

Chairperson's Message

by Annette Cassar

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With conference only a matter of weeks away, I thought it was an opportune time to discuss the role of professional development in our industry.

Over the years I've been in practice I've found it is easy to fall into a rut, to lose direction on where your business is heading and even what conditions and areas you would like to focus on. I call this 'losing your mojo'. Losing your mojo is detrimental to your clients, your business and your wellbeing. I have discovered how learning new skills can give your business that much needed lift: your clients are very appreciative of your new-found skills and techniques when you add them to your treatment plans.

Professional development is a career-long obligation. Well-rounded professional development provides benefits that are all encompassing: it safeguards our clients, ourselves as employers, as a professional and ultimately our career. Professional development is integral to the process of becoming a high quality professional.

It's also important to understand your professional development goals don't need to start and finish with the 100 CEU points required for health fund provider status. While necessary, this should provide a baseline for your professional development, a minimum to be reached, not necessarily a maximum.

What are your professional development goals? If you don't have some you should take a moment to think about what it is you want to achieve. Well-rounded professional development goals should include all the following:



- networking;
- updating and learning new techniques; and
- developing your business acumen.

This last point is important as our professional service doesn't rest with our hand skills. To enable us to deliver a professional service to our clients and employees, and to have a more effective workplace, we need to understand our legal and financial obligations.

AMT values best practice and strives to provide opportunities for its members to meet all aspects of their professional development goals, through our annual conferences, members' days, regional branch activities, other workshops and events, and through the various social media platforms we provide which support professional dialogue. This fits perfectly with our mission which is, in part, to support our members and professionalise the industry.

The more skilled we are in **both** business and massage the greater the likelihood of our business' success.

There is an abundance of choice when it comes to professional development opportunities (not just through AMT but via the numerous great conferences and workshops held by other organisations and providers). So much so it can become overwhelming. Having goals helps to narrow down your focus to those that relate to what you want to achieve. Although it's interesting to note the majority of professional development in our industry focuses on the first two points I made above regarding goals, there is much less choice when it comes to increasing our business knowledge. It's for this reason I'm immensely disappointed about the lack of response to AMT's scheduled Brisbane workshop on Employment, Tax and Superannuation. It is especially surprising given the amount of time AMT's secretary invests in providing industrial advice to members about workplace entitlements and contracts. Is it possible there is

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September edition

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a serious divide between the skills development we need and the skills development we actually undertake? This is an issue the AMT Board is currently exploring in developing a new strategic plan to guide us forward.

DEADLINE

**Deadline for the
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To finish I'd like to share this quote by motivational blogger Sivaprakash Sidhu, "Investing time to learn something in your profession makes you rich in your knowledge, if you are not then it will make you poor in your performance."

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Melbourne.....	12 & 13 Sep
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Sydney.....	18 & 19 Feb
Melbourne.....	27 & 28 Feb
Melbourne.....	25 & 26 Mar
Perth.....	10 & 11 Jun

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3 or 5 days*

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Melbourne.....	29-31 Aug (3 day)
Cairns.....	1-5 Oct (5 day)
Cairns.....	3-5 Oct (3 day)
Brisbane.....	26-30 Nov (5 day)
Brisbane.....	28-30 Nov (3 day)
Sydney.....	20-22 Feb (3 day)
Sydney.....	18-22 Feb (5 day)
Melbourne.....	27-29 Mar (3 day)
Melbourne.....	25-29 Mar (5 day)

*Conditions apply. See our website for full details

Secretary's Report

by Rebecca Barnett

*Turning and turning in the widening gyre
The falcon cannot hear the falconer;
Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed, and
everywhere
The ceremony of innocence is drowned;
The best lack all conviction, while the worst
Are full of passionate intensity.
(William Butler Yeats, *The Second Coming*)*

Over the past three months, I have been taking advantage of a free Netflix subscription by ploughing through the entire seven seasons of the television show 'Mad Men'. For those of you who may not be familiar with it, Mad Men is set in a New York advertising agency in the 1960s and early 70s, and centres on the life of the enigmatic ad man, Don Draper.

At a key point in the story arc, the agency is sacked by its largest client (and chief source of income), a cigarette company. As the agency teeters on the brink of financial ruin, Don Draper unilaterally decides to throw the dice in a bid to save the firm. Draper places an "advertisement" in the New York Times – an open letter explaining why the agency would no longer be taking on tobacco companies as clients.

Please bear with me for a moment while I reprint the text of a letter from a fictional TV show. Rest assured, I am heading somewhere:

"Recently my advertising agency ended a long relationship with Lucky Strike cigarettes and I'm relieved.

For over 25 years we devoted ourselves to peddling a product for which good work is irrelevant because people can't stop themselves from buying it. A product that never improves, that causes illness, and makes people unhappy. But there was money in it. A lot of money. In fact, our entire business depended on it. We knew it wasn't good for us but we couldn't stop.

And then, when Lucky Strike moved their business elsewhere, I realized, here was my chance to be someone who could sleep at night, because I know what I'm selling doesn't kill my customers.

So, as of today, Sterling Cooper Draper Pryce will no longer take tobacco accounts. We know it's going to be hard. If you're interested in cigarette work, here's a list of agencies that do it well: BBDO, Leo Burnett, McCann Erickson, Cutler Gleason & Chaough, and Benton & Bowles.

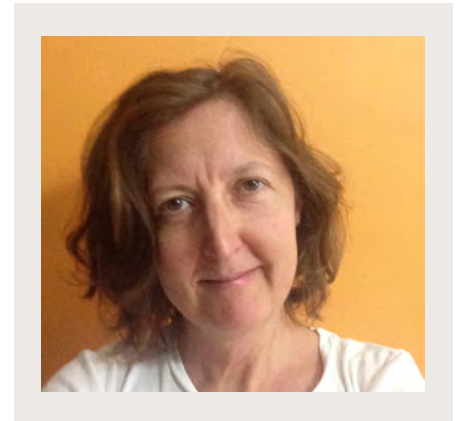
As for us, we welcome all other business because we're certain that our best work is still ahead of us."

"The letter" is a risky manoeuvre and a piece of sublime moral expedience. It's also potentially an act of professional suicide for Draper and further entrenches the financially precarious position of the agency at a time when tobacco companies constituted the bread and butter income of many Madison Avenue advertising firms.

So, why this opener?

As you all know, AMT is celebrating its 50th anniversary this year. Reaching such a significant milestone is obviously conducive to reflecting on where AMT has been and also planning for what is ahead. This inevitably involves grappling with what AMT does at the core of its business. And although AMT obviously does not sell cigarettes on behalf of tobacco companies, we need a clearly defined "product" or purpose and a client base (members) to be a viable organisation.

What is less well known than the Association's 50th milestone is that I reached my own professional milestone a few months ago – ten years as secretary of AMT. Combine that with the fact that I also recently celebrated my 50th birthday and you have a recipe for self-reflection on an epic scale.



I feel like I am edging perilously close to my own personal "tobacco letter" moment.

When I first joined AMT 20 years ago, the Association was known as AMT NSW and, from memory, had a membership base of just under 1000. Back then people joined AMT seeking to be part of a community, to feel like they belonged to something bigger than themselves and to identify themselves in the marketplace as qualified practitioners. Massage therapy was only recognised by a handful of very small health funds - none of the major funds or other third party payment agencies were on board subsidising the cost of treatments.

AMT members were incredibly loyal animals, and immensely proud and supportive of the professional advocacy role that AMT played. About 20% of the membership attended the annual conference year in, year out, reconnecting with old friends and making new ones. AMT felt like a professional home. I volunteered my time pretty much from the minute I became a member and started officially editing the AMT journal in 1999, which allowed me free rein to publish edgy little pieces of personal whimsy alongside the more weighty and substantial contributions from other AMT members.

Pretty much every time I wrote something for the journal, someone complained. It kept me amused and made for some lively Letters to the Editor.

In 2006, when I accidentally became secretary of the Association, AMT was teetering on the brink of collapse. We had become national in 2004, dropping the NSW from our name. This was an immensely positive step, however, a crisis in the form of a death, ineffective management and poor staffing choices had the Association haemorrhaging members. We were rapidly losing our relevance and needed to make changes in a hurry. At our lowest point, the membership slipped below 1000 again. AMT was running an operating deficit of \$1000 a week when I was “volunteered” into my official position.

Within a few months, I also needed to take over the role of AMT Treasurer, a development that my banker brother found hilarious and had me experiencing a slew of sleepless nights. I was pretty confident we could stem the open wound and resurrect AMT to its former glory but I was grappling with a bad case of imposter syndrome – with no management or financial credentials, how could I even presume to think I could competently take on those positions? It was a ludicrous proposition (I am not kidding when I say I accidentally took them on. Like most of my “career” trajectory, this leap was governed by serendipity. I just happened to be in the wrong place at the wrong time when there was a job that needed doing.)

