has worked with several graphic designers and Claudia, our own designer, has modernised our logo while keeping the teal colour theme. The board and I love the new look and we hope all our members are just as happy.

Our 50th Anniversary Conference is being held on the 23rd and 24th September this year at the iconic Luna Park. This venue is a great place for a celebration and the conference team is busy organising a fabulous line-up of presenters. Any suggestions or recommendations would be greatly appreciated.

By now all members should have had the chance to visit the revamped website and use the member login and the new 'Find a Therapist' search facility. How easy is it to pay membership and load the information by using your member login?

This year is going to be full of celebrations so stay tuned for further announcements of coming events.

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Secretary's Report

by Rebecca Barnett

In the beginning, it was exhilarating. We seemed to be able to read each other's thoughts, anticipating every need and responding unconditionally. We wanted nothing but the best for each other. We were utterly absorbed by the seductive promise of our future together. There was never a sour moment, an impatient sigh, a bad word, a raised voice. We were in love ... truly, madly and deeply in love.

It's hard to know whether there was an exact moment when everything began to inexorably shift. The slide was so slow and incremental that we barely registered until it was too late. We were like the frogs who forgot to jump out of the boiling pot of water and, before we knew it, we were killing each other with calculated, withering, soul-destroying disdain. Respect and esteem had been usurped by censure. We fell drastically short in each other's estimations and it seemed like there was no way forward.

It's time for our profession to break its crippling codependence with private health insurance companies. There. I've said it.

At first glance, this bold statement might seem completely at odds with much of AMT's advocacy program over the past 20 years, including our massive public campaign last year to retain the private health insurance rebate for massage. Why, when AMT has worked so hard to establish qualified massage therapists as health fund providers, would I even think to question the validity or value of our relationships with the private health insurers? Clearly, I have gone mental. At the very least, I have some serious splainin' to do ...

Let me start by acknowledging how much the private health insurance industry has done to help promote massage therapy as a health intervention over the last 15 years.

Time was, there was nary an advertisement for ancillary health cover that **didn't** feature an image or footage of a happy health fund member receiving a massage. There's a good reason for this: the target market for these advertisements was the young, fit and well. Health funds need lots of young members who don't have complex or chronic health conditions because they subsidise the premiums of those that do, principally the elderly unwell. But young, fit people need inducements to take out ancillary cover and rebates for massage is one of the big carrots that the funds began to dangle more than a decade ago. By all accounts, the strategy of promoting massage as an ancillary benefit appears to have been incredibly successful (perhaps too successful), with annual claims through large funds such as Medibank Private growing exponentially over the last five years.

Clearly, insurance companies have helped to raise the profile of massage therapy, introducing it to a new generation of privately insured Australians who may not have considered seeking treatment otherwise. That's a great thing.

And our clients being able to claim back a portion of their treatment costs is a great thing as well, right? Or is the situation not quite that straightforward?

Through tax incentives and rebates, the Australian government subsidises the private health insurance industry to the tune of around \$11 billion annually. Yep, you read that right. \$11 billion. It costs the taxpayer more than five times the amount the car manufacturing industry used to, before we stopped subsidising it. Public commentator John Menadue (2016) puts this in blunt terms:

"[T]he Australian motor manufacturing industry did produce things – cars. But the PHI (private health insurance) companies don't produce anything of value. They don't deliver any healthcare at all. Zilch. These companies are expensive financial intermediaries shifting money from the pockets of taxpayers into the pockets of high income earners who then jump the queue for hospital admission."

To make matters worse, some of these PHI companies are foreign owned so these taxpayer dollars effectively flow offshore.

So, what about those rebates we proudly promote to our clients as an incentive to seek treatment? We're all paying dearly for them before our clients have even paid the premiums that will enable them to claim a small amount back. Is this an arrangement we want to continue to not only tacitly endorse but also wholeheartedly promote in our marketing? We need to think it through at the very least.

Over time, we've also seen a steady decline in the level of ancillary benefits flowing back to health fund members under their cover. Most funds have a maximum claims limit of \$200 per annum for massage and that's at the more generous end of the spectrum. Some funds give back as little as \$12 for an individual treatment. That would barely even buy you a cut lunch now.

To add insult to injury, the gradual winding back of benefits occurred in the context of several funds' increasing intervention in our education standards. Having been at the coalface of this incursion in my capacity as secretary of AMT, I would say that this has been a significant breaking point in the relationship.

It remains completely untenable that health funds presume to set educational criteria outside the national health training package standards - the standards that are agreed and established by industry as an outcome of extensive consultation with representative bodies, educators, employers and other stakeholders.

Then there's the conditional love that underpins the relationship. Those of you who have the diligence to carefully read the terms and conditions you agree to when you become a provider for a fund will know there's more to the contract than just upholding the kind of professional standards that your Association expects of you anyway. Treatments that attract a rebate are highly circumscribed - Medibank's communication to providers late last year is axiomatic of this phenomenon. We're corralled firmly inside the disease model of care, while prevention, wellness and relaxation are exiled to the outer reaches of clinical irrelevance. Fund benefits can only be paid out to "fix" or "remediate" something that is broken or injured, rather than being used to support maintenance of good health and wellbeing.

It is perhaps this last point that troubles me the most since it sounds the biggest alarm that we're losing our way as a profession. When we started out on this relationship with the funds, did we genuinely intend to become all about the treatment of injuries? Can we be confident that we can and will hold out against the incentive to pathologise normal which seems to be endemic to a disease-based model of health care? Do we really just want to fix broken stuff all the time? Can we successfully balance this path - and let's hope it is indeed a path and not a blind alley - against the need to honour the irreducible benefit of treating the whole person for the sake of, well, the whole person? Do we really want to abandon the very thing that got us all here in the first place - the profound impact of plain old, unmediated touch?

The disconnect between the image of massage traditionally promoted by private funds and what they actually pay out on is also creating a huge headache for us. While it appears to be all about the bliss, relaxation and indulgence in the marketing, at the coalface we're clearly required to be all about the injury and dysfunction. So where do all those healthy young people with perfectly functioning bodies stand if they actually want to claim on a 'clinically unnecessary' relaxation massage? Well, they're basically screwed. But it's not the health funds that will be breaking that news to them ...

However, my biggest beef about our relationship with the health funds is that they need us way more than we need them, yet we operate as if it's the other way around. There's a level of desperation and obsession within our profession around being a health fund provider that is not borne out in the marketplace. It's not uncommon for AMT members to take up to a year to discover they are no longer registered as providers. Too many of us are driven by the perception that all of our clients are making insurance claims or relying on rebates but, in reality, there are vast numbers of clients who don't, can't or perhaps just can't be bothered claiming.

Fundamentally, though, my personal dis-ease boils down to this: I believe our profession has outgrown the relationship. It's time to renegotiate and redefine our boundaries. We don't depend on private health funds to bring clients to our door. We actually never have. *We* have created, and continue to create, unprecedented public demand for massage therapy, not the funds. *We* have dedicated ourselves to the care and service of our clients, not the funds. *We* have demonstrated the profound benefits of massage to countless clients, not the funds. *We* have shown that massage is a credible health intervention, not the funds. *We* have earned the loyalty, respect and even gratitude of our clients, not the funds. *We* can stand on our own two feet. *We* should bloody well be bursting with pride, rather than dancing to the tune of insurance companies.

AMT turns 50 years this year. We've been blessed to both nurture and witness the extraordinary maturation of the massage therapy industry into a fledgling but strong profession.

We all built this city. We can accept the health funds as tenants but I reckon we're still lords of the domain. **■amt**

REFERENCE:

Menadue, J. (2016). *John Menadue. The Policy Scandal of a \$11b Taxpayer Subsidy to Private Health Insurance.* Retrieved January 28, 2016, from <http://johnmenadue.com/blog/?p=5149m>

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March edition

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Shoulder Impingement Syndrome - A Clinical Perspective

by Andrew Shepherd

Shoulder impingement syndrome is a common presentation for therapists. However, the term encapsulates a wide range of conditions, presentations and causes.

The following is a case I encountered in 2015 in my clinic in Mosman and I will describe my approach to this case with regards to history, physical examination and subsequent diagnosis. The client is de-identified in accordance with the *Privacy Act 1988*. The case will be followed by a discussion on this syndrome.

