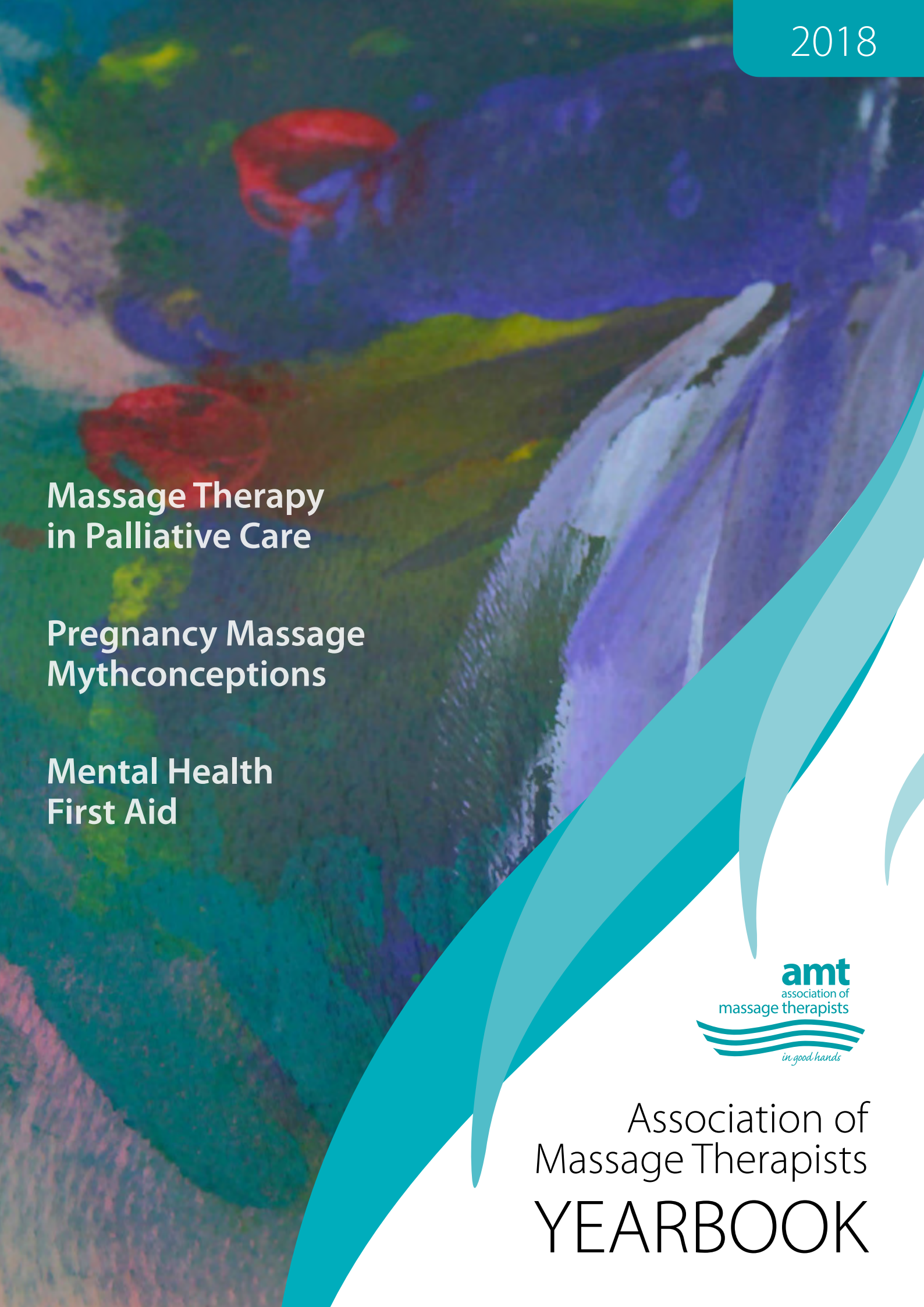

2018

Massage Therapy in Palliative Care

Pregnancy Massage Mythconceptions

Mental Health First Aid

amt
association of
massage therapists
in good hands

Association of Massage Therapists YEARBOOK

The front cover image is a collaboration between AMT member, Anna Zayas, her sister and her cousin.

Anna was inspired by the imaginary patterns that her hands made as she massaged so she decided to use body paint to depict the "art of massage".

Photographer: Felicity Townsend
Model: Alexi Petersen
Massage Therapist: Anna Zayas

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Editorial

By Michelle McKerron

It is my pleasure as current Chairperson of AMT to introduce this remarkable publication.