AMT was fortunate to have a large core of members who had enough faith and loyalty to stick by us in our hour of need. Many of those members are still with AMT, having provided the wind in our sails as we took stock, fixed our internal problems, reclaimed our relevance and surged forward as an industry leader again. I think it’s fitting to pause at this moment and salute those people. Not only are they the bedrock of AMT but they’re also the bedrock of a profession that has grown astronomically over the past decade.

Therapists who have entered the sector in more recent years can thank these “elders” for the central role they had in building the profile massage therapy currently enjoys in the minds of a massage-loving public.

In my first official secretary’s report, published in the December 2006 AMT journal, AMT had just celebrated its 40th anniversary and held a research-themed conference. This is what I said about the focus of the conference at the time:

“Feedback from the conference revealed a small degree of disgruntlement with the heavy research focus and complaints that there was not enough hands-on content. I’d like to respond to these comments with a simple plea: consider that there is more to excelling in our field than just hand skills ... Having an understanding of how we achieve the clinical effects we are aiming for can only enhance the quality of our work and the quality of our communications with our clients. It will also ultimately help to build a bridge between the massage therapy profession and the established medical fraternity.”

It’s worth back tracking a lot further at this point. On the occasion of AMT’s inaugural conference in 1990, AMT received a congratulatory letter from the then Prime Minister, Bob Hawke. This is what Bob had to say:

“I am pleased to have this opportunity to congratulate the Association of Massage Therapists for its initiative in organising its inaugural conference.

We all, quite understandably, focus a lot of our attention on our economic wellbeing, but it should also be the case that we pay close attention to what we call our “health stocks”. Good health is an individual and national asset of considerable value about which every Australian deserves to be better informed. In particular, I believe that more knowledge on preventative health care would allow us to have a more direct and positive impact on our own health status.

A positive approach to preventative health will ensure that we don’t become over-reliant on drugs and invasive therapies.

With the benefit of a more personal responsibility for our own wellbeing, we can help to strike a correct balance between curative and preventative treatments.

It is also important, however, that the efficacy of alternative health therapies, which can assist individuals to maintain good health and avoid health-damaging behaviour, should be well established. One way of doing this is for people who are directly involved in this area, both consumers and practitioners, to be able to evaluate and openly discuss the options and procedures being proposed to advance our health.

It is in forums such as this Inaugural Conference that this process can proceed and I wish all participants a fruitful weekend.”

It turns out that Bob’s words were not only wise but also remarkably prescient. Sixteen years after Bob penned those sentiments and six years after we held our first exclusively research-themed conference, we were called to account by Australia’s Chief Medical Officer and asked to provide evidence to the National Health and Medical Research Council on the safety and efficacy of massage therapy. We made submissions and presentations. We argued a solid case based on strong foundations and, as a result of the process, we now have an acclaimed classified massage therapy research database which is downloaded from the AMT website around 180 times per month. The only other major AMT document that is more consistently downloaded is the AMT Code of Practice, which gets downloaded over 2500 times a month. Pause to think about that for a moment! That’s an awful lot of exposure.

AMT is now a large and thriving association with 2800 members, five full and part time staff and three contractors (and yes, we pay our contractors’ super as per the legal requirements in case you were wondering!). We’ve made major submissions to various government agencies; reviewed national competency standards for massage therapy; had David and Goliath encounters with private health insurers; developed and released a Code of Practice; built a comprehensive research database from

scratch; kept our members informed of developments by staying ahead of the pack; made current research available via newsletters and social media; held 26 conferences and innumerable small, local events; and all the while tried to honour and foster that sense of professional community and belonging that AMT was originally founded on.

So, given AMT's astronomical growth and major achievements over the last decade, it may seem a bit perverse that I find myself currently riddled with melancholy and self-doubt over the part I have played in shaping the Association's recent trajectory. As I write this, I am nursing a heavy sense of loss and imposter syndrome, as if my management fakery has finely caught up with me. We achieved financial stability and spectacular membership growth over the past decade, and ticked off some major accomplishments, but have these been at the expense of that old-fashioned and, frankly, reassuring sense of community and camaraderie?

Has AMT somehow mindlessly transitioned from analogue to digital - gaining clarity, crispness and definition but losing some warmth along the way? Has our core business changed without notice or without us fully noticing? Is it time for AMT to redefine its relationship with the members it strives so hard to serve?

One of the defining moments for AMT in recent years was the transition to the Private Health Insurance Accreditation Rules in July 2009. This was the precise moment that, under legislation, remedial massage therapists had no choice but to become members of an association if they wanted to continue to provide rebatable services to privately insured clients with ancillary cover. It was also the first time in AMT's long history that we started to have members joining AMT for the sole reason of gaining provider status with health funds. In other words, AMT was suddenly in the position of providing what was effectively a subscription service to some of its members rather than the traditional suite of membership services - community, advocacy, information, support, education - the association had developed and refined over four decades.

This was a significant shift in the core business of AMT. Effectively, we began servicing two different classes of members from that time: those who were still accessing and interacting with the full suite of membership services that AMT had always offered (including being health fund providers) and those who were basically only interested in "subscribing" to health funds.

Is there something we can't stop ourselves from buying, which never improves and which makes us unhappy? What is our industry's big tobacco?

Perhaps surprisingly, it is the latter class of members that has turned out to be the hardest for AMT to look after because, although their expectations are lower, they're the most likely to be dissatisfied with the product AMT is providing them. They're only interested in the tobacco - the product that not only never improves but also actually erodes over time and makes us increasingly unhappy (think about the systematic erosion of benefits paid out under health insurance against the rising costs for those taking out insurance). Ironically, it's also the end product that AMT has the least control or influence over.

From where I sit, these "subscribers" are missing out on the best that AMT has to offer and, I'd like to hope, our best work yet to come. However, the mere fact we have subscribers in our membership ranks at all has me fundamentally questioning my value to AMT - I am not paid to sell tobacco; I'm paid to grow and lead a professional community under the direction of the AMT Board. And it's hard to express how fundamentally disheartening it is to invest so much in trying to nurture a profession only to find you may have accidentally raised an entirely different kind of beast altogether (*what rough beast, its hour come round at last, slouches towards Bethlehem* - Yeats).

I imagine this feeling of doubt and failure is akin to how the classical composer, Aram Khachaturian, felt about his majestic ballet suites *Spartacus* and *Gayane* being utterly overshadowed by

the enduring fame and popularity of the throwaway 'Sabre Dance'. Khachaturian himself likened the disappointment to investing countless hours in sewing a lavishly detailed, sumptuous coat and having someone come up and admire a single, shiny button. (If you now find yourself humming the gorgeous *Adagio* from *Spartacus*, you're definitely one of my tribe.)

Being health fund administrators has never been at the core of AMT's business. We were never just peddling a product for which good work was largely irrelevant. It's just a single shiny button in a lavishly detailed, sumptuous coat. It turns out that being a health fund provider isn't even a particularly good proxy for being a health professional. As time goes by, it seems the gap between the two may even be widening. That's a very sad thing for me to contemplate in reflecting on the last ten years. At the moment, it feels like a catastrophic personal and professional failure.

For those of you who rate the value of AMT solely by its capacity to administer health fund requirements efficiently, I invite you to consider trading your AMT subscription for something much more satisfying and valuable. If you pull back the curtain, you'll see there's a whole community out there waiting to support and welcome you. You'll realise that AMT Head Office staff, AMT management and fellow members were always there waiting for you to genuinely join rather than just subscribe.

We've always been here, building a profession. We'd really like you to help us build it.

I obviously can't say for certain whether we're all hurtling towards our tobacco moment in terms of redefining our relationship with the private health insurance industry but it looks like I just wrote my tobacco letter. I'll sleep well tonight.