The Case

Megan is a fifty three year old marketing executive and single mother of three of slight build presenting with a three day history of increasing right-sided shoulder pain with overhead movement. The pain is located deep in the anterior portion of the right deltoid and is described as a "catchy" sensation with overhead movement. Megan stated she had a similar issue four years ago after falling on her right shoulder whilst skiing but the pain settled on its own. She admitted she has been doing more overhead weights at the gym lately but denied any pain whilst training. There have been no neurological signs or symptoms, neck or upper back pain.

Physical examination began with a structural observation which revealed an elevated and protracted position of Megan's right shoulder and scapula. Her shoulder range of motion was normal but felt catchy at end range flexion, abduction and external rotation. The right pectoralis minor, upper trapezius and levator scapulae were all hypertonic and tender to palpation and palpation of the right supraspinatus was exquisitely tender and reproduced her shoulder pain, as did palpation of the insertion on the greater tuberosity.

All orthopaedic tests of the shoulder were negative.

Based on Meg's history and physical examination I made a working diagnosis of mild right-sided supraspinatus tendinopathy and proceeded to treat the condition with soft tissue work of the region and mobilisation of the right glenohumeral joint.

The initial response to treatment was positive, however it was re-aggravated by further overhead weights at the gym. Presentation on the second appointment was now of greater pain and restriction of shoulder ROM and palpation plus painful weakness on resisted abduction of the shoulder. I advised rest from the weights and conducted further treatment.

On the third session, Meg's shoulder pain had again worsened despite no training and she felt working long hours at her computer had aggravated the shoulder. The presentation was similar to the second appointment with the addition of further painful and weak resisted shoulder abduction and a positive Neer's orthopaedic test for shoulder impingement. I suggested referral to her GP.

Ten days later, Meg called to say she had woken a week ago with agonising pain and immobility in the right shoulder and was referred to a surgeon. Diagnostic imaging of the right shoulder with CT revealed a ten millimetre full thickness tear of her right supraspinatus muscle. This was treated with a cortisone injection, analgesics and muscle relaxants followed by rehabilitation work with a physiotherapist.

Discussion

Although fairly severe, Megan's case is not uncommon. Shoulder impingement syndrome can take on many forms from mild tendinopathies to subacromial bursitis to full tears and tendon ruptures.

In some cases, particularly in older and elderly people, previous supraspinatus tears that have healed can cause a loss of space under the acromion due to tendon thickening with scar tissue. The tendon continues to become irritated through constant chafing in the narrowed space leading to further micro-tearing and fibrotic change ultimately leading to greater levels of impingement and disability.

In younger people, this syndrome can be brought on by overuse and tendon inflammation or a high velocity ballistic injury such as a fall, a heavy pull on the arm or throwing a ball too hard. In Megan's case the tear most likely occurred from the fall whilst skiing, healed and scarred on its own and then was further aggravated years down the track from the overhead weights.

Overhead movement tends to be the main aggravating factor as the head of the humerus comes into close proximity to the acromion process with full flexion/abduction and external rotation of the shoulder. This in effect sandwiches the supraspinatus tendon in the subacromial space and any inflammation in the area can lead to the "painful arc" that is commonly seen in these cases.

Important questions to ask when clients present with these cases are whether there have been any previous injuries to the region and what kind of activities they perform on a daily basis. Constant computer work tends to elevate and protract the glenohumeral joint leading to a postural narrowing of the subacromial space. Overhead weights and throwing and racquet sports can also have this effect, which is multiplied if the client works all day at a computer and then lifts weights for exercise.

Important physical examination features include forward head carriage, thoracic hyperkyphosis and shoulder elevation and protraction. Painful abduction and/or flexion of the shoulder are common signs, as are painful palpation of the supraspinatus and its insertion. Orthopaedic tests include Neer's, Empty Can Test and painful and weak resisted abduction of the arm, although there are many other orthopaedic tests for the shoulder to differentiate between different conditions and these do not usually fall within the scope of training for massage therapists.

It is also important to note that not any one sign, symptom or test is good enough to make a provisional diagnosis. A combination of these are imperative, much like taking pieces of a puzzle and putting them together so the clinical picture becomes clear.

Conclusion

Shoulder impingement syndrome, although common, can be a complex issue to both diagnose and treat. Clinical assessment alone may sometimes not be enough to properly diagnose the complaint and diagnostic imaging and medical referral may be necessary to both diagnose and treat the complaint properly. In practice, I usually decide to refer the client if there is no change, or indeed worsening of the condition within three treatments. Recovery can be long and slow and specialised rehabilitation exercises are always necessary to give the best chance of resolution. ■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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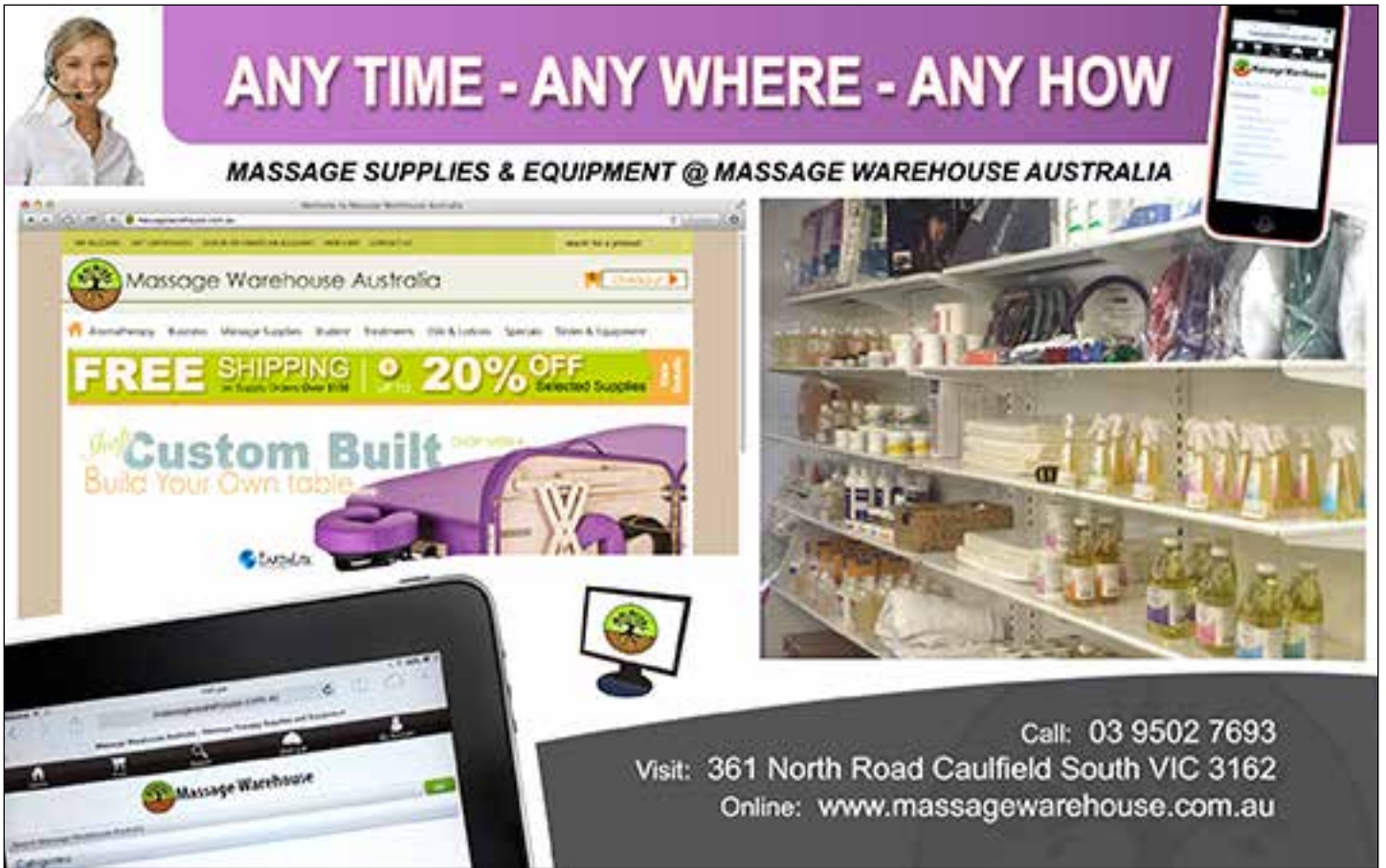
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Brisbane.....	14-18 May (5 day)
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Perth.....	13-15 Jun (3 day)
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Sydney.....	11-13 Jul (3 day)
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Unwinding the Pattern of Rheumatism

by **Andrea Randall**

Abstract

The author describes her participation in a residential rehabilitation program in Spain that treated patients with rheumatic disorders, showing how the principles of structural integration were applied to effectively enhance the patients' well-being and health. Her experience illuminates how structural integration can be a component of a multidisciplinary approach to rheumatic disorders within a medical paradigm.