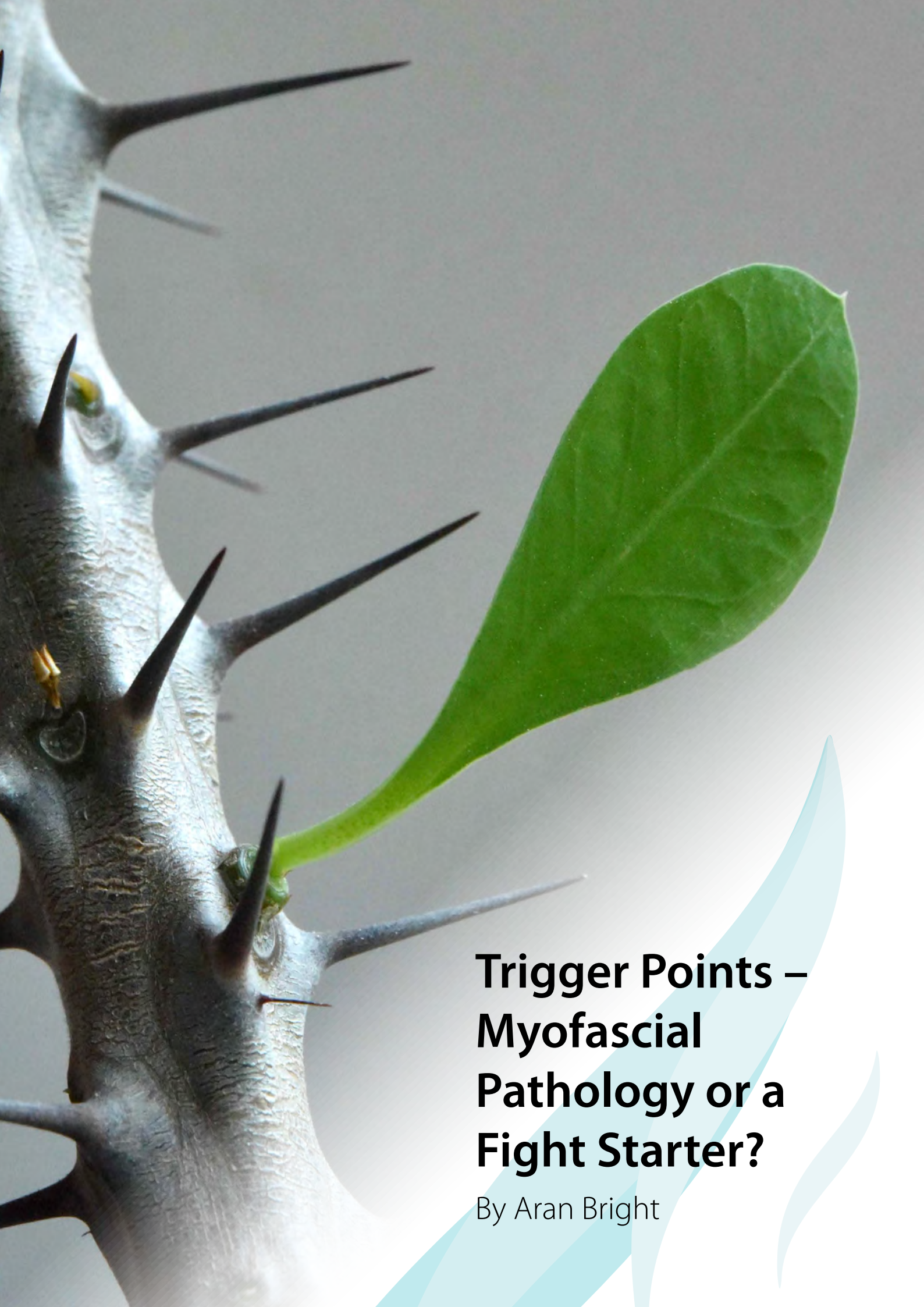
This is no ordinary yearbook. It is a collection of brilliant, thought-provoking messages we should all be able to relate to, not only as Massage Therapists but also as human beings.

I can't help but exclaim "what a line-up of contributors!": Aran Bright, Ronna Moore, Sharon Livingstone, Tim Clark, Vanessa Hough, Joe Muscolino, Rebecca Barnett and Sam McCracken are all names that are well regarded within the AMT family. We thank them for their contributions, and the discussion and debate that their ponderings will no doubt stimulate.

A lot has changed since I entered the massage therapy profession over 20 years ago. Much of what I learned as a student is now being rethought through the lens of two decades of research and insights from the front line of clinical practice. Some common bodywork techniques and approaches have come and gone, and others have become central to the work that massage therapists now perform. In many ways, I sense a welcome return to our roots as holistic practitioners, deeply invested in a model of person-centred care that encompasses the physical, social and existential needs of our clients in the face of the escalating stresses of modern life.

Bearing witness to this evolution of ideas and practice is a constant reminder to me to stay curious, humble and open. It can be challenging to let go of entrenched habits and beliefs but it's also liberating and exciting!

As you read (or reread) this publication, I hope the articles will inspire you to think through the way you practice and re-evaluate the way you speak with your clients about pain; encourage you to look deeper into your results (and maybe write a blog about them!); and reassure you that there are many others in the same position as you with whom you can connect, discuss, learn and grow your skill set.



Trigger Points – Myofascial Pathology or a Fight Starter?

By Aran Bright

Trigger points are a core principle in musculoskeletal pain. Since Travell and Simons instigated the concept it has been fundamental to any professional in musculoskeletal health. But trigger points have become more than a cause of myofascial pain – they lead to some of the most heated arguments amongst doctors, physios, massage therapists and scientists.

What Can We Agree On?

There isn't a huge amount the experts agree on about trigger points but here are some commonly agreed theories on what a trigger point is:

- A point in a muscle that is hypersensitive to touch
- A feeling of a nodule or band of muscular tightness
- A site of pain referral which can be aching, deep, burning and variable in sensation.