■am



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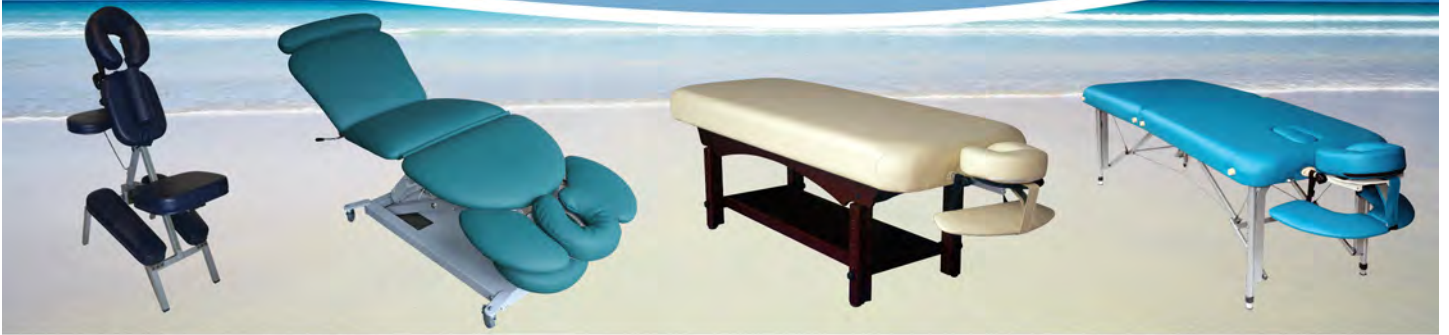


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Scar Tissue, the most overlooked issue in Healthcare

by Marjorie Brook

What do all of the following have in common?

- Caesarean "C" section
- Breast reduction
- Breast augmentation
- Appendectomy
- Laparoscopy
- Arthroscopy

Well, that is easy right? They are all surgeries. But would it surprise you to know that 6 out of 10 women who walk into my office do not consider C-sections or breast work surgeries? Yes, you did read that correctly.

There is an alarm going off in my head. At first it was a small ding and as the years have gone by it has been getting louder and louder. These days it is going off like an air raid siren. When a new client comes to see me, I have them fill out a medical history intake form. It is very common for people to "forget" about past injuries, illness and, yes, even a minor surgery. It has always amazed me nonetheless, I mean, really, how does one forget they broke an arm or an ankle?

Here are some of the many conversations/comments that have resulted from the "please list all surgeries" section on the form:

"Surgery? No... not really. Well... I had a C-section but I do not consider that surgery."

"Why is that?"

"Well... it wasn't planned it was an emergency."

"No surgery... I just had my breasts done but that doesn't count."

"I did have my toe chopped off, but they sewed it back on and that was so long ago it doesn't matter."

"No... No surgeries... just had some work done on my mouth twice."

"Do you mean you had Oral surgery?"

"Yes"

"Well I did have my uterus taken out."

But they did that through my belly button- you can barely even see the scar... so no, no surgery."

During a session I will observe a scar and inquire as to its origin. The client inevitably says, *"What scar? Where? Oh right?... That's from when I wiped out on my motorcycle... yeah I ruptured my spleen and they had to do surgery" and this one on your leg? "Oh that? I was dragged by the bike on asphalt. Pretty narly, huh?!"*

I have been a licensed massage therapist for over 19 years and, in all that time, a recurring theme seems to have prevailed. The presence of scar tissue can have a lifelong physiological effect on the body — a fact that seems to have eluded traditional healthcare professionals. This realisation, combined with my clinical experience, education, teaching and research, has led to my developing the **STRAIT (Scar Tissue Release And Integrated Therapies) Method** to release restricted tissues and restore balance and freedom of movement.

During the course of my career I've treated many patients whose problems could be traced back to a scar they had forgotten they even had. Everyone has a scar - their bellybutton. While not every scar presents a problem, often they can. This is due to the fact the body is one large, three-dimensional piece of fascia that envelops us like an intricate spider web. Any kink, pull or restriction in one area affects the whole matrix.

Scar tissue and adhesions are the result of our body's natural healing process and it occurs both internally and externally. The process, if working correctly, is supposed to eliminate the scars and adhesions once the wound is healed.

In some cases, a person's body does not break down the scar tissue. In others, adhesions have built to help support the body due to poor posture, repetitive use or injury. The adhered tissue continues to spread which can trigger a cascading effect of compensations throughout the body.

The STRAIT Method is a series of fascial techniques that release and realign the restrictive tissue from the starting point (visible scar) to the end point (where the line of frozen fascia stops). This release system, which I have developed and now use with my clients, differs from traditional methods because it approaches the multi-faceted matrix of fascia three dimensionally.

What is scar tissue?

Scars are areas of fibrous tissue that have replaced normal skin, or other tissue, after injury. A scar results from the biologic process of wound repair (protective, useful barrier) in the skin and other tissues of the body. Scar tissue is never as functional as the original tissue it has replaced. With the exception of very minor lesions, every wound (both internal and external) results in some degree of scarring.

What are adhesions?

Adhesions are bands of scar tissue that anchor and support the wound. It binds all tissue it comes into contact with together. Adhesions may be thought of as internal scar tissue. Although adhesions can occur anywhere, the most common locations are within the stomach, pelvis and heart.

Importance of incorporating scar tissue release therapy into your repertoire of services

Scars and the multitude of issues that can be traced back to them are generally overlooked by health professionals.

This is simply because the extent of physiological effects scars can have on the body have never really been acknowledged. As massage therapists we know the slightest restriction in the elaborate matrix of fascia can have major repercussions from one end of the body to the other:

- A simple scar from a childhood accident to major surgery can have a lifelong effect both physically and mentally for your client;
- Scar tissue has the potential to spread in any direction, including internally, throughout the body;
- Scar tissue can restrict movement or function anywhere in the body from a joint to an organ.

Working scar tissue is extraordinarily simple to learn, easy to apply and yields powerful results that can prevent a lifetime of compensation, complications and pain.

Scar tissue therapy release success stories: specific client challenges & long term complications

I have used scar tissue release therapy with success for clients who range in age from children to seniors and who have experienced a broad range of problems. In many cases the results have been achieved within one to three sessions.

Below are the stories of four clients who have experienced dramatic results from scar tissue release therapy (client names have been changed to protect their identities):

Client Story 1: "Laura", Female, Age 40 Years - Knee complications from vein removal surgery.

Another client for general relaxation massage referred Laura to me. Prior to starting our first session she forewarned me (out of being embarrassed) that her leg was "scary" looking due to vein removal surgery she'd had several years prior. I've seen and helped many clients with scar tissue resulting from vein removal surgery but was stunned at hers. Starting about two inches above her knee all the way down to the middle of the foreleg was a scar every inch and a half – with skin puffing up in between.

It looked as though she had been bitten by a shark. In addition to the physical scarring, she experienced pain in her knee and down her leg (which made it difficult to keep up with her four boys). She was also very self-conscious; she had not worn shorts since the surgery. She was frustrated that she couldn't keep up with her mother's walking pace while out shopping. She was angry because her doctor told her nothing could be done it just healed that way. After just one scar treatment session, Laura experienced relief physically; by the end of three sessions the swelling was gone, the scars were reduced and Laura was thrilled. Laura's scars have faded by 85%. She now wears shorts and was able to actually go skiing with the boys for the first time in four years.

Client Story 2: "Debbie", Female, Age 35 - Hand issues due to childhood mishap.

Debbie came to me several years ago for help with what she thought was carpal tunnel syndrome. After observing a large scar on Debbie's wrist I inquired as to its origin. When she was nine years old she had put her hand through a window chasing her brother. After working on her hand for two sessions, scars from the glass cuts were reduced visibly by about 80%, she obtained range of motion back in her hand/wrist and the numbness was gone.

Client Story 3: "Bobby", Male, Age 13 - Leg pain due to deformity and surgeries.

Bobby's dad was a regular massage client and one day he inquired about my services for his ten-year-old son. Bobby, who is very active in sports, was born with a clubfoot and was experiencing a lot of pain in the Achilles tendon of his good leg. After three surgeries his foot was locked in an inverted position causing him to walk on the outside edge of the foot. He was also scheduled for a fourth in a series of seven surgeries. After a thorough evaluation it was clear that it was not the deformity of Bobby's club foot that was holding his foot in this position but the scar tissue and adhesions from the past surgeries which were wrapped around the ankle into the arch of the foot and up the back of the Achilles tendon.

Due to the inversion of the foot, Bobby was using his hip flexors to move his leg forward. After working on Bobby's good leg, I asked his parents if it would be all right if I worked on the other foot. Much to the parent's shock, after the first session of scar release therapy, Bobby's foot released about 90 degrees. Upon seeing her son stand with his foot almost flat on the ground, Bobby's Mom said half in shock and half in anger "why didn't the doctors tell us to work on it!"

Client Story 4: "Cathy", Female age 45 –

Cathy had surgery on the arch of her foot which according to the doctors led to reflex sympathetic dystrophy syndrome (RSDS). After a year of shots, as she refused the surgery to have the nerve regulator put in her spine, she not only still had nerve pain but had compensated herself into plantar fasciitis and hip issues. It took ten minutes (half of which was a slow, light approach and conversation to gain her trust so she would let me touch the area) of scar tissue release for all nerve pain to be gone. 30 minutes of integrated therapeutic stretching and her hip was reset and heel pain gone. 30 minutes of body mechanics training (how to simply stand up, walk etc) and Cathy was both dancing and crying (from joy/relief) at the same time. "...and they wanted to cut my back open! Where were you a year ago?!"