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is considered a clinical syndrome, which involves several inflammatory cascades that lead toward persistent synovial inflammation and associated damage to articular cartilage and underlying bone (Scott, Wolfe, & Hiuzinga, 2010). Scott et al. summarized the condition:

Rheumatoid arthritis is characterized by persistent synovitis, systemic inflammation, and autoantibodies ... Fifty percent of the risk for development of rheumatoid arthritis is attributable to genetic factors. Smoking is the main environmental risk. In industrialized countries, rheumatoid arthritis affects 0.5 to 1.0% of adults, with 5 to 50 per 100,000 new cases annually. The disorder is most typical in women and elderly people. (2010, p.1094)

Symptoms and Etiology

A recent systemic review to promote early diagnosis identified screening tools that increase detection of individuals with inflammatory arthritis. These self-reporting tools, such as the Connective Tissue Disease Screening Questionnaire (CSQ), include questions about symptoms and identify RA and a variety of connective tissue diseases (Kung & Bykerk, 2014).

Patients described that predictable symptoms, such as joint swelling, stiffness, pain, and tenderness, as well as fatigue, weakness, and the emotional impact of those symptoms, preceded the onset of RA. Foot and hand joint pain was most commonly described; larger joint involvement was less common. The study identified emotional distress including anger, fearfulness, and depression. The authors suggested that emotional well-being should be explored in patients at risk for RA.

Patients with arthralgia (joint pain) and early RA report common themes:

- Pain in the joints, muscles, and tendons.
- Intermittent or sudden symptoms such as
 - tingling sensations,
 - weakness and loss of strength,
 - fatigue and sleeping difficulties,
 - swelling, redness, and warmth, and
 - joint stiffness.

The intensity of the symptoms was noted to worsen through the spectrum from arthralgia to early RA. For example, patients with arthralgia only described pain as being bothersome and annoying, whereas the patients with early RA had pain that intensified to excruciating levels before diagnosis. This suggests that pain intensifies as inflammation increases just before diagnosis. Patients with arthralgia commonly reported short episodes of intermittent joint swelling, pain, and fatigue versus more persistent symptoms in patients with RA. Patients with RA reported a significant change in swelling occurring soon before diagnosis (Kung & Bykerk, 2014).

Synovial and cartilage cells are the dominant cells in joints affected by rheumatoid arthritis. Synovial cells include fibroblast-like and macrophage-like synoviocytes.

Macrophage-like synoviocytes are believed to be the predominate cause of overproduction of pro-inflammatory proteins, and fibroblast-like synoviocytes display abnormal behavior in rheumatoid arthritis. Implantation of fibroblast-like synoviocytes with cartilage in experimental models has shown fibroblasts invading cartilage, which resembles joint destruction. Osteoclast activation seems to be a key process leading to bone erosion in joint destruction, and inhibiting osteoclast activation has been proven to reduce joint destruction; however, joint inflammation is not affected. It is unclear whether arthritis starts as a primary problem in the bone and then moves to the joint, or starts in the joint and moves to the bone. Arthritis in five or more joints might develop by fibroblast-like synoviocytes altering their behavior and spreading between joints (Scott, Wolfe, & Hiuzinga, 2010).

Scientists have identified genes that are associated with ankylosing spondylitis (AS), a form of arthritis that causes inflammation and possible bone growth on the spine. The HLA-B27 gene is found in nearly 90% of people with AS, but is present in only 8% of the general population. Two additional genes (IL23R and ARTS1) have also been identified (Arthritis Australia).

A new classification criterion for early detection of arthritis has been designed by The American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR). These criteria (Sidebar 1) assess joint involvement, autoantibody status, and acute-phase response and symptom duration (American College of Rheumatology, 2010).

Classification Criteria for Rheumatoid Arthritis (RA)

Score-based algorithm: A score of six or more is needed for classification of a patient as having definite RA. (Scores listed in parentheses)

A. Joint involvement (0-5)

- 1 large joint (0)
- 2-10 large joints (1)
- 1-3 small joints, not counting large joints (2)
- 4-10 small joints, not counting large joints (3)
- More than 10 joints, with at least 1 small joint (5)

B. Serology (0-3; at least one test result is needed for classification)

- Negative RF and negative ACPA (0)
- Low-positive RF or low-positive ACPA (2)
- High-positive RF or high-positive ACPA (3)

C. Acute-phase reactants (0-1; at least one test result is needed for classification)

- Normal CRP and normal ESR (0)
- Abnormal CRP or abnormal ESR (1)

D. Duration of symptoms (0-1)

- Less than 6 weeks (0)
- 6 weeks or more (1)

It is common that treatment for RA involves some or all of the following professionals in a health care team: a general practitioner physician, rheumatologist, orthopedic surgeon, dietitian, exercise physiologist, occupational therapist, nurse, physiotherapist, podiatrist, and pharmacist. Water exercise and strength training are common forms of exercise-based treatment for people with RA.

3H Rehab Program

In 1998, Bibiana Badenes, a physiotherapist and Rolfer®, was invited to run part of the physiotherapy program for Haga Rehab, a Swedish organization, to provide rehabilitation for Swedish patients with rheumatic conditions.

This created 3H Rehab, a four-week residential program for adults and three-week residential program for children in Benicassim, Spain, located along the "Great Blue" Mediterranean Sea with white sandy beaches and beautiful, green parks. This had the advantage of being a non-hospital environment. The health care team consisted of Bibiana, three additional physical therapists (trained in myofascial release and postural alignment), one massage therapist (trained in aquatic teaching), a Pilates and tai chi instructor, a nurse, an ergonomic therapist, a physician, and myself (trained in structural integration and musculoskeletal therapy).

The physician assessed the health condition of each patient at the beginning of the program and after the program. A pain analogic scale and joint measurements were taken before and after the program, and spinal measurements were recorded for those presenting with ankylosing spondylitis. The patients completed questionnaires at the start of each day and at the end of the program.

Patients received daily treatments including hydrotherapy, movement exercises, body awareness exercises, cinesotherapy (therapeutic active and passive movements), and myofascial release. Some treatments were provided in groups and others were given individually. The activities depended on the needs of each person; there was not a single standard program provided for all participants.

Structural Integration in the 3H Program

Bibiana started the 3H Program with a conventional physiotherapy program, but through the years realised that working only with symptoms was not enough, and that the residential program gave the opportunity for more education and self-care. Bibiana's Rolwing™ education changed her understanding of a person: rather than focusing on the patient's symptoms, the goal was to engage the patient in understanding the condition. This goal became the core of her approach to organise the multi-disciplinary team.

Bibiana incorporated Rolwing / structural integration into the program since many problems she saw were related to the person's structure—the uneven distribution of stress in the body—not only to the rheumatism itself, and she adapted SI principles to work with rheumatoid arthritis clients.

As an example, in manual therapy she positioned the tissue to challenge the joint and tissue restrictions while applying gentle and firm pressure. She listened to the body and waited for the person's nervous system to respond so that motion restrictions diffused as the client's awareness grew.

As part of the myofascial release (MFR) therapy program, Bibiana and I delivered sessions using structural integration strategies to accomplish goals of balance and alignment. Our structural integration work was not based on the classic 10 session model; rather it was based on structural integration's unique understanding of the human body and structure. The hands-on treatments were delivered to the clients in 25-minute sessions, two to three times each week. Patients rotated among therapists throughout the program without a specific protocol for each patient to receive care from each therapist. Some patients requested to have a specific therapist; sometimes the request could be accommodated and sometimes not, due to the schedule.

For the adult program, I worked 20 days and delivered approximately 90 sessions for 27 patients. I saw each patient at least once. Approximately 80% of the sessions I did used structural integration strategies to accomplish the goals of increased balance and alignment. In the remainder, I applied general myofascial release and massage. Eight patients received consecutive structural integration sessions.