Many experts also agree that recognition of pain is important in identifying a trigger point that could be described as "active".

However, no one seems to agree that a referral pattern is predictable and consistent from one person to the next.

Dommerholt and de-las-Penas provide a more detailed description of what some experts agree on, in their paper *"International Consensus on Diagnostic Criteria and Clinical Considerations of Myofascial Trigger Points: A Delphi Study."*[1]

It does appear that trigger point locations tend to be consistent from one person to the next, which brings us to the main topic of debate …

What Is A Trigger Point (apart from something that starts epic social media arguments)?

There are two main camps:

Muscle lesion – this model is based around concepts such as motor end plate hyperactivity causing continued muscle spasm or micro tears in the muscle structure, leaking calcium ions and triggering local contracture. (This is most likely the birthplace of the most horrendous of myths around "calcium balls" that need "breaking up" to "release" the muscle.) This is where the concept of ischemia or poor blood flow to muscle comes from - essentially, if the muscles spasm, it chokes the local area of blood flow.[2]

Neuropathy – the main opponents to the muscle lesion model of trigger points contend that the muscle lesion model is, at best, a hypothesis that has never been conclusively proven. It appears that the best evidence around trigger points tends to be either sonographic or electromyographic, which is hardly conclusive as to what the physiology of a trigger point actually is. As far as this author can tell, no one has ever actually "seen" a trigger point, except through ultrasound imaging.

The opponents to the traditional model of trigger points contend that we should be considering other potential causes for trigger points that are more directly related to the nerves themselves, such as a neuritis (nerve inflammation) or peripheral nerve sensitisation. The best summary to better understand the opposition to the muscle lesion model is Quinter, Bove and Cohen's critical evaluation of the trigger point model.[3]

Why Does It Matter?

It is tempting to think, who cares? Most experts agree that trigger points are real, they hurt, and we can make them better with massage or whatever method we choose to treat them. There is some truth to this but, if we assume that there is some muscle lesion or dysfunctional motor end plate, then we should be choosing the most effective method in our toolbox to address it. Likewise, if the problem is more a product of the nervous system, then we should be choosing the method that is most suited to this physiology.

To demonstrate this point let's explore one of the hot treatment approaches right now.

Dry Needling

Dry needling is definitely not new – any acupuncturist reading this will quite possibly be throwing things and screaming "4000 YEARS!" Dry needling is a product of Travell and Simons who actually proposed using hypodermic injection of anaesthetic into the site of a trigger point. At some point, someone got either cheap or lazy and started using thinner filiform acupuncture needles, and dry needling was born.

The theory behind dry needling is that the needle penetrates the muscle lesion and destroys the motor end plate. This is typically performed with a perforating or thrusting technique of the needle that is often quite painful and invasive.

Now, if there truly is a muscle lesion, then does it automatically follow that deep dry needling should be superior to, say, a thumb?

Well, here is where things get tricky. On the surface, the evidence does seem to suggest that dry needling is better than other approaches. For example, a systematic review of trigger point dry needling by Gattie, Cleland and Snodgrass in the Journal of Orthopaedic and Sports Physical Therapy states:

"Very low-quality to moderate-quality evidence suggests that dry needling performed by physical therapists is more effective than no treatment, sham dry needling, and other treatments for reducing pain and improving pressure pain threshold in patients presenting with musculoskeletal pain in the immediate to 12-week follow-up period."[4]

But here is the conclusion:

"Although findings of this review provide very low-to-moderate quality evidence for the effectiveness of dry needling for reducing pain and improving PPT when compared to other physical therapy interventions during the immediate to 12-week follow-up period, ***the small effect sizes and the varied study populations and comparison interventions utilized do not support a strong recommendation of dry needling over other physical therapy interventions."***[5]

The article goes on to state that the general "superiority" of dry needling is just over 1 point on the visual analogue scale. As an example, if someone received massage for a trigger point, they might see a pain reduction from 8 to 5. With dry needling, they would expect to see 8 to 4. Considering the extra muscle perforation and discomfort involved in dry needling, not to mention the risks, is that really worth it?

Does dry needling demonstrate clinically meaningful effects that would be an indication that there is a muscle lesion of some sort? The most generous conclusion would be that this is yet to be demonstrated.

Anyone stating with absolute certainty that they know what a trigger point is should be viewed with some scepticism.

An Alternative Approach

To avoid getting too much deeper into a science wormhole, the Gattie et al systematic review did demonstrate that manual techniques were effective in reducing myofascial trigger point pain. The purpose of this article is to hopefully open your mind as to **why**. The best answer is that we don't know.

Anyone stating with absolute certainty that they know what a trigger point is should be viewed with some scepticism.

We should be considering alternative explanations, and hopefully ones that don't involve repetitive thrusting with sharp pointy things.

To provide you with some sense of what *might* be going on when you press on a trigger point and the pain is reduced, please consider two theoretical mechanisms that have undergone significantly more investigation than trigger point physiology and are much more broadly accepted by neuroscientists and scientists in general.

1. **Descending Inhibition –** this is the current mechanism that is proposed (and has been around for about as long as trigger points) for the effects of manual therapies such as massage. Basically, it is the "turning down" of nociceptive pathways at the level of the spinal cord.