I never know what amazes me more: the body's ability to respond so quickly to the release of adhered tissues or the shock on the patient's face when their body is freed from its restrictions and pain. But the one thing I do know is that ignorance is not bliss. The time has come for the public to be made aware of the effects of scar tissue and adhesions.

It is my hope that with modern science starting to recognise the importance of fascia and the effects of scar tissue on the body that scar tissue release will be brought to the forefront of therapy. Therapists can make significant and long lasting changes in the health and well-being of their clients/patients by incorporating scar work into their treatments.

It is my experience that the release of scar tissue, followed by proper rehabilitation exercises, can play a major supportive and therapeutic role in helping anyone living with the physical, emotional and mental effects of scar tissue and adhesion restrictions. ■amt



Marjorie Brook
is a licensed
massage therapist,
author and
international
educator. Marjorie
has developed
a system for

alleviating the trauma caused by scar tissue. She has also developed a series of user friendly manuals on stretching, aimed at both therapists and clients.

For more information, please visit
Marjorie's website:

www.marjoriebrookseminars.com

The e-Journal ^{club}

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Member Profile: An Update on Mery Di Milia

by Anita Mack

In the June edition of *In Good Hands*, AMT profiled Mery Di Milia. Mery revealed to us how important working in hospital settings, specifically in the area of pre- and post-operative care, has been to her career. At the time of the June journal going to press, Mery hadn't given up on her dream of working in a hospital setting.

Recently, Mery was offered the opportunity to fulfil her dream. *In Good Hands* caught up with her to find out the details.

Where are you working?

I've signed an agreement with a postoperative and rehabilitation private hospital, the Eastern Suburbs Private Hospital.

How did you get the job?

I communicated to many people my wish to work in a medical setting.

Coincidentally, an acquaintance referred me to one of Eastern Suburbs Private Hospital's physiotherapists at the right moment [as] they were planning to look for a massage therapist. They appreciated my long-term experience and passion.

What does the job involve?

I've been appointed to supply massage therapy treatment to patients, mostly referred by physiotherapists and rehabilitation doctors, to support postoperative recovery and/or pain management, as well as to help release muscle stiffness and improve range of motion. In a nutshell, I guide patients in promoting their body's natural healing process.

Mery is keen to find like-minded members who have experience practising in a hospital/medical setting. If you are interested in talking further with Mery about this area of practice please contact her at merydimilia@gmail.com



Mery Di Milia



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Massage as a Health Priority

by Jenny Richardson

Did you know that “musculoskeletal conditions” (including arthritis) is one of nine National Health Priority Areas (Table 1) identified by the government (AIHW, n.d.a)? Most massage therapists have at some time bemoaned the perceived lack of interest in musculoskeletal pain throughout the medical and healthcare world – so it will possibly come as a surprise that the government ranks it among the most important conditions that need to be researched and managed for Australians. Given this dichotomy, it is interesting to understand how the figures actually stack up.

NATIONAL HEALTH PRIORITY AREAS

- Cancer control
- Cardiovascular health
- Injury prevention and control
- Mental health
- Diabetes mellitus
- Asthma
- Arthritis and musculoskeletal conditions
- Obesity
- Dementia

Table 1: NHPAs (AIHW, n.d.a)

During the 1990s, the Australian government developed the nine National Health Priority Areas (NHPAs) in response to the World Health Assembly’s 1977 vision of “achieving health for all” (WHO, 1998), and Australia’s need to set priorities around the increasing burden of chronic disease in an ageing population. (Dewar, 2000). Each of the identified priorities poses economic, financial and personal burdens on Australians and the government does not impose one particular marker of significance, but recognises that addressing all of these conditions is crucial in dealing with Australia’s current and future health challenges.

The NHPA summary classifies the most significant musculoskeletal conditions broadly as osteoarthritis, rheumatoid arthritis, juvenile arthritis, osteoporosis and back pain and problems.

While the literature tends to focus on arthritis, it is interesting that back pain has the largest prevalence – at 14% of the Australian adult population, with osteoarthritis at 8% and osteoporosis at 3%. Up to 80% of Australians will experience back pain at some point during their lives (AIHW, n.d.b).

It is important to look at comparative data involving the NHPAs. If mortality is a measure of importance, then diseases like cardiovascular disease and cancer stand out. However, other indicators are very different. International study, the Global Burden of Disease (GBD), shows that for Australia musculoskeletal disease is the **largest** contributor to the non-fatal burden of disease (morbidity) indicator at 23.65% of the total. It ranks **third** (13.63%) of total disease, behind only cancer and mental illness. (Institute for Health Metrics and Evaluation, 2013a).

The BEACH study shows that musculoskeletal problems are the **most commonly seen** specified “problem” by GPs across Australia (University of Sydney, 2015, p51, 57). The Australian Bureau of Statistics Disability Survey (2009) reported that musculoskeletal conditions were the **most common disabling** condition (Figures 1 and 2). Finally, despite the low mortality rate, the GBD data shows that between 1980 and 2010 the mortality rate due to musculoskeletal conditions almost doubled from 0.2% to 0.36% (Institute for Health Metrics and Evaluation, 2013b).

That’s a huge amount of pain that Australians are suffering from – and why the need for therapists who deal with musculoskeletal pain and injury is not going away any time soon.

From an economic perspective, current data from the AIHW shows that 28% of adults have a musculoskeletal condition (AIHW, n.d.a) and associated health care costs were **\$5.7 billion** in 2008-09 (AIHW, n.d.d) compared with \$4.6 billion for cancer (AIHW, n.d.e) and \$1.5 billion for diabetes mellitus (AIHW n.d.f).

Back pain and arthritis are the number one reason for loss of labour force participation due to chronic disease. One third of productivity loss, costing the Australian economy more than \$14 billion a year, is accounted for by these musculoskeletal conditions alone (Schofield et al, 2015). Clearly, despite its lower profile than fatal diseases, musculoskeletal disease has an extremely significant cost to Australian society both in prevalence and economic cost.

The data on prevalence, impact on disability and healthcare spending on musculoskeletal conditions leaves no doubt as to their significance and the reason for their inclusion in the NHPAs. In contrast, the figures for research funding listed by the National Health and Medical Research Council (NHMRC) suggest that musculoskeletal problems are given little attention with funding in 2014 for arthritis and osteoporosis of only \$24 million (NHMRC, n.d.a). Despite the greater prevalence of back pain, it was not ranked in the NHMRC reporting. In comparison, cancer received \$182 million (NHMRC, n.d.b), mental health \$78 million (NHMRC, n.d.c) and cardiovascular disease \$124.5 million (NHMRC, n.d.d).

Currently listed NHMRC publications show a similar picture. There are just three publications for musculoskeletal conditions (NHMRC, n.d.e), compared to 26 for cancer (NHMRC, n.d.f).

Anecdotally, public education for different types of cancers, for diabetes, for mental health and for heart disease are all much more widely recognised and understood than health campaigns involving musculoskeletal diseases. To support this theory, many bodies involved in health education do not even mention musculoskeletal conditions in their strategies (National Preventative Health Taskforce, 2009; AIHW, n.d.g.; Public Health Association Australia, n.d.; Australian National Preventative Health Agency, 2013).

Despite being a priority area, and a significant health burden, it seems that musculoskeletal conditions are given little public health focus or research support.

However, hiding behind all these figures is a vitally important factor that is not discussed in the commentary of any of the government statistical or financial reports. Musculoskeletal conditions are usually significant because they result in pain - back pain, joint pain, inflammation, stiffness - the symptoms that all massage therapists deal with every day. Pain often results in a reduction in mobility. The research is immensely clear that lack of movement is a huge contributor to chronic disease (Kohl et al, 2012). Movement and physical exercise decrease a person's risk for:

- cancer (Friedenreich, Neilson & Lynch, 2010),
- cardiovascular disease (Hulsegge, van der Schouw, Daviglus, Smith & Verschuren, 2015),
- depression,
- anxiety (Lindwall, Gerber, Jonsdottir, Borjesson & Ahlborg, 2014),
- diabetes (Ekelund, Griffin & Wareham, 2007) and
- dementia (Denkinger, Nikolaus, Denkinger & Lucas, 2012; Graff-Radford, 2011)

– all NHPAs in their own right.