The children presented differently than the adults and fewer knew English, so I was less able to apply structural integration for them. I worked 15 days in the children's program and delivered 45 sessions (only about 30% being structural integration) for 33 children and teenagers.

Delivering care in an environment where SI and MFR were seen as interchangeable created challenges for me as an SI practitioner: how to work, how to apply my knowledge of SI, and how to be part of a team of therapists co-treating patients? At first, I wondered how I could possibly facilitate integration in a client in a 25-minute session, but I soon learned to make a quick decision about structure based on posture, gait, and verbal complaints. I remembered from my SI training to "make the most of each buck" (that is give the most value to the person for whom you are caring), so I worked with few strokes on areas I could see and feel were key zones impacting the person's structure.

On reflection, the shorter sessions did give adequate time for clients to integrate spatial relationships of the body. Knowing that I would potentially see the patient two days later helped me to know that I'd be able to work progressively deeper.

I adhered to Ida Rolf's method of working the body from the sleeve to the core with great focus on the feet and hands due to their sensory potency, functional importance in daily activities, and continuity with the core of the body.

The hands and feet are sensory organs, which listen as well as act, receiving stimulation which feeds the entire rest of the body. They feed the core with vital information, not least of which is auditory, for the palms and soles can hear. (Maupin, 2005, p.V)

The work I delivered to each client was shaped by her physical complaints and the disorganisation I could see in her structure. I looked for lack of support, limbs dragging on the upper or lower poles, lack of groundedness through the feet, lack of mobility in the ribs underlying shoulder and neck complaints, pelvic tilts, shifts of weight, plus emotional response to life and herself on that particular day.

For example, I worked with a lady who presented with a painful right shoulder and abduction limited to 70 degrees.

On observation I realized that I needed to organise her lateral line. I worked in three sessions to bring her pelvis to a more neutral position, increase the inhalation movement of her ribs, lessen the drag of her arms on the shoulder girdle, and increase the extension of her thoracic spine in accordance with mobility of her shoulder girdle. After the sessions, shoulder abduction increased to 140 degrees.

Another patient was a woman who rode horses and complained of pain across her low back and pain in her right knee. I observed that the medial line of her thighs and lower legs needed to be integrated; her pelvic floor needed to drop down and her weight needed to ground through the medial line of her legs. I released the medial line and the ramus of her ischium as she made micro-movements of knee flexion, knee extension, and anterior and posterior pelvic tilts. Afterwards, she reported a decrease in pain and a sense of being more grounded when walking.

A man presented generally fatigued, with lack of balance and coordination. I observed a disconnect between his abdominals, pelvis, and feet. I concentrated work on his legs and feet, brought his pelvis toward neutral, and taught him to use his legs and to breathe with his diaphragm. Afterwards, I observed that he had more mobility in the pool exercises and was more coordinated in his gait.

Structural Integration and Myofascial Release

I saw MFR as complementary to SI, particularly as preparatory work: softening the tissue and creating body awareness. When possible, I worked using SI strategies for the patient to have a better relationship in gravity. I determined whether to provide SI or MFR based predominately on the patient's structural presentation, as Bibiana explained that the effects of RA are felt more in the weak areas of a person's structural pattern.

If I saw a chronic postural pattern that any person could have regardless of being diagnosed with rheumatoid arthritis, I worked to balance, align, and integrate structure. I applied MFR when the patients had other medical complications presenting: when their energy was low, when they seemed to need to not participate, and with the young children who couldn't speak English.

In the cases where I applied massage, I used Swedish massage, lymphatic drainage, and remedial massage techniques.

Additional Therapies in the 3H Program

Structural integration complements the other therapies offered in the 3H Program.

- Hydrotherapy and land exercises were included, starting with mobility exercises and progressing slowly into cardiovascular and resistance exercises.
- Integral Aquatic Therapy, which works with the fascial and joint restrictions of the client within the lower-gravity environment of a heated swimming pool, was offered. In this method, the client is supported by the water and therapist while being moved in ways that are not easily accessible on a table to achieve fascial release and activation of the parasympathetic nervous system.
- Short sessions following the concepts of Gabrielle Roth's Five Rhythms were also adapted for the RA clients, giving them the opportunity to explore movement in a raw sense without effort, force, or perfectionism.
- Tai chi was also offered to provide structural support as well as spatial, emotional, and mental adaptability.

Each soft tissue therapy session and activity was modified to benefit the whole client by recognising the structural, functional, and energetic dysfunctions, conflicted worldviews, as well as emotional and physical trauma impacting the body as it organized itself in gravity. Clients were able to continue most exercises and activities in their home environments.

Movement education and body awareness were important aspects of the exercise therapy so patients could adequately adapt and maintain new movement and alignment patterns. "Awareness" was the word often repeated, so patients could change the way they perceived and understood their bodies. Thus the movement programs supported one of the tenets of SI as explained by Ed Maupin in *A Dynamic Relation to Gravity: Volume 1*:

Structural integration uses the experiencing subject as a partner in the process. It assumes a fundamental wisdom in the body, which can participate, seeking to find its optimal pattern. Awareness, the body's own experiential awareness, is what makes the change. (2005, p. 3)

Education also included how to release and use the feet, and how to walk and sit with the support of gravity. Many exercises were also done on the floor and adapted to the patient's needs. Repetition of exercises was not forced; the exercises were encouraged to be felt to create a new movement experience. This education was included in the hydrotherapy sessions, benefiting from the resistance and buoyancy of the water; in land-based mat, step, and gym ball exercises to create adaptability to gravity; when walking with the aid of Nordic walking sticks to increase awareness of the two major gravity centres of the body and enhance fluidity of movement; and during personal coaching of the developmental stages of movement.

Structural Integration as Part of a Health Care Team

Sharing patients with other therapists was challenging for me as I didn't know how other treatments affected the level of integration in the patient or what other processing may have been occurring. Furthermore, the specifics of how an area was worked by other therapists were unknown.

Also, I desired to follow up with patients, to know how they responded from treatment I had given them, when they were not scheduled to see me again.

However, I equally saw the benefit of patients receiving treatment from different eyes and hands, being given new perspectives, and being able to experience similar, yet different, approaches.

In this environment I felt spontaneous, creative, and very much in the present moment. This was due mostly to the time schedule and working with how the patient presented on the day—not necessarily following up on what they received two days previously. Treating the patients consecutively with SI goals was much more rewarding for me: to see and to know that a change occurred and a new way of being in the world had emerged.

Discussion

When designing the program to include structural integration principles, Bibiana asked herself "How [can you] discover, even with your limitations, that you can be healthy?" She seeks to educate each person to live in his or her own body and said this is something that is missing many times in rheumatism. They only live when they have pain. And when they are fine, they are not really enjoying their bod[ies]. To live in their body is what I want for them. Come back to your body. Come back to your own perception. Come back and feel you are alive. (Personal Communication, September 2014)

The 3H program offered the RA clients time to recognise and learn to respect the potential of their ability on a given day, neither forcing an unrealistic expectation of performance nor being hindered by the physical limitations of the previous day. In my opinion this acknowledgment and acceptance of being in the present is very important for fascial release. A number of the patients attended the program several times. One woman reported that the first time she participated in the program seven years ago, she could not do up her bra and had minimal movement of both her shoulders. Over the years she eventually regained full range of motion of her shoulders.

A Swedish patient, Else, who had attended the program a number of times, describes the program well.

I love my treatments in Haga / 3 H Rehab. It's not just for my pain; I got help. It's for my whole body. When you [are] always in pain, it will be problem with your soul, too. We do exercise for the whole body every day, we have exercise in the garden, train in the pool, we learn how to breathe, how to walk in the right position. The individual treatments [I received] I have never felt anywhere else. It's not painful, but the therapists work in our body in a way that really helps people. Bibiana and her staff are all very well educated, and I always learn something new about my body, and we learn a lot that we can use in our home. (Personal communication, December 2014)

Through my experience in this program, I learned that the principles of structural integration can be developed, modified, and continue to evolve for different structural dysfunctions including rheumatic disorders. Structural integration can be used effectively within a team of other health professionals to provide life-giving opportunities for clients of different ages with rheumatism.