   It goes a little something like this:

   Massage Therapist: *Presses firmly on tender trigger point*

   Nerve Ending: *stimulated*, *sends message to the spinal cord along sensory nerve*

   Sensory Nerve: *sends signal to brain*

   Brain: *interprets message as pain*

   Client: "Ouch."

   Brain to self: "Hmm, even though sensation is painful, it is occurring in a safe, therapeutic space."

   Brain to Sensory Nerve: "Thanks very much for that information but I am kinda busy soaking up this massage."

   Brain: *turns down the pathway to that sensory nerve at the spinal cord so it can still hear it but just in the background*

   Brain: *goes back to "soaking up" massage*

   Client: *experiences a "release" regardless of what actually happens in the muscle*

2. **Diffuse Noxious Inhibitory Control –** This is most likely what is going on when someone receives intense needling, extreme instrument assisted soft tissue manipulation or one of those torture sessions that some people confuse as massage.

   Client: *receives intense sensation to the sensory nerves* "Ouch!"

   Spinal cord: *fast tracks intense sensation to the brain*

   Brain: "WTF!" *runs straight to internal medicine cabinet and grabs whatever it can find (generally a mixture of endogenous opioids)*

   Brain: *gets drunk and ignores irritating sensory nerves*

   Client: In some cases, the client will experience a reduction in symptoms.

   Massage Therapist: *sees themselves as some kind of demi-god – kind of a mixture between Maui and Thor*

It would be appropriate at this point to apologise to any neuroscientists reading this, and encourage anyone who wants a better description of these two mechanisms to read Ossipov, Morimura and Porreca[6], or the ridiculously readable Lorimer Moseley[7].

Summary

Trigger points are real, no one questions this, but exactly *what* they are or their clinical significance is unclear.

It is important that we consider all the options on the table as it is likely to be *"a little from column A and little from column B".*

The mechanisms by which we treat trigger points should also be viewed with an open mind. Massage works, dry needling works, but the best methods are probably yet to be defined. Please remember: our best understandings of why massage and manual therapies reduce pain are functions of the nervous system, not fixing some part of a muscle.

We work on a human being. Let's not get stuck on one area of anatomy, be it the muscular or the nervous system. Rather, communicate with your client to understand how best to help them because no two people are going to want to be treated exactly the same.

About the author

Aran Bright started his career as a massage therapist in 2002 after graduating from the Australian College of Natural Medicine in Queensland. In 2006, Aran completed his Diploma of Remedial Massage and, in 2007, his Bachelor of Health Science in Musculoskeletal Therapy. Aran graduated from University of Queensland with a Graduate Certificate of Sports Coaching, completed a Certificate IV in Fitness and an Advanced Diploma of Myotherapy. He currently runs his own businesses, Bright Health Training and Brisbane Workplace Massage, with his wife, Sheree.

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Strengthening the presence of massage therapy in palliative care

By Ronna Moore

The practice of professional nursing ushered in by Florence Nightingale in the 1800s included training in massage skills. In many countries, including Australia, nursing textbooks continued to document applications for massage until the 1970s.[1]

Contemporary medical care has greatly reduced the capacity for nurses to provide massage to hospital patients and it is no longer generally recognised as a component of the nurse's skill set. Nevertheless, acknowledgement of the benefit of comfort-oriented massage for the seriously ill person has never entirely diminished, with its continued presence most evident in the area of palliative care. In the United Kingdom it is estimated that over 70 percent of hospices offer massage therapy.[2] In Australia, with smaller numbers and a lower profile, massage has been provided by massage therapists for decades in hospitals, hospices or in the community in pockets of activity across the country.

What is palliative care?

In simple terms, palliative care refers to the medical and other care provided to persons of any age with a life-threatening illness, having minimal or no prospect of a cure, until their death. It is a relatively recent branch of medicine, having emanated from the hospice movements of the United Kingdom, Canada and the United States in the latter half of the 20th century.[3]

The word palliative derives from the Latin word 'palliare' meaning 'to cloak'. It is believed that the word was introduced by the Canadian physician, Balfour Mount, seeking to capture the sense of 'wrapping' or 'enveloping' implicit in the model of care pioneered by Dame Cecily Saunders. Saunders was a British nurse, social worker and physician who began working with terminally ill cancer patients in the late 1940s. It was her response to the general neglect and unrelieved suffering of these patients that led to her establishment of St Christopher's Hospice in London in 1967. Mobilised by compassion but informed by rigorous science, this hospice enabled her to put into practice the holistic approach to caregiving she inspirationally envisaged.[3,4] Her simple philosophy was to address the multi-dimensional nature of the suffering of the dying person.

Contemporaneously, influence from other sources emerged to bolster what was seen as a paradigm shift in the approach to professional care provision. In 1969, Elisabeth Kübler-Ross published her book *On Death and Dying,* which facilitated a more open discussion about the needs of the dying.[5] Additionally, the biopsychosocial model of medical care came from the United States, conceptualised by physicians such as George Engel.

Engel's proposition was that a comprehensive understanding of all the factors encountered by a person facing a medical crisis would lead to a beneficial impact on care.[6] Not only was this approach more humane, it also ensured better clinical outcomes, a proposition which has consistently been borne out in studies demonstrating the benefits of palliative care.[7,8]

'Rather than disease-focused, person-focused'. [9]

These intersecting concepts culminated in the framework for providing support to terminally ill patients and their families, defining palliative care as it is generally understood today.