Sufficient movement is important in the management of obesity and a contributor to other conditions. In other words, not acknowledging the importance of musculoskeletal conditions through research, treatment options and especially education raises the likelihood that people with back pain, arthritis or other musculoskeletal issues move less and therefore are more at risk of the other eight conditions listed as NHPAs. As a group of conditions causing a common symptom, musculoskeletal conditions have the potential to positively or negatively influence every other NHPA condition.

The statistics are clear that musculoskeletal conditions place a huge burden on Australia and Australians. It is also quite obvious that the focus placed on understanding or preventing musculoskeletal conditions is not commensurate with that direct burden – or with the role achieving this could play in managing many other health issues and diseases. As massage therapists, we know that for many people, early treatment and basic education about their bodies can make a big difference.

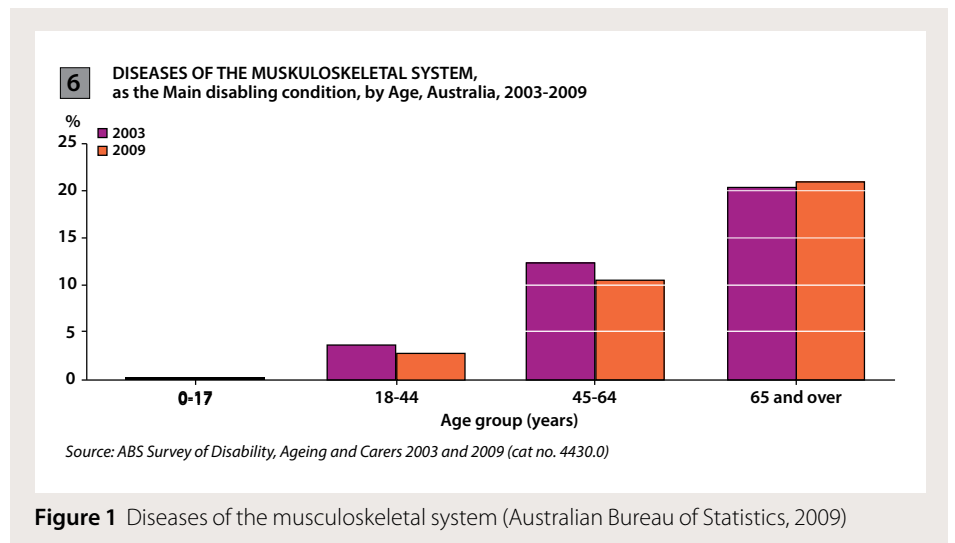


Figure 1 Diseases of the musculoskeletal system (Australian Bureau of Statistics, 2009)

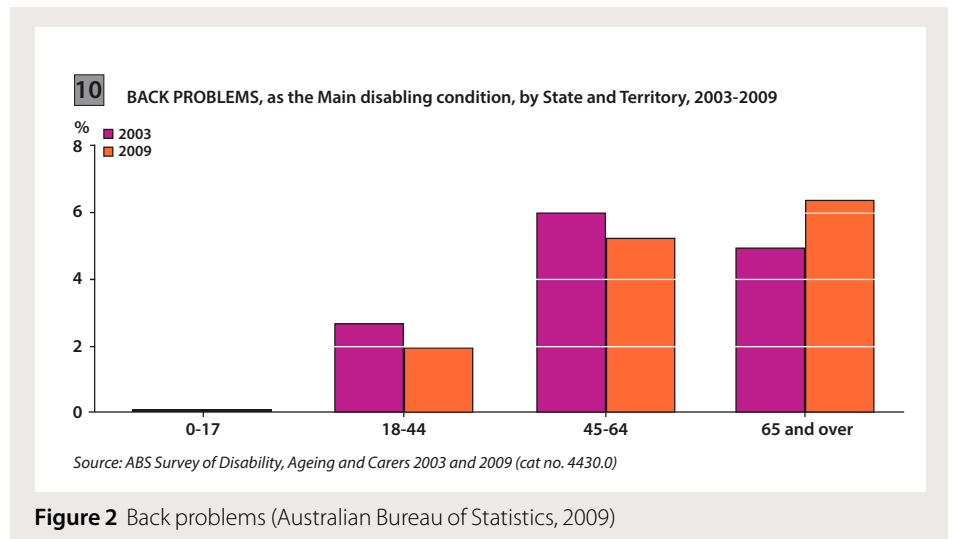


Figure 2 Back problems (Australian Bureau of Statistics, 2009)

And that educational programs could help prevent or minimise many musculoskeletal injuries. In turn this would almost certainly positively affect not only the individual, but our ability as a society to start to address our future health care crisis. The government has recognised the impact of not managing musculoskeletal conditions – it is important that funding and public awareness be raised to meet the glaring gap that currently exists.

We all know that most people only think about their health when something goes wrong, and then they rely on the medical system to fix them. Can we use our interactions with our clients to raise society's awareness of musculoskeletal conditions being addressed with the same significance as cancer or diabetes – not because they kill, but because they leave people more vulnerable to diseases that do kill (let alone the personal and economic

costs). Can you find ways to use the figures above to have dialogues with clients, other health care providers and your local community?

As therapists who know this field better than most of the medical world, can we help raise the profile of musculoskeletal conditions and encourage greater funding for research, prevention and early treatment? Can we use our own research to promote a message even bigger than the benefits of massage – but also the need for the response to match the priority of musculoskeletal conditions as shown by the figures as outlined above? Massage associations understand and work towards this – but the power comes if every massage therapist has conversations with many people until this area of health can no longer be brushed away as not important because it doesn't have a high mortality rate.

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Jenny is a Myotherapist who has been practising in Canberra for the last 10 years. After 11 years in the public service, Jenny did a number of things while searching for a career that was more meaningful and rewarding – and fell into massage by accident. She's very glad she did. She discovered she is passionate about understanding how the body works and using this to help clients with chronic pain.

A passion for learning means Jenny has trained with teachers such as Dr Antonio Stecco, David Weinstock, Dr Kathy Dooley, Katy Bowman, Thomas Myers, James Waslaski, Dr Paul Conneely and our very own Jeff Murray.

Jenny presented at the *Soft Tissue Therapy* conference in 2015, and for several years has acted as Teaching Assistant in Levels 1 and 2 Neurokinetic Therapy workshops in Australia and Level 3 overseas. Similarly, Jenny was recruited as Training Assistant with James Waslaski on his past two tours of Australia.

Hot Whiplash

by Til Luchau

Excerpt (with permission of Til Luchau) from:

Luchau, T. (2016). *Working with whiplash, Pt 1: Hot whiplash. In Advanced Myofascial Techniques, Volume 2: Neck, head, spine and ribs, (pp. 87-96). UK: Handspring Publishing.*

For hands-on practitioners, there is good and bad news about whiplash. The bad news first: whiplash injuries puzzle and befuddle manual therapists. How do we know this? Not only do we hear this regularly from practitioners in our Advanced Myofascial Techniques courses, but when we surveyed 100 experienced practitioners on the conditions they would most like to learn more about, whiplash was the most frequently mentioned issue.

More bad news: Whiplash is common. Although estimates vary, several sources cite about 1.8 million new cases of whiplash per year in the US alone (Croft, 2009). *Estimates of whiplash prevalence ranges from a low of 120,000 new cases annually (Healthgrades, 2015), to a high estimate of 1,800,000 new annual cases (as cited in several chiropractic sources, including Croft (2009)).*

Whiplash is also complicated—sufferers experience a wide array of physical, neurological and psychobiological symptoms, which may not appear until weeks or months after the original injury. Symptoms can persist for months or years and, for a significant number of sufferers, get worse over time. One study published in the European Spine Journal found that during the first and second years following a motor vehicle accident, the symptoms of over 20 percent of whiplash sufferers worsened (Olivegren et al, 1999).

A study published in the European Spine Journal found that during the period of time between the first and second years following a motor vehicle accident, over 20 percent had symptoms worsen (Olivegren et al, 1999).

Although there have been hundreds of studies on whiplash, and more are conducted each year, there is widespread disagreement on diagnosis, treatment, and even terminology, most interventions for whiplash injury are considered “medically unproven” (Spitzer et al, 1995) and the reasons for whiplash’s intractability are only beginning to be understood.

The term “whiplash” was first used to describe cervical injuries in 1928 by orthopedic surgeon Harold Crowe, and is subject to some controversy. Physical medicine texts variously prefer the terms “acceleration-deceleration injury”, “hyperflexion-hyperextension injury”, or “cervical strain-sprain injury”.