Structural integration is a powerful method to be implemented in more holistic programs and, as Bibiana has demonstrated, a structural integrator can be a coordinator for these programs, because she has the ability to see, work holistically, create a better structure and a more functional body, but also to prevent future problems, engaging the person to take care of herself, to be educated, to have a higher quality of life. I believe that this kind of understanding can be applied not only in programs for rheumatic patients, but within any program for well-being: for back pain disorders, personal growth, and preventative programs for children at school. Bibiana summarized the effectiveness of the 3H Program:

We want people who are willing to get involved with the process of recuperation and therefore enable a team to be formed between patient and therapist.

Through the years I have realised that although we must deal with the presenting symptoms, what is most important is to emphasise education when the person is not in an acute crisis. Our patients improve vastly when we integrate a more mindful approach. We achieve our best results working with prevention, noting where the compensations occur and where we anticipate the next problem area. Taking care of oneself is not just taking medicine or doing exercises. Self-care with RA is about understanding yourself as a person. Discover[ing] the potential in people and find[ing] a way to create vitality, equilibrium, and well-being is our goal. I have no doubt that prevention carried out in a way that we enjoy it is the best medicine there is. Our thoughts, our emotions, our postures, and movements are the history of our lives and they have taken toll during the years. 3H Rehab is not just any holiday, it is the beginning of a new outlook towards health, well-being, and mindfulness." (Personal communication, September 2014)

From my experience and what I gather from the design of the program, a traditional SI program would be effective for the rheumatic patients delivered in shorter sessions more frequently.

For example, I think working with one goal in a 30-minute session and having three sessions each week could be integrative in a progressive and gentle manner for those experiencing RA.

Two clients I treat in my clinic who have lupus, a subset of rheumatism, have responded very positively to the traditional series with full length sessions.

From this experience, I think the goals and strategies are very applicable to patients with rheumatism and a more structured delivery of treatment would further enhance their health. At the same time, I believe it is extremely important that all therapy is delivered to the individual needs of each patient. Often these patients have other health complications that need to be addressed or taken into consideration with a complementary health professional.

For more information please contact Bibiana Badenes at 3H Rehab, www.bibianabadenes.com or info@bibianabadenes.com

Acknowledgements

I would like to thank Michael Stanborough for his valuable teaching of structural integration, and for providing the foundation to seek education and work opportunities abroad. With gratitude I wrote this article with the support of Bibiana and would like to thank her immensely for the extraordinary opportunities and experiences she gave me in Spain. The teachings gained from those experiences are shaping my daily life as well as my clients. I thank Bibiana sincerely for her contribution to this article, to my education, and my life. With all my heart I thank the team and Haga Rehab for their passion and commitment to the patients to receive the best results. I thank the adults, children, and parents who participated in the programs May and June 2014, for I will always remember them for their care, commitment, and encouragement to each other and to our team. ■ amt



Andrea Randall, structural integration (SI) practitioner, graduated from SI Australia in 2011, and holds a Bachelor of Health Science (Musculoskeletal Therapy) degree from Endeavour College of Natural Health, graduating in 2008. In May 2014 she had the privilege of working with a team coordinated by Bibiana Badenes, Certified Advanced Rolfer TM and Rolf Movement® Practitioner, in a residential program for Swedish clients with rheumatoid conditions where she was able to apply the skills and principles of her structural integration training. The visible changes in the clients' movement and attitude toward life at the completion of the program prompted her to write this article. Andrea lives and practices in Brisbane and can be reached at andrearandall5@gmail.com.

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The Explain Pain Handbook: Protectometer, by G.L. Moseley and D.S. Butler

Book review by Clyde Andrews

I had an epiphany!

No, not the type of epiphany that's associated with the divine, or even one that can be confused with gaining something without any basis or thought of fact, but an honest to goodness epiphany of knowledge. This epiphany of knowledge came from a little book with a powerful message.

This little book is about pain. How to recognise it, how to measure it, how to deal with it, and—more importantly—how to cope with it so the road to recovery won't seem like walking the highway across the Nullarbor. It's done with easy to understand language and features wonderful illustrations, too. It's called: "The Explain Pain Handbook: Protectometer" and it's by G.L. Moseley and D.S. Butler, two fantastically flamboyant gentlemen who have had more than 60 years experience in the field of pain. Even though the book is lightweight in pages (about 50), by no means is it lightweight in ideas—and powerful ideas that any health professional can utilise in their practice with their clients (and you can use yourself).

I have to say it took me a long time to read this book—far longer than any other book of that length. Why? Simply because each sentence is powerful. It has ideas that require, no, demand deep thought and consideration to fully absorb and comprehend. Pages are re-read over and over, because everything has profound meaning, and through that meaning (and the digestion of it) comes understanding... and then that epiphany of knowledge I talked about.

So, what is "The Protectometer"? Well, it's our own individual gauge on how we are doing, to put it simply.

According to the authors, and all of their evidence based research that has been amassed over the years, "When the credible evidence of DANGER to your body is greater than the credible evidence of SAFETY to your body" (p.14) you will experience pain.

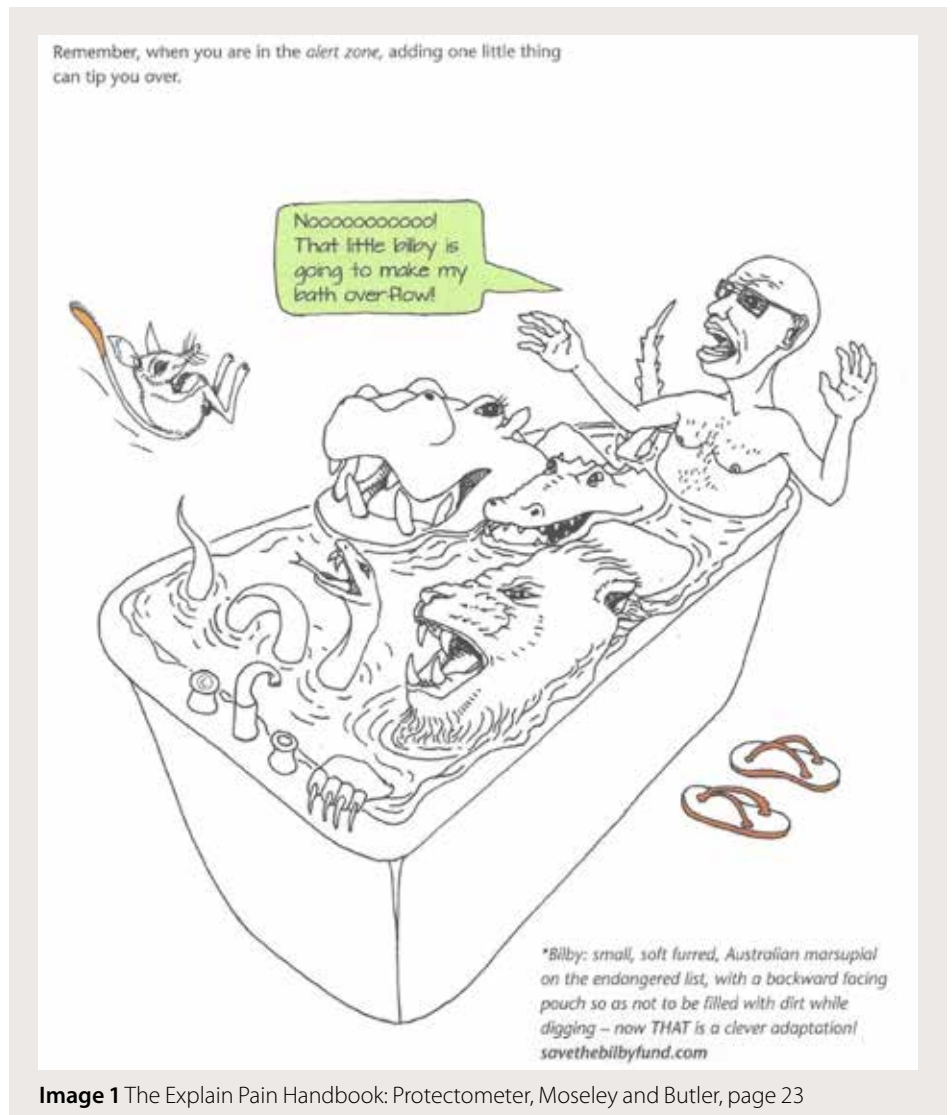


Image 1 The Explain Pain Handbook: Protectometer, Moseley and Butler, page 23

There are no nerves that transmit pain, it is your brain that makes pain from the messages it receives from the body. No exceptions. Ever.