World Health Organisation Definition

Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[10]

Other salient features of palliative care in the expanded WHO definition are that it affirms life but regards dying as a normal natural process; it intends to neither hasten nor postpone death; and it offers a support system to help the person live in accordance with their needs and wishes, as actively and comfortably as possible, be it days or years, until death. A key characteristic of the palliative approach to care is that primary caregivers are included in the unit of care: it is expected that the information, guidance and support provided to the unwell person will also be available to assist the family or other people important to them to cope throughout the illness, dying and death, continuing into bereavement. Other core values of palliative care relate to equity of access, empowerment in decision-making and advocacy, and excellence and accountability on the part of the health professionals involved.[10]

This broadness of scope in goals of care means that no one person can be expected to deliver the complete suite of expertise required. Thus, care is typically devolved across a range of collaborating disciplines linked within multi or interdisciplinary teams. The creation, formally or informally, of such teams is a hallmark of palliative care. Seamless co-ordination between all team members, and patients and families, is considered fundamental both to the effective implementation of the palliative approach to care and to minimising the burden of suffering.[10]

Who's in the team?

General practitioners, nurses, specialist physicians, specialist nurses, nurse practitioners, family support workers, psychologists, psycho- oncologists, psychiatrists, bereavement counsellors, art therapists, music therapists, massage therapists, pastoral care workers, occupational therapists, physiotherapists, personal care assistants, aged care workers, volunteers, speech therapists, dietitians and any other practitioners identified by the patients or their families as meeting their needs, for example, naturopaths, doulas or nutritionists.

This model of care, and the values attaching to it, has been adopted as the means through which quality palliative care can be delivered to all Australians. The Standards and Codes of Practice documented by Palliative Care Australia (and most of the State and Territory Palliative Care bodies) reflect this commitment.[12]

While there may be universal agreement about the fundamental philosophy of palliative care, variations in interpretations, practices and applications are not uncommon. Terminology reflecting current usage is summarised in the "Definitions" box in the right column. A key area of difference in practice relates to the timing of palliative care involvement. The current model advanced in Australia proposes the initiation of a palliative approach to care at the time, or shortly thereafter, of a person receiving a diagnosis of either a malignant or non-malignant life-threatening condition. The involvement of health professionals from diagnosis forwards is based on a holistic accounting of a person's needs matched with a consistent aspiration to improve quality of life.

Definitions

Supportive care: all the elements of palliative care, sharing the same goals, but sometimes used where there is a prospect of a cure or where disease may be considered chronic, rather than progressive, and may include rehabilitative treatment. Survivorship, having holistic principles in common with palliative care, is currently being actively encouraged as the supportive care provided, particularly in oncology settings.

Palliative approach to care or generalist palliative care: the holistic elements of palliative care delivered by health professionals and carers not necessarily specialised or credentialed to provide palliative care.

Palliative treatment: (as compared to active or curative treatment) chemotherapy, radiotherapy, surgery or other treatment aimed at alleviating symptoms arising from disease progression.

Terminal care: in the palliative community this refers to the latter days or hours of life, alternatively referred to by the same community as:

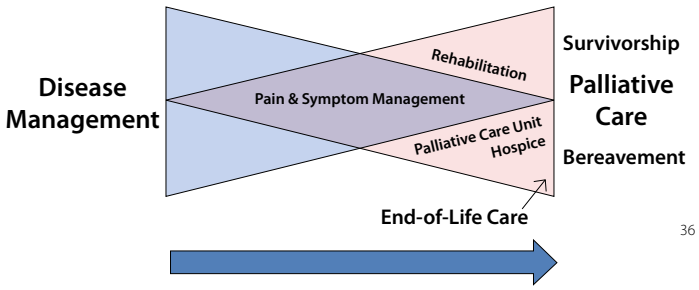
End-of-life care: in the general community this can refer to the latter months or years of life. Terminal and end-of-life care is part of palliative care but not synonymous with it.

Specialist palliative care: the meeting of multiple or complex needs by a team of specialist health professionals whose primary focus is palliative care. May be community based where persons receive care in their homes.

Hospice: in Australia this generally refers to a facility where people who are no longer receiving active treatment may be admitted for symptom management, respite or end of life care. 'Hospice care in the home' is its outreach version (similar to hospice as it is applied in the United States of America).

Aged care: may include palliative care but more generally describes care provided to the elderly.

This means that some palliative care services may be provided simultaneously with active, curative or life-prolonging treatment, until such treatment is no longer desirable or beneficial. This has implications, not only for which service will be involved, but also for how the service will be delivered: as a person's disease progresses, the focus of care swings more comprehensively towards addressing symptom management, quality- and end-of-life and bereavement needs. Advances in the oncology setting are resulting in some cancers being amenable to management as chronic diseases rather than terminal, leading to the concept of care known as 'survivorship'.[35] This change is reflected in the illustration below depicting the Bow-Tie Palliative Care Model of The 21st Century.[36] It is also evident that there is a role for massage therapy at all or any points along this trajectory, whatever the outcome.