The psychobiological impact of whiplash has long been recognised, and significant numbers of whiplash sufferers experience anxiety, depression, or symptoms similar to post-traumatic stress (Munro, 1961). *In 1961, physician Robert Munro wrote: “In its pure form and when rightly diagnosed, the symptoms of ‘whiplash’ injury are those of cervical muscular spasm often complicated by neurosis.” (Munro, 1961, p573).* What is more, whiplash patients can be involved in legal or insurance difficulties, which may complicate and even hinder recovery (Grottkau, 2003). *Statistically, whiplash sufferers with workers’ compensation claims or lawsuits have significantly worse outcomes than those who do not. In fact, in studies designed to judge the efficacy of interventions,*

investigators often exclude such patients or report their results separately (Grottkau, 2003).

If this wasn’t enough bad news, manual practitioners observe that whiplash symptoms can worsen after bodywork — almost as if their hands-on work had opened a Pandora’s Box of pain, soreness and spasm.

Despite all of the above, there is good news about whiplash. In spite of its complexity, hands-on body therapy can help. Skilled practitioners are getting very good results by using soft tissue release together with neurologically based approaches. Gentle encouragement of motility, such as that provided by sensitive and competent manual therapy, in combination with moderate activity, is one of the most widely agreed-upon conventional treatments for whiplash. Immobilisation and cervical collars, once the most common treatment, are now rarely used, as they have been observed to produce more problems than they resolve (Lowe, 2003). *Use of immobilisation and cervical collars after whiplash injury have been observed to produce temporomandibular dysfunction, joint adhesions, muscle atrophy, and myofascial trigger points (Lowe, 2003).* An increasing understanding of the effects of trauma on the nervous system is expanding manual therapists’ ability to help clients whose symptoms were previously only aggravated by hands-on work.

The effects of whiplash

The effects of whiplash range from mild to severe, can change over time, and may include any or all of the following:

- Tissue damage at the sites of injury, from local overstretching or micro-tearing of fascia, muscle, or nerve tissues, typically in the neck, shoulders, and back.

- Harmonic forces in the body, bracing reactions, and fascial connections can cause tissue injury and inflammation in unexpected, non-local areas anywhere in the body, such as the ribcage, limbs, or pelvis.
- Instability or weakness from tissue damage, and from dissociation of the muscle spindle/Golgi postural reflex relationships in the injured muscles, resulting from overstretch (Cailliet, 1991, p88).
- Restricted motion as a result of either acute muscle spasticity/splinting reflexes, or from chronically adhered and shortened connective tissues, including the tissues around articulations.
- Pain, anywhere in the body. Causes may include direct tissue injury, neurologically referred pain, peripheral or central sensitization, or autonomically associated pain, e.g. post-traumatic headaches.
- Vertigo (dizziness) and balance impairment: cervical instability can result in splinting and fixing of the neck and head (especially by the suboccipital muscles), which reduces the adaptive capacity of the vestibular system (Figure 1). Post-traumatic vertigo is also postulated to be related to sympathetic nervous system imbalance (Cailliet, 1991, p112).

- Sympathetic (fight or flight) activation of the autonomic nervous system (ANS) from the trauma of the incident itself; from direct injury to sympathetic nerve fibers in the neck (Figure 2) (Cailliet, 1991, p112) or from ongoing sympathetic stimulation from vestibular and balance impairment. Symptoms can include sleeplessness, headaches, anxiety, or depression.

Some of the more severe effects of whiplash, such as prolonged anxiety or depression, obviously necessitate referral to a qualified specialist. In particular, clients with vertigo, nausea or ocular discomfort that worsen with head movement should be referred to a physician for evaluation before any manipulation is performed, as this can indicate vascular, ligament, or spinal cord issues. These examples aside, many of the effects of whiplash are well within our power to ameliorate.

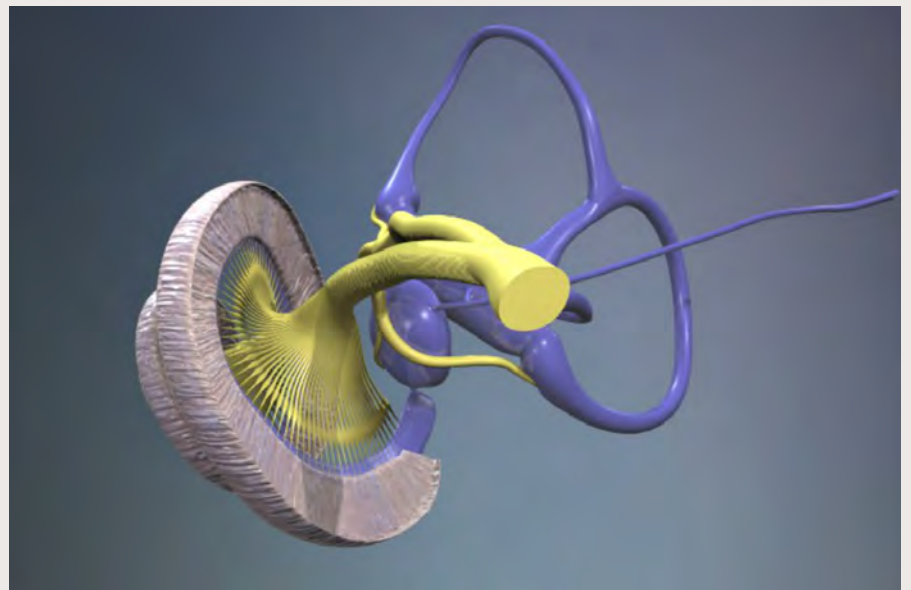


Figure 1 The structures of the inner ear. Dizziness and vertigo after whiplash can be exacerbated by loss of adaptability in the neck. This can limit the body's ability to position the head and adapt to stimulus from the balance mechanisms of the inner ear's semicircular canals (blue, right). Image source: Primal Pictures

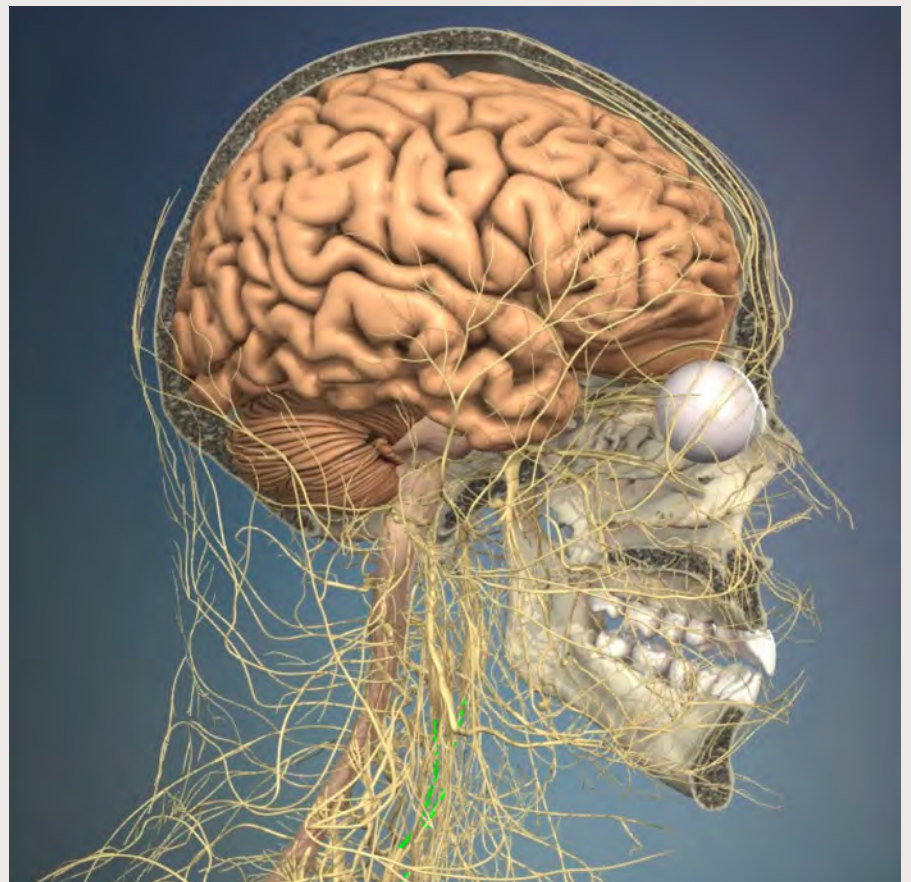


Figure 2 It can be helpful when working with hot whiplash to imagine working on a bare nervous system. Hyperextension injury to the cervical portion of the sympathetic trunks of prevertebral ganglia (green, anterior neck) is thought to contribute to vertigo and other autonomic symptoms associated with whiplash. Image source: Primal Pictures