In other words, just looking at biomechanics isn't enough—which is what we do as therapists, isn't it? (We see how our clients move; their posture and gait). However, you also need to include neuroplasticity, or how the brain interprets the world and makes changes accordingly. It's the brain that rules the roost.

It's the brain that makes biomechanical changes if danger is perceived. So, putting biomechanics and neuroplasticity together, we get what is known as BIOPLASTICITY. The Protectometer goes into great detail about how bioplasticity affects everything from thirst to feeling blue, to how it impacts us when we're injured.

Of course, because of bioplasticity, the experience of pain is individual and that's why getting to the crux of the issue can be important. For example, a violinist who injures their finger is going to experience more pain than a runner. Why? Because a finger is more important to the violinist, and harm to it affects them in a more profound way than the runner would experience. The perceived danger is more tangible for the violinist, so their brain increases their Protectometer rating, which results in more pain.

On the flip side of that, ever noticed how you can hurt yourself without even knowing it? For example, sometimes it takes someone else to point out that you've cut yourself. This is because our own individual Protectometer has decided that the danger of the cut (say, from a thorny bush) isn't as great as the *safety* of it. How can this happen? Well, if that cut from the thorny bush happened while you were running across your front garden to stop your child from going after a ball that's rolled onto the road, then your Protectometer wouldn't consider the cut a sign of danger. It may only be afterwards, when you have stopped your child from going onto the road, that pain is registered from the cut, if at all.

Sometimes the pain we experience may not even be about an injury, or the injury could be quite minor yet have a profound effect on you. The injury was simply the tipping point because your Protectometer was in the alert zone (a place just before pain is registered). Let me show you what that means in the fantastic way the book shows us: (Image 1)

I've printed out heaps of copies of this illustration and I use it in my clinic with my clients to think about and discuss. In this illustration we can soon see we're all swimming in a bath of our own problems and issues (and the more there are in that bath with you, the more you head on upwards past the alert zone ... and into pain). The lion for you could represent the lack of sleep due to worry. The snake could be that your partner is unwell. The crocodile could be that you're not quite thinking straight due to the demands of family ... and so on. Yet, our brain perceives the little bilby—which could simply be an ankle sprain—as the danger, because you already have so much in the water with you.

So, of course, you go and see a health professional because of your ankle sprain. Yet, that sprain wasn't really your problem, just the tipping point. To be a health professional who recognises this in their clients can be profound and, with the help of this little book, you can too.

This little book then goes on to discuss how you—as your own individual with your own Protectometer—can address the issues that cause pain and what you can do about it. Recognising your DANGER, or DIM (Danger in Me) and the off-setting SAFETY or SIM (Safety in Me) is a great tool, and one that can be done by yourself, or in consultation with a health professional who understands the mechanisms that accelerate or decelerate your Protectometer; or you can do it with your clients.

Only recently I had a client with a shoulder sprain that wasn't getting better when it should have been. It wasn't until I started discussing her Protectometer, and the guides within the pages of the book, that I found out her son was recently in hospital and she had extreme demands on her at work. She was very stressed, yet her brain perceived her sore shoulder as the danger. Clearly, the shoulder sprain was her tipping point, and only by getting her to talk about her DIMS and SIMS (and using other exercises from within the book), did her shoulder begin to get better.

As a remedial therapist, I can't solve the issues of life such as those I've mentioned above, but I can help my clients recognise them so their road to recovery can get started. You can certainly help your client (or yourself) set up their base camp; which is a great tool to use to get the ball rolling and to help them recognise limits and how things can be improved every day by harnessing bioplasticity. Remember, how we think, feel, talk, what we see, hear, touch and taste, what we do and where we go all affect our Protectometer. Thought and fear can become pain, just as easily as a physical muscle injury.

Using the Protectometer handbook, by absorbing the knowledge and examples within, photocopying pages, scribbling on them and discussing openly, it can really set up a new world of possibilities for ourselves and our clients. I simply wouldn't be without my copy of this book. It's a once in a lifetime purchase that really can, and does, make a difference.



You don't have to be a psychiatrist to weave the wisdom of the book into your practice; just someone who listens, is empathetic and understands that pain is individual and caused by so many things; which we all are as manual therapists, aren't we? Five stars out of five! ■amt

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After some 25 years in a dead-end retail job, Clyde's mid-life crisis didn't take the form of buying a Lamborghini or a Bugatti Veyron, but rather the need to help others--and besides, having such a nice car would have played havoc on his OCD as no one would have been able to even breathe on it. So, taking the plunge, and after almost 3 years of going through MIIMT and coming out the other side as a new 'reborn' individual, Clyde now has his own business and is quite happy working for himself and at his own pace. He's ever keen to learn more and through that knowledge pass it on to his clients. Bring on the future.

30th Kinesio Taping Research Symposium, Tokyo

Review by Dave Moore

The 30th Kinesio Taping Research Symposium, Tokyo, examined the latest research in Kinesio® Taping and its effectiveness.

Pre-symposium

The pre-symposium workshop, *Kinesio Taping in Sport*, was presented by the head athletic trainer of American major baseball team, Seattle Mariners. Rick Griffin, and his associate Dr Masahiro Takakura, discussed causes and treatments of the most common injuries suffered by professional baseball players. Rick produced interesting statistics on the number of player hours lost to injury in the American major league and the comparison between best and worst teams was quite astounding. In 2014 the Baltimore Orioles finished the season second and had one of the lowest number of days lost, while the Colorado Rockies had the highest number of days lost and finished nearly last in twenty-ninth place.



Rick Griffin in demonstration mode



Rick Griffin, Dr Kenzo Kase, Dr Masahiro Takakura



Symposium attendees

THE SYMPOSIUM PROPER

Day 1:

Around 250 participants (researchers, physiotherapists, chiropractors, massage therapists and even vets!) from all over the world participated and enjoyed presentations, workshops and papers from experts in many fields.

The inventor of Kinesio® Tape, Dr. Kenzo Kase, spoke on *Tissue Repair and Kinesio Taping*. He outlined his current thinking on the effects of Kinesio® Tape on the enhancement of capillary action on tissue repair. His well-illustrated presentation spoke about how capillaries have varying degrees of permeability: some allow only the exchange of small molecules such as oxygen and carbon dioxide (CO₂), others allow hormones and ureic acid to pass and those in bone marrow were 'leaky' enough to allow the passage of whole cells and large protein molecules.

His discussion of the structure and function of the dermis and its associated fat layer was an introduction to his *Hydrokinetic Theory* and the importance of the flow of intracellular fluids to our wellbeing. Particular emphasis was placed on the importance of these fluids having the space to move freely. Kinesio® Tape is effective in creating this space in a way that aids in the reduction of heat and increases capillary circulation due to its unique properties of adhesion.

Advances in treatment are outlined in his latest book: *Dr Kase Therapy, An Approach to Soft Tissue Injuries* (self-published).

I attended American Richard Cheung's workshop *Are My Hamstrings Really tight?* which examined the biomechanics of the pelvis and the relationship of pelvic tilt to hamstring tightness. Attendees self-assessed their ability to touch their toes and had a colleague measure and note their level of success (or lack of it - ME). We then applied Kinesio® Tape to facilitate the function of our transversus abdominis muscles. After retesting most of us saw a measurable improvement! Richard added that, by noting each individual's movements and adjusting the tape procedure to include the obliques and/or rectus abdominis, even better results may be obtained.



Richard Cheung discusses hamstring tightness

Kinesio Taping in Sport was presented by another American, Jim Wallis, and Italian Stefano Frassine. Jim and Stefano offered their insights and experience, demonstrating some of their favourite sports techniques, followed by the group conducting practical applications to test their conclusions.



Stefano Frassine tests a Shoulder

Australia's own Thuy Bridges conducted a workshop on *Kinesio Taping for Low Back and Pelvic Girdle Pain: Assessment and Application*. Thuy is a physiotherapist who has run very popular workshops at AMT conferences in the past.