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This holistic, integrated biomedical, psychosocial and spiritual approach to care provides the best chance for a person with a serious illness to live as well as and as long as possible: the 'best care possible' as described by Byock in his book of that title.[12] There is growing advocacy for more widespread application of this approach across the medical system as a whole. That such care is not reliably delivered in our complex, overextended and under-resourced health system is not a failure of the model itself.

The experience of living while dying

The provision of exemplary care is a universal goal of health care providers. However, by definition, palliative care has an expanded focus of care and this means that all health professionals are engaged in meeting the 'total pain' needs of clients and their families across the physical, psychological, social and spiritual dimensions of care'.[13]

With the above mind, it is incumbent upon therapists to have an appreciation of the totality of circumstances that the person in front of them is likely to be facing. There can be very few other circumstances in life that present as profound a challenge to one's equilibrium as receiving a diagnosis of a life-threatening illness, with or without a poor prognosis. The impact of such a life crisis is likely to flow across every aspect of a person's life, affecting all 'domains of personhood', physical, emotional, social, familial, psychological and spiritual.

Each one of these domains or dimensions is likely to have substantial and sometimes overwhelming challenges associated with it. There are those of a physical nature: adjustment to distressing changes or losses wrought upon the body by the disease itself; the day-by-day coping with variable and difficult symptoms; the effort to manage a health care schedule, medical treatments, and their sometimes debilitating side effects, singularly or in combination.[5] The psychological, emotional or existential consequences may be equally overwhelming: uncertainty, anxiety, coping with fear, finding the means to express feelings or maintaining a sense of self, a potentially diminished capacity to sustain relationships, to negotiate role or identity changes, or manage financial concerns. All of these may threaten a person's capacity to cope. In the face of such ruptures to 'normal' life, preserving hope or maintaining a sense of dignity or meaning might seem impossible.

A tsunami of emotional and behavioural responses may arise: shock, fear, frustration, sadness, anger, disbelief, resentment, regret, shame, grief, resignation, demoralisation, depression, helplessness, hopelessness, disillusionment and despair.[14] For family members also, similar challenges and responses are just as likely to be present, perhaps exacerbated by a high burden of care or anticipatory grief.

Most studies indicate a prevalence of emotional distress and mood disorders among cancer sufferers and the terminally ill, and their families, with emotional distress perceived by some in the field to warrant consideration as the 'sixth vital sign'.[15]

However, human crises also precipitate counter responses: courage, composure, gratitude, acceptance, grace, kindness, openness, humour, resilience, clarity, insight, resolution, joy, dignity, relief, hope, equanimity, a sense of wellbeing, meaning or transcendence.[14]

The experience of being seriously ill is distinctly individual for each person. It will be mediated by such things as the specific impacts of the disease itself, its timing, its trajectory, or perhaps the meaning of illness or dying in the person's religious or spiritual belief system. In combination with the person's demographic (age, gender, ethnicity, cultural and socio-economic background), individual coping styles, intellectual ability, level of education or prior experiences may all confer a confounding or moderating effect. The degree to which there are formal and informal supports in place, the presence of family or other close relationships, the tenor of concurrent life and a range of other personal variables may also impact upon this process in unique ways.[5]

Experiencing challenging circumstances or a broad spectrum of emotions is by no means confined to the palliative population. However, there is an amplifying quality that renders the palliative landscape a particularly intense one for its inhabitants. And this necessarily includes the health professionals, massage therapists among them, whose role is to support their clients at this perilous time.

How does massage therapy fit into this picture?

The goals for massage therapy in the palliative context are to provide physical comfort and relief from suffering.[16]

Touch delivered with the intention to calm, relieve or soothe is clearly a fundamental human experience. When skilful touch is delivered by a trained massage therapist, there is often an expectation that comfort will follow. Simple compassionate touch can often offer solace to the potentially traumatised or sensitised person - mind, body and spirit.

The significant beneficial impact on a range of specific symptom and quality of life issues that may flow from the comfort-oriented massage is perhaps less well articulated or appreciated. The range of benefits traverse physical, social, psychological and spiritual domains of care and, as a consequence, massage therapy sits readily within the palliative model of care.

Targeted issues for which massage therapy may routinely be considered for referral include:

- Anxiety, distress/stress [17, 27, 34]
- Care-giver burden[18]
- Constipation[20]
- Demoralisation/depression[19]
- Disrupted body image[19]
- Existential suffering [20, 21]
- Fatigue[23]
- Generalised discomfort[28]
- Grief and loss[19]
- Musculoskeletal impairment[24]
- Nausea[21, 22]
- Oedema/Lymphoedema[28]
- Pain[25, 26]
- Physical immobility[24]
- Shortness of breath[23]
- Sleeplessness[27]
- Social isolation[19]

This is a substantial list, supported by either strong or indicative evidence of effectiveness and efficacy. In circumstances where there may be a high symptom burden (and in what is often a highly medicalised environment), massage therapy demonstrably delivers a safe, effective and non-invasive means of ameliorating 'total pain' suffering. Massage therapists are therefore entitled to have considerable confidence in the value of their hands-on skills in contributing significantly to the wellbeing of terminally ill persons and their families.