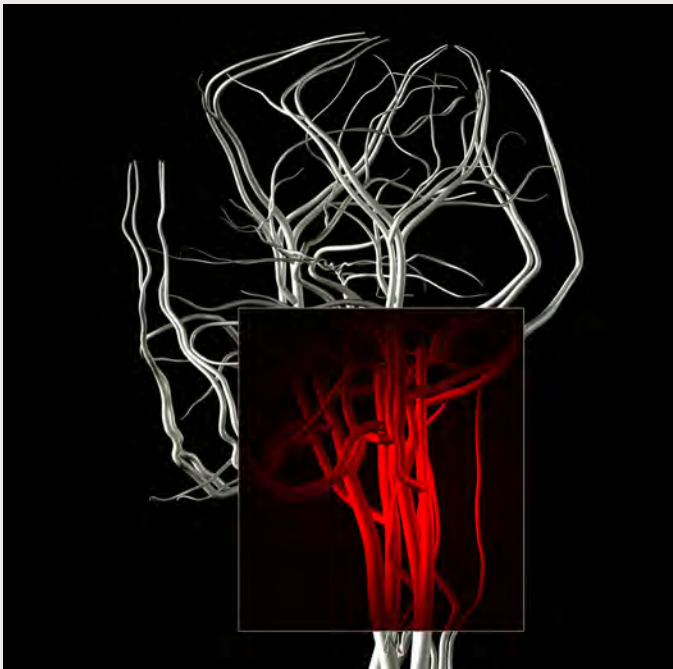


Figure 3



Figure 4

Metaphorically, whiplash can be thought of as having hot and cold qualities. Though a whiplash injury typically progresses from hot to cold over time, even an older whiplash can exhibit hot qualities, particularly if reinjured or worked too aggressively. Image source: Thinkstock

Hot and cold whiplash

Metaphorically, it can be helpful to think of whiplash as having either “hot” or “cold” qualities (Figures 3 and 4). A recent whiplash (less than 3–6 weeks) will tend to show more hot qualities, while cold whiplash is typically older (although older whiplash can also be hot, or can turn hot if reinjured or worked insensitively). Table 1 summarises differences between these two phases of the body’s response. Although you can see elements of both hot and cold whiplash in the same client, it is important to differentiate the way you work with each type of symptom, as hot and cold whiplash can respond very differently to the same interventions.

Hot whiplash is distinguished by being sensitive, fragile and reactive, as the fight-or-flight responses of the autonomic nervous system are still aroused. The head and neck are typically immobilised by muscular spasm or hypertonus since the postural reflexes recruit muscular tension to provide the inherent structural stability that has been compromised by the injury. Because of tissue damage, inflammation will be a factor in a recent or unresolved whiplash.

The tissue in injured areas will feel softer or puffy to your gentle palpation (though not always literally hot). Your client may respond to direct touch with guarding, uneasiness or pain, which further increases sympathetic activation.

In contrast, cold whiplash is typically older, less autonomically reactive, and restricted at the ligamentous or joint level (as opposed to being primarily immobilised by muscular spasm). Cold whiplash is characterised by stubborn, dense, hardened tissue deep around the joints. Hot whiplash often becomes cold (restricted) once initial tissue damage has begun to heal; cold whiplash can become hot (re-activated) if worked too quickly or aggressively. For this article the focus is on hot whiplash.

Working with hot whiplash

When working with hot whiplash, our primary goal is to calm our client’s autonomic activation before trying to work with any tissue restrictions. To get a sense of this, imagine that you’re working on an exposed, unprotected central nervous system. In a way, you are—after a traumatic event, our ability to filter out or tolerate intense experience decreases, leaving us feeling vulnerable and unshielded.

How would you touch a client who was nothing but a bare brain and spinal cord? Hopefully, very delicately and carefully—this is the ideal way to approach a recent or hot whiplash.

As sympathetic re-activation can happen by working either too long, too fast or too deeply, it is important to pace your work. Try to do shorter sessions with small, supportive, calming interventions. Watch to see how your client responds to your work, both within and between sessions. Gradually increase duration, scope or depth as your client is ready—you can always work a little more next time but it is hard to take back your work if you’ve done too much.

Work elsewhere in the body, before and after approaching any injured or painful areas. This broadens your client’s awareness beyond their places of injury and pain. Use the metaphor of a tangle of yarn or string: you wouldn’t go right to the tightest part of a tangle and start pulling (Figure 5). Instead, work at the periphery, gently and patiently loosening the overall pattern.

	HOT	COLD
Time Since Injury	Usually recent.	At least 3–6 weeks since injury.
Symptoms	Pain, instability, spasm; guarded or careful movement.	Pain, immobility, inflexibility; restricted or stiff movement.
Mobility Restriction	Muscular hyper-tonus (spasm).	Fascial hardening; ligamentous and articular restrictions.
Tissue Quality	Inflamed, puffy, slippery; sometimes soft, sometimes hyper-toned; touch is often painful.	Hard, dense, rigid, especially at deep levels. Can be insensitive to light touch.
Goals	Calm unresolved fight-or-flight activation; encourage subtle motility; broaden client's focus beyond injury.	Release tissue restrictions; restore lost gross mobility.
Strategy	Work primarily with nervous system; work within client's range of active motility; address myofascial restrictions only away from injured areas.	Work with myofascial restrictions and movement barriers to restore mobility, both locally and globally.
Metaphor	Imagine working on a bare nervous system: use delicate, slow, gentle touch.	Imagine melting frozen tissue with the warmth, pressure, and patience of your touch.

Table 1: Hot and cold whiplash compared.



Figure 5 Whether hot or cold, approach whiplash in the same way you might gradually untangle a stubborn knot in a rope or cord: avoid pulling at the tightest places; instead, tease the tangle apart by loosen the periphery, and gradually work your way in. Image source: Thinkstock

Encourage motility, instead of trying to mobilise. Use your client's gentle active motion (i.e. motility) to restore subtle movement to spastic areas, instead of applying passive manipulation, stretching, or direct release techniques (which can mobilise, but could re-aggravate). Breath, active exploration of range of motion and even micromovements will help restore disrupted reflexes and prevent tissue adhesion. Direct work with gross movement barriers or tissue restrictions come later, once muscular splinting has subsided and injured tissues are less inflamed.

There are many ways to work that accomplish these goals; much of what you probably already know about relaxing and calming can be extremely effective when applied with the above considerations in mind. A specific technique that incorporates these principles is the Breath Motility Technique.

Breath Motility Technique

Breath has the power to calm the nervous system, to catalyse lost motility and to bring proprioceptive awareness to the otherwise healthy regions that have been eclipsed by the painful areas.

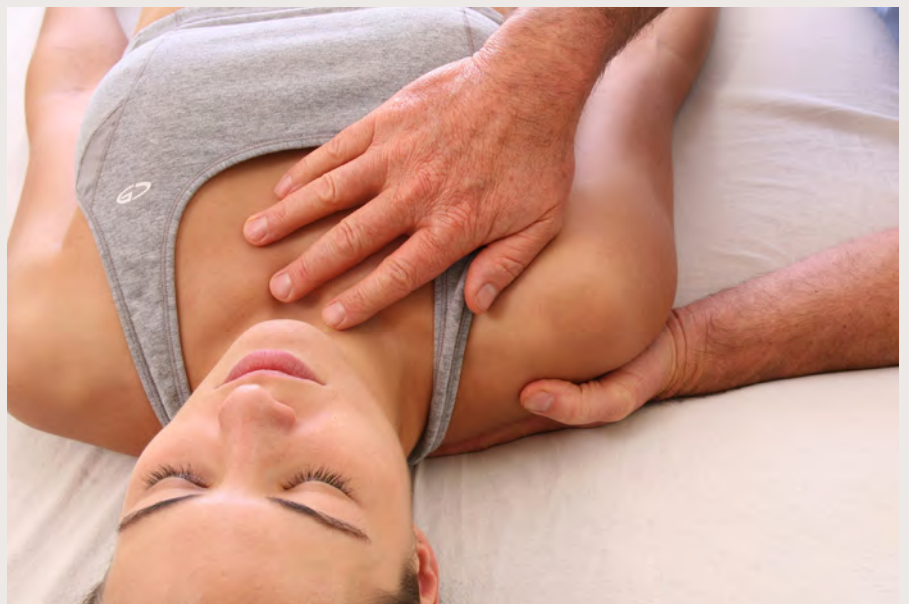
Begin by asking your client to take a normal breath and look to see where the thorax moves the most with inhalation. Using a soft, receptive touch, sandwich that place, front and back, between your hands, as in Figures 6 and 7.