Thuy Bridges presents her workshop

Other workshops were:

- Lymphatic Applications in Kinesio Taping – Gudrun Collins & Sabrina Arnulf (UK)
- The Psychological Factors in Kinesio Taping – Tsutomu Tanaka (Japan)
- The Kinesio Taping Manual Direction Test – Masahiro Takakura (USA)
- The use of Kinesio Taping for the Paediatric Population – Patricia Martin and Audrey Yasukawa (USA)
- Mitate Process: The Choice of effective Kinesio Taping – Tamotsu Ohashi (Japan)

The day concluded with a celebration dinner which was a great opportunity to mingle with fellow participants.

A traditional Kagami Biraki (sake barrel lid breaking) ceremony ensured we all got a taste of Japan's favourite brew.



Traditional dinner and drinks

Afterwards I joined a group of my newly found friends and introduced them to Japanese Kushi-Yaki pub culture...just around the corner from our hotel!

Day 2:

Keynote speaker Professor Hans-Michael Klein (from Germany) presented his research into *The Influence of Kinesio Taping on Post-Operative Pain and Wound Management in Cardiac Surgery*. Professor Klein is a cardiac surgeon who has researched the effectiveness of Kinesio® Tape on the healing of patients who have undergone 'zipper' type cardiac surgery (where the sternum is sawn down the middle to gain access to the heart). His results were positive and Professor Klein commented that given the cohort of patients (elderly Germans - notoriously resistant to new thinking) he believed placebo effects would be less than normal.



Keynote speaker Professor Hans-Michael Klein

Seven shorter presentations followed covering a diverse range of Kinesio® Tape research subjects. Questions from the floor were encouraged and points raised were discussed openly.

Keynote speaker, Frenchman Dr Jean Claude Guimberteau, shared his fascinating work: *An Attempt to Explain the Efficiency of Taping through Endoscopic Observations*. During his presentation he showed stunning videos, taken while he performed surgery, of the cellular matrix using endoscopes on living tissue. This enabled us to actually **see** tissue working beneath the skin and demonstrating the effect of the application of Kinesio® Tape. This presentation was the highlight of the Symposium for me. It clearly demonstrated significant differences in the structure of living tissue compared with what is seen in text books, which are based in the main on cadaver explorations. He concluded by launching his book *Architecture of Human Living Fascia*.



Jean Claude Guimberteau

More shorter presentations followed, one of which, *Kinesio Taping and its Effects Beneath the Skin* (by Norwegian Frank Tore Jacobsen), offered a literal kitchen bench demonstration of how Kinesio® Tape created lift under whatever it was stuck to. Surprisingly, a narrow strip creates more lift than a broad one.



A boatload of therapists

Day 3

The final morning included a session of short presentations and case studies before Dr Kenzo Kase presented an *EDF Workshop*.

He spoke on a diverse range of subjects, mostly from a chiropractic viewpoint, and offered many insights into how he viewed the structure of the body and its response to stimulus. He discussed his understanding of the skin and related it to Dr Guimberteau's findings. The presentation then moved on to the roles of muscles and fascia, and the importance of hydration, including its relationship to ageing.

He completed his presentation by actively demonstrating his latest Kinesio® Taping techniques and other treatments developed from his ongoing research including:

- Screening Assessment
 - Eight functional tests to be carried out as part of every assessment/ treatment/reassessment protocol.
- Kinesio® Taping
 - Latest advances from ongoing research, showing it is better to stretch the skin and allow the tape to lift tissue rather than stretching the tape.
 - The differences between Kinesio® Tex and Kinesio® FP tape and when each should be used.
- Cryotherapy
 - Applying cold and vibration simultaneously to penetrate deeper into the tissue. Dr Kase emphasised the importance of constant attention and care when using cryotherapy.
- Muscle Fascia Slacking Therapy
 - Using specialised vibrating devices to produce a focused slackening of muscles and joints.
- Osteorosa
 - A form of tapotement using specially designed hammers.
- Chiropractic adjustment
- Muscle Unit Training
 - A form of exercise where targeted movements are actively carried out by the patient and repeated once a second for ten reps.

At the conclusion of this session it was time to board a bus to spend the night in a traditional Japanese spa or Onsen, but that's another story.

The next symposium is being held in 2017 in Hawaii.

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■ amt

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After an interesting career in the entertainment, broadcast and audio-visual industries, Dave Moore's fascination with the human body resulted in a career change. He opened a home-based clinic after qualifying in 2000, at which time he joined AMT.

Dave decided to continue and extend his studies by travelling extensively to attend courses and workshops in a wide range of conditions and treatment techniques and advanced anatomy and physiology.

In addition to AMT, Dave is a member of Kinesio Taping International and Sports Medicine Australia (Soft Tissue Therapist).

celebrating
50
 1966-2016 years

50th Anniversary Interview: Susan Davis – AMT's Longest Serving Current Member

by Anita Mack

In recognition of the Association's 50th Anniversary this year, In Good Hands sat down with AMT's longest serving current member, Susan Davis, to talk about massage, her career and the role AMT has played in it all.



Susan Davis

Our longest serving member joined AMT 38 years ago in 1978, however her association with AMT and massage is much older. Susan's mother, Cynthia Davis, was also a massage therapist (and an ex-AMT president). You can read more about Susan's memories of her mother's work in the earlier *In Good Hands* article - *Cynthia Davis: An Inspiring Life* (March, 2014).

Susan completed a three-year apprenticeship in nursing which she finished in about 1976. Her mother needed help in her massage clinic so in 1978 Susan started work as a massage therapist (which is when she registered with AMT). It was with her mother that she completed her massage apprenticeship.

In the late 1980s she wanted to do more study. At the time there was nothing available in the field of massage at university, so instead she studied a Bachelor of Health Science at the University of New England.

Later Susan enrolled in a Masters of Clinical Science focussing on pain and sleep.



Young therapist Susan Davis (standing)

In the late '70s massage therapy looked different. Susan remembers "therapists were divided into sports or esoteric massage. Men mostly practiced sports therapy." Female therapists used to wear white uniforms (nursing style) and they didn't have much equipment. The room at the Davis' clinic had a set plinth. It was the old fashioned doctor's table with an end that came up, wooden framed and with a tray underneath covered in vinyl. There were three or four different height tables so the therapists each found the table that best suited them.

The clinic had a steam box in the corner so clients would have a ten minute steam followed by a thirty minute Swedish massage. The use of heat and cold, influenced by polio treatments, was very big at the time. Susan started as a therapist in that environment so that's what she practiced. She used to do ice massages using ice on the end of a paddle-pop stick.

In those days the people who came for massage treatment were nearly all women, hardly any men and no children.

The women who attended the clinic all knew one another. The room at the Davis' clinic was very open. There was a curtain in the middle of the room with beds on each side, but the curtain would get pulled back and the two clients would chat to each other while getting their massage. Imagine 40°C in Sydney with no air-conditioning, a steam box in the corner and everyone in one room.

Of course clinic administration was managed differently. Susan recalls that "everything used to be written on client cards. I'm highly electronic now. My appointment book is on my computer, I work with an iPad and I use Endnote to write my client notes. I have books, but because I have the computer on my desk I have all the information at my fingertips."

These days Susan has moved on from ice massages. She now practices in the field of chronic pain management and her clients are aged from 15 to 96 years old. "I do a lot of medical related things with people on renal dialysis, colostomy bags, wheelchair clients. Mostly I see people when they've tried absolutely everything and can't do anything with their pain. It's a multi-disciplinary thing as they're also seeing their doctors."

Susan also teaches at the Avondale College School of Nursing in their chronic pain unit. What she teaches is not how to become massage therapists, but what it is and what it looks like. Included in her classes is a very basic 'how to do stroking' so they get an idea of what it feels like to give massage, so they can look at how it can be utilised as part of treatment.

Most recently she's submitted a chapter on general massage for a book written for doctors. "The thing I tried to get across in the chapter is that massage therapists are trying to work the whole body, not just the problem area. We're with clients for an hour. No other therapist is with them for an hour."



AMT tent at the NSW Senior Citizen Day

For Susan the most important thing about her job is the clients and the trust they put in her as their therapist. As she puts it, "strangers will walk into my room and take their clothes off and allow me to work on something that is so important to them, their body. It has always amazed me. I have always treated it with so much reverence and privilege. That is the basis of where I come from. That's the basis of my whole life, my treatment, my everything."