Specialised training pathways

The vulnerable palliative client brings a cornucopia of special conditions, unique challenges and potential risks, with potentially serious implications for the massage therapist. Although almost all of the standard techniques within massage therapy practice can be beneficially incorporated, the capacity to modify and adapt techniques is central to the safety and effectiveness of massage therapy in this setting.[29] Resting upon a thorough understanding of the presenting and historical circumstances of each client at each session, the therapist must bring high-level technical skills and considerable flexibility to the application of them.

Along with familiarity with disease processes, common treatments and their consequences, the nature of these modifications is the foundation for specialist massage skills training in the palliative arena.

How can the massage treatment address either generalised or specific pain where there are widespread bone metastases or thrombi present?

How will massage be delivered to the person undergoing chemotherapy where platelets have plummeted?

How will dyspnoea, fatigue or nausea impact how massage is administered?

How might the level of opiate cover affect the delivery of massage?

How can techniques adapt to the different stages of motor neuron disease?

How does the therapist negotiate surgical or open wounds, ascites, cachexia, cellulitis, a rapid flare in a symptom, compromised immunity, haemodynamic instability, indwelling catheters, a wheelchair?

Even where the symptom or issue for treatment may appear to be unrelated to the disease state, modification for safety remains the guiding principle. Gayle MacDonald, the highly regarded North American massage therapist and teacher, has written extensively for therapists on the subject of massage therapy for the medically vulnerable. She has articulated a simple strategy from which both planning and implementation of modifications can be progressed: her pressure, site, position framework equips therapists with *'a general tool to anchor them in this highly specialised world'.* [29]

There is presently no formal post-graduate level training specifically for massage therapists in palliative care in Australia.

Self-awareness and self-knowledge are keys to the creation of therapeutic relationships in all settings but perhaps even more so in the palliative environment.

However, comprehensive education for qualified massage therapists providing massage for persons living with cancer is available through a number of private providers. Additionally, units of competency within the Health Training Package are available in some Registered Training Organisations, which introduce the student to the concepts of working with seriously ill people. International training is available from a number of course providers such as Gayle McDonald, Tracey Walton or Healwell in the USA, with some content accessible on-line.[30] Training for additional hands-on modalities such as manual lymphatic drainage or sub-specialities such as massage treatments for neurological diseases or paediatrics, may be invaluable.

However, it is imperative that palliative care massage training not be confined to practices focused on the musculoskeletal dimensions of care. Expanded knowledge, skills and competencies addressing the psychosocial and spiritual aspects of care are needed to match the expanded holistic focus of palliative care. That being said, it is not that massage therapists are expected to be counsellors, for example, but rather that they will be more effective when they have the knowledge and resources to skilfully respond to whatever arises. This includes being alert to the need to seek the involvement of other care team members when the limits of scope of practice are encountered.

Principles of palliative care, including ethical considerations, cultural awareness, family dynamics, grief, loss and bereavement, high level communication skills, familiarity with common assessment tools, and mental health first aid are some of the indicated areas of study or training. Individual units of study in these subject areas are available at various universities, including on-line, with both fee paying and open access options. There are also opportunities for education provided by The Australian Government Department of Health in collaboration with Flinders University and Palliative Care Australia, such as PEPA, the Palliative Care Curriculum for Undergraduates (PCC4U) and Dying-to-Learn on-line modules. Knowledge cross-fertilisation with other professional streams, such as nursing, also presents possible training pathways for massage therapists. The Palliative Care Knowledge Network (CareSearch) is an invaluable portal to education, clinical evidence, information, tools and resources. The Australian Centre for Grief and Bereavement is an additional source of training. There is a host of other less formally structured learning environments which may appeal to the specific interests of therapists.[11,37]

Formal post-graduate level study in palliative care intended for health professionals (nurses, physicians, social workers, psychologists) is available at a number of universities (for example, the University of Melbourne, La Trobe, Monash, Flinders, Charles Sturt and UTS). Prerequisites do apply but, if met, such courses are accessible to massage therapists and are a highly recommended means of strengthening professional competency and improving the profile of massage therapists in the palliative environment.

Self-awareness

All of the above indications for training are important but will be rendered ineffectual if the personal characteristics of the therapist are not compatible with engaging with seriously ill people. Palliative care can be hazardous for workers![31] A caring and empathetic nature is a necessary but insufficient attribute. Exposure to the risks of vicarious traumatisation or burnout is high, clearly injurious to the therapist and potentially compromising to the quality of care. As Strada states, "Learning self-assessment skills is central to self-care and the maintenance of well-being. It is a skill that needs to be fostered, developed and constantly nurtured." [31]

Self-awareness and self-knowledge are keys to the creation of therapeutic relationships in all settings but perhaps even more so in the palliative environment. Sometimes the therapeutic transactional loop between giver and recipient is uncomplicated; sometimes the space between becomes intimate, delicate and raw. The massage therapist may encounter challenging conversations, distressing circumstances and bear witness to suffering so they must have a clear awareness and appreciation of their own attitudes and responses to suffering, grief, loss, death and dying, and be comfortable in those of others. Being in possession of carefully cultivated personal and professional resources will confer the capacity to remain consistently open, receptive, empathetic, responsive, non-judgemental, compassionate, resilient and present.

This environment can be joyous and heart-warming. There is much that is life affirming and deeply rewarding in supporting the seriously ill person to live as well as possible. *As Mehta states,* "Clinical excellence and tender human caring can co-exist".[12]

What's ahead for the massage therapist in palliative care?

Encouragingly, a number of factors are contributing to a growing receptivity to the provision of massage therapy within the Australian palliative setting. This includes recent policy initiatives by Government, both federal and state, to address palliative and end-of-life care needs; a universal shift in focus in the healthcare sector towards a person-centred, collaborative approach to service delivery; and an energetic public discourse about care for the terminally ill, and death and dying in general.[32] This interest has been amplified by robust calls for change from high profile medical specialists and by a mounting critique of futile treatment and a plea for a more compassionate and responsive medical system.[33]

Sustained growth in accessibility to professional massage therapy throughout the wider community, a consolidating recognition of its benefits to consumers, and the increasing availability of specialised training for therapists have also had a positive impact.

This confluence of factors serves to further strengthen the integration of massage therapy within the established health and medical system. For the skilled and motivated massage therapist there is a world of possibility in this challenging but profoundly rewarding area of service.

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About the author

Ronna Moore is a remedial, oncology and palliative care massage therapist and lymphoedema practitioner. She is one of the team of seven massage therapists employed by Eastern Palliative Care, a community-based service. Ronna has also been in private practice for over 30 years. Having received a scholarship from Palliative Care Victoria and the Victorian Department of Health, Ronna completed a Graduate Certificate (Honours) in Palliative Care from the University of Melbourne in 2017. She is currently continuing her Masters study in Health Promotion Palliative Care at La Trobe University. Ronna sits on the Forum of the Palliative Care Research Network Victoria and has just completed a pilot study exploring the provision of massage therapy in the hospice setting in one of Melbourne's largest hospitals. She is also the palliative care consultant for Oncology Massage Training Australia. In addition, Ronna is a certified meditation teacher (MBSM) and a trained teacher of Mindful Self-Compassion.

This is a revised edition of an article that first appeared in the AAMT journal in 2017.

Ten pregnancy massage mythconceptions

By Sharon Livingstone

"Sometimes massage therapists, when confronted with the lack of evidence to support this idea, will respond, "Well, I'll avoid it just to be careful." One should always err on the side of caution when in doubt, but that does not mean we have to be governed by false fears. By erroneously thinking they need to avoid the feet and ankles "just in case", massage therapists perpetuate this misconception."[1]

Alice Sanvito, Massage Therapist, Massage St Louis

Did you know that 64% of people who receive massage and other CAM treatments prior to pregnancy continue to have treatment during pregnancy?[2]

When a pregnant person books in to have a massage, they actually want a massage. No pregnant person wants to be refused treatment based on misinformation, false information and unsubstantiated myths.

So Where Do The Myths Come From?

Pregnancy massage myths aren't only spread by massage therapists. They're prevalent in massage schools, beauty schools, online forums for pregnant people, and even trip up many GPs.

Leslie Stager, author of Nurturing Massage for Pregnancy[3], wrote an article about pregnancy massage misinformation that discusses where the myths originated. Stager discovered that during the 1900s, when midwives and home birthing were being replaced by a medical model of care, *"Pregnancy was identified as a dangerous and fragile condition with many forms of activity viewed as potential adversaries to a healthy outcome"*.[4]

Although there was a shift back to the home-style and less intimidating birthing methods during the 1970s and 80s, for some unknown reason massage therapists remained in the "pregnancy is a dangerous and fragile condition" camp. We were still being taught that the slightest touch would damage a pregnant person and/or their baby.

During the 1990s, evidence of the benefits of prenatal massage was growing. According to Stager:

"Research indicated that massage could help decrease stress and the production of catecholamines (stress-related hormones), improve hormonal functions, speed labor, reduce pain from contractions, and increase the frequency and ease with which a mother touched her new infant, benefits known to traditional birth attendants long ago."

The Myths of Pregnancy Massage

1. Massage causes miscarriage

This myth underlies most of the other pregnancy massage myths and ignores commonsense. Miscarriage has many causes but massage is **not** one of them.

Medline Plus lists causes and prevention of miscarriage on their website. Massage is not listed.[5]

In her article on Clearing Up Misconceptions About Pregnancy and Massage, Alice Sanvito from Massage St Louis wrote:

> "For most miscarriages, the cause is unknown, but some known causes are chromosomal defects, failure of the fertilized egg to implant properly, maternal age, or excessive use of drugs or alcohol. Moderate exercise, sex, and working outside of the home do not cause miscarriage. If normal activity is not sufficient to cause miscarriage, there is no reason to believe that a relaxing massage would in any way cause it, either."[6]

There is no evidence to suggest that massage causes miscarriage.

Miscarriage has its own set of myths. The "Further Reading" section at the bottom of this article includes some useful information on miscarriage.

One of the most common reasons I've heard from Massage Therapists for not treating pregnant people is a fear of litigation. If miscarriage occurs after a pregnant person receives massage, there appears to be a belief that the Massage Therapist will be sued. Stager failed to find any evidence of a successful lawsuit. Equally, I found no information on a massage therapist being sued (successfully or unsuccessfully) for causing a miscarriage.

2. Massage is contraindicated in the first trimester

This myth seems to arise out of the first myth and may be connected to the fact that miscarriage most commonly (