Whether the breath starts in the belly, diaphragm or chest, ask your client to allow the space between your hands to fill gently with a normal breath. Note: We don't say, "push the breath between my hands," or even "breathe here." Those imperatives will evoke a more efforted response than the invitation to simply "allow" the breath to fill between your hands. Our aims are: calm the autonomic responses, induce gentle active movement in places that have lost it and increase proprioception. Try it in your own body—a forcibly inhaled breath doesn't accomplish those aims as well as a breath that you simply allow to come in on its own. You'll be able to palpate the difference in your client's breath too. Continue to coach and encourage your client until the breath is effortless and it is tangibly clear to each of you that the breath is moving in between your hands, both front and back.

When both you and your client feel the breath moving in an area, move to a new place nearby and repeat. Keep the pacing even and the breath normal. Deep or fast breathing, especially high in the chest, will increase sympathetic activity rather than calm it. Continue to get agreement from your client about his or her ability to sense the breath in each new area. Stay encouraging, interested and focused. If it is difficult for your client to feel the breath in a new place, or if you don't feel it with your hands, return to the last spot where it was clear and move out gradually from there. Repeat this pattern with the entire thorax and abdomen, on both left and right sides. Take at least 10 minutes for this technique, although allowing longer for it would be time well spent. This simple technique could be the bulk of an entire session, which would leave your client feeling more settled and relaxed.

Incidentally, if you notice that your client's movement is guarded or painful, you may want to perform this technique with your client seated rather than supine. Seated work in general can be very helpful if the act of lying down is painful or difficult.

These ideas should help you avoid the "Pandora's Box" effect of making whiplash pain worse with inappropriately deep or direct work.



Figures 6 and 7 The Breath Motility Technique is used when initiating work with hot whiplash, in order to soothe the nervous system, increase motility, and broaden the client's proprioceptive awareness beyond painful areas. See video of the Breath Motility Technique at www.a-t.tv/ad05

Key Points: Breath Motility Technique

Indications include:

- Signs of sympathetic (fight or flight) autonomic activation.
- Recent (less than 3–6 weeks) or "hot" whiplash.
- Immobility due to muscle spasm or splinting.
- Also useful whenever increased proprioception of breath is indicated.

Purpose

- Increase proprioception of breath.
- Calm autonomic nervous system.
- Encourage breath motility in all directions.
- (In pain or acute injury,) increase awareness of non-painful areas of the body.

Instructions

1. Observe client's breath, noting areas of diminished movement.
2. Gently "sandwich" this area between your hands.
3. Invite the client to allow breath into this area, using normal, un-efforted breathing.
4. Give verbal feedback and encouragement. Make sure both you and your client feel breath movement.
5. If difficult, begin in another area where breath motility is obvious to the client, then move into areas of less movement.
6. Take your time, working any areas of diminished motility in the thorax and abdomen (or elsewhere in the body).

■amt

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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 recognise members with HLT42015, HLT40302/07/12 Certificate IV in Massage Therapy, HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, 22248VIC Advanced Diploma of Myotherapy, 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 Health Science (Soft Tissue Therapy).
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	
GMHBA	Railway & Transport Health Fund Ltd	
health.com.au	Reserve Bank Health Society	
Health Care Insurance Limited	St. Luke's Health	
HIF WA	Teachers Federation Health	
Latrobe Health Services (Federation Health)	Teachers Union Health	
Mildura District Hospital Fund	Transport Health	
Navy Health Fund	Westfund	
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BUPA		BUPA recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy).. Existing providers remain eligible. Providers must also meet BUPA's \$2million professional indemnity insurance requirement to be eligible.
CBHS Health Fund Ltd		CBHS recognises all AMT practitioner levels.
The Doctor's Health Fund		Doctors' Fund recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, Advanced Diploma of Applied Science (Remedial Massage), Advanced Diploma of Health Science (Soft Tissue Therapy), 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 or 5-digit AMT membership number.
GU Health		GU Health recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 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 Health Science (Soft Tissue Therapy). Existing Senior Level One and Two providers remain eligible.
HBF		HBF recognises Senior Level One and Two members.
HCF		HCF recognises members with HLT52015, HLT50302/07 Diploma of Remedial Massage, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy), 22248VIC Advanced Diploma of 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 HLT52015, HLT50302/07 Diploma of Remedial Massage, HLT52115, HLT50102/07/12 Diploma of Traditional Chinese Medicine Remedial Massage, HLT52215, HLT50202/07/12 Diploma of Shiatsu and Oriental Therapies, 22248VIC Advanced Diploma of Myotherapy, 21920VIC or 21511VIC 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

September 2016		CEUs
3-5	Tensegrity Spine - FRBSB. Presented by Julie Hammond. Perth, WA. Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	105
3-4	Myofascial Cupping Technique™. Presented by David Sheehan. Gold Coast, QLD. Contact 03 9481 6723 or info@comphs.com.au www.comphs.com.au	70
4	Rocktape Introduction Course - Full Day. Presented by Rocktape. Sydney, NSW. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
4	Employment, Tax and Super: Know your Rights, Know your Responsibilities. Presented by Jonathan Regazzoli and Ross Ashcroft. Melbourne, VIC. Contact 02 9211 2441 or info@amt.org.au Download the registration form here	35
9-11	Oncology Massage Module One. Presented by Amy Tyler. Castle Hill, NSW. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
10-12	Tensegrity Spine - FRBSB. Presented by Julie Hammond. Sydney, NSW. Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	105
11	Gua Sha Day. Presented by Bruce Bentley. Melbourne, VIC. Contact 03 9576 1787. www.healthtraditions.com.au	35
17-19	Oncology Massage Module Two. Presented by Tania Shaw. Maroochydore, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
18	Wetsuits, 'S' bends, Bones and Pulses. Presented by John Bragg. Randwick, NSW. Contact 0410 434 092 or john@johnbragg.com.au www.johnbragg.com.au	35
23-24	AMT 50th Anniversary Conference. Luna Park. Sydney, NSW. Contact 02 9211 2441. info@amt.org.au	100
26-28	Oncology Massage Module One. Presented by Kate Butler. Daylesford, VIC Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
27	Illawarra Branch Meeting. Corrimal, NSW. Contact Linda White 0417 671 007	15
30	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
October 2016		CEUs
1-5	NurtureLife® Pregnancy Massage Practitioner. Presented by Catherine McInerney. Cairns, QLD. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	175
3-4	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Cairns, QLD. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	70
3-5	Practitioner of Pregnancy Massage. Presented by Catherine McInerney. Cairns, QLD. Contact 03 9571 6330 or info@pregnancymassageaustralia.com.au www.pregnancymassageaustralia.com.au	105
6-8	Oncology Massage Module One. Presented by Kate Butler. Melbourne, VIC. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
7-9	Oncology Massage Module One. Presented by Tania Shaw. Toowoomba, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
8-9	Shoulders and Arms - FRBSB. Presented by Julie Hammond. Perth, WA. Contact 0415 707 130 or info@anatomytrainsaustralia.com www.anatomytrainsaustralia.com	70
8-9	Advanced-Trainings.com Spine, Ribs and Lower Back. Presented by Til Luchau. Tweed Heads, NSW. Contact 02 9211 2441 or info@amt.org.au To register download and complete the form here	70
8-10	Oncology Massage Module One. Presented by Tania Shaw. Cairns, QLD. Contact Kylie Higgins 0408 077 123 www.oncologymassagetraining.com.au	105
9	Rocktape Introduction Course - Full Day. Presented by Rocktape. Melbourne, VIC. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
10	Advanced-Trainings.com Advanced Ribs. Presented by Til Luchau. Tweed Heads, NSW. Contact 02 9211 2441 or info@amt.org.au To register download and complete the form here	35
13-17	Short Course in Certified Infant Massage Instruction. Presented by Glenda Chapman. Brisbane, QLD. Contact 02 6262 4346 or support@iaim.org.au www.iaim.org.au Class runs 13, 14, 15 and 17 October (No Class runs on Sunday 16th)	140
14-16	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley. Brisbane, QLD. Contact 03 9576 1787. www.healthtraditions.com.au	105
14-18	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley. Brisbane, QLD. Contact 03 9576 1787. www.healthtraditions.com.au	175
15-16	Fascial Fitness Intro. Presented by Divo Muller. Sydney, NSW. Contact Budiman 0402 059 570 or terrarosa@gmail.com Register at www.terrarosa.com.au	70
15	Rocktape Introduction Course - Full Day. Presented by Rocktape. Brisbane, QLD. Contact 08 9379 3400 or education@rocktape.com.au rocktape.com.au	35
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