■amt

Images courtesy of Susan Davis.

We can give positive input into [the client's] therapy and I think that's disregarded a lot. I appreciate that person's time. They've given us an hour to see if I can help them."

Some of the most significant moments in Susan's career were events run by AMT. The first was when American John Harris, who worked for the 1984 Olympics, attended an educational weekend at Narrabeen Sports Centre.

Others were when Susan attended events as a representative for AMT. In the days before social media AMT raised its profile by offering free massages at events. These included the Sydney marathon and the NSW Government's Senior Citizen Day. Remembering those events Susan said, "It was great working with other therapists. [Those] events...were a highlight of my career for a long time."



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Provider Recognition Criteria

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.

HEALTH FUNDS AND SOCIETIES		CRITERIA
ahm Health Insurance	Medibank Private	These funds recognise Senior Level One and Two members. Providers must also meet Medibank's Diploma duration requirement of one year to be eligible.
A.C.A Health Benefits Fund	Onemedifund	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.
Cessnock District Health Benefits Fund	Peoplecare Health Insurance	
CUA Health Limited	Phoenix Health Fund	
Defence Health	Police Health Fund	
Frank Health Insurance	Queensland Country Health Ltd	
GMF Health	Railway & Transport Health Fund Ltd	
GMHBA	Reserve Bank Health Society	
health.com.au	St. Luke's Health	
Heath Care Insurance Limited	Teachers Federation Health	
HIF WA	Teachers Union Health	
Latrobe Health Services (Federation Health)	Transport Health	
Mildura District Hospital Fund	Westfund	
Navy Health Fund		
Australian Unity		Australian Unity recognises members with HLT50302/07 Diploma of Remedial Massage, HLT50102/07 Diploma of Traditional Chinese Medicine Remedial Massage, HLT50202/07 Diploma of Shiatsu and Oriental Therapies, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), Diploma of Health Science (Massage Therapy), Advanced Diploma of Applied Science (Remedial Massage) and Advanced Diploma of Soft Tissue Therapies. Existing Senior Level One and Two providers remain eligible.
BUPA		BUPA recognises members with HLT50302/07 Diploma of Remedial Massage, HLT50102/07 Diploma of Traditional Chinese Medicine Remedial Massage, HLT50202/07 Diploma of Shiatsu and Oriental Therapies, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy). Existing providers remain eligible.
CBHS Health Fund Ltd		CBHS recognises all AMT practitioner levels.
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). Existing providers remain eligible. They require you to use their provider number. This number is AMXXXX, where the Xs are your 4-digit AMT membership number.
GU Health		GU Health recognises members with HLT50302/07 Diploma of Remedial Massage, HLT50102/07 Diploma of Traditional Chinese Medicine Remedial Massage, HLT50202/07 Diploma of Shiatsu and Oriental Therapies, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), Diploma of Health Science (Massage Therapy), Advanced Diploma of Applied Science (Remedial Massage) and Advanced Diploma of Soft Tissue Therapies. Existing Senior Level One and Two providers remain eligible.
HBF		HBF recognises Senior Level One and Two members.
HCF		HCF recognises members with HLT50302/07 Diploma of Remedial Massage, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), Advanced Diploma of Applied Science (Massage) and Diploma of Health Science (Massage Therapy). Existing providers remain eligible. Providers must also meet HCF's Diploma duration requirement of one year to be eligible.
NIB		NIB recognises members with HLT50302/07 Diploma of Remedial Massage; HLT50102/07 Diploma of Traditional Chinese Medicine Remedial Massage; HLT50202/07 Diploma of Shiatsu and Oriental Therapies; Advanced Diploma of Remedial Massage (Myotherapy)
WorkSafe Victoria		Worksafe Victoria recognises Senior Level One and Two members.

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 up to four practice addresses. Medibank Private will only issue provider numbers for three practices.

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

Calendar of Events

March 2016		CEUs
5	Rocktape Introduction Course - Full Day. Presented by Steve Stahl. Melbourne, VIC. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
6	Rocktape Introduction Course - Full Day. Presented by Hans Lee. Sydney, NSW. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
6	Curly Customers, Muscles that Confound. Presented by John Bragg. Randwick, NSW. Contact 0410 434 092 or john@johnbragg.com.au www.johnbragg.com.au	35
6	ACT Branch Meeting. Wanniasa, ACT. Contact 0438 235 333	15
7-8	Modern Cupping Therapy. Presented by Bruce Bentley. Perth, WA. Contact 03 9576 1787. www.healthtraditions.com.au	
9-13	Neurostructural Integration Technique Basic. Presented by Wendy Eyles. Sydney, NSW. Contact 0412 417 719. Email: harmony4massage@gmail.com	175
11-13	Oncology Massage Module One. Presented by Anne-Marie Halligan. Cottesloe, WA. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
12	Rocktape Introduction Course - Full Day. Presented by Lucy Beumer. Gold Coast, QLD Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
12	Gua Sha Day. Presented by Bruce Bentley. Melbourne, NSW. Contact 03 9576 1787. www.healthtraditions.com.au	35
13	AMT Annual General Meeting and Workshop. Brisbane, QLD. Contact 02 9211 2441. Email: info@amt.org.au 15 CEUs for AGM only, 40 CEUS for AGM and Workshop	15
13	Rocktape Introduction Course - Half Day. Presented by Rocktape. Maitland, NSW. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	20
15-17	Oncology Massage Module One. Presented by Bronwyn Sutton. Corowa, NSW. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
16	Gua Sha Day. Presented by Bruce Bentley. Adelaide, SA. Contact 03 9576 1787. www.healthtraditions.com.au	35
16-20	Short Course in Certified Infant Massage Instruction. Presented by Glenda Chapman. Sydney, NSW. Contact 02 6262 4346 or support@iaim.org.au www.iaim.org.au Class runs 16, 17, 18 and 20 March (No Class runs on Saturday 19th)	140
17-19	Oncology Massage Module One. Presented by Kate Butler. Launceston, TAS. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
18-20	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Adelaide, SA. Contact 03 9576 1787 www.healthtraditions.com.au	105
18-22	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley. Adelaide, SA. Contact 03 9576 1787 www.healthtraditions.com.au	175
18-19	Onsen Techniques Volume 2 Functional Assessments & Treatments of the Lower Body. Presented by Jeff Murray. Kingscliff, NSW. Contact info@beyondmassage.com.au www.beyondmassage.com.au	70
18	Rocktape Introduction Course - Half Day. Presented by Rocktape. Surry Hills, NSW. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	20
18-20	Oncology Massage Module One. Presented by Anne-Marie Halligan. Riverdell, SA. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
19-20	Myofascial Cupping Technique™. Presented by David Sheehan. Melbourne, VIC. Contact 03 9481 6723 or info@compchs.com.au www.compchs.com.au	70
19-21	Oncology Massage Module One. Presented by Tania Shaw. Mackay, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
19-20	Neurostructural Integration Technique Introductory. Presented by Wendy Eyles. Sydney, NSW Contact 0412 417 719. Email: harmony4massage@gmail.com	70
19	Rocktape Introduction Course - Full Day. Presented by Jo Bouckley. Perth, WA. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
19	Rocktape Introduction Course - Full Day. Presented by Sonja Saar. Brisbane, QLD. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
19	Rocktape Introduction Course - Full Day. Presented by Daniel O'Sullivan. Canberra, ACT. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
19-21	Oncology Massage Module One. Presented by Tubi Oyston. Griffith, NSW. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
19	Rocktape Full Day. Presented by Daniel O'Sullivan. Canberra, ACT. Contact education@rocktape.com.au rocktape.com.au	35
19-20	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	70
19-20	Hot Stone Massage. Presented by Master Zhang Hao. Strathfield, NSW. Contact 0416 286 899 www.chihealing.com.au	70
19-23	NurtureLife® Pregnancy Massage Practitioner. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	175
19-20	Anatomy Trains. Presented by Tom Myers. Auckland, New Zealand. Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	70
20	Rocktape Introduction Course - Half Day. Presented by Rocktape. Wollongong, NSW Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	20
21-22	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne, VIC. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	105
21-22	Modern Cupping Therapy. Presented by Bruce Bentley. Adelaide, SA. Contact 03 9576 1787. www.healthtraditions.com.au	70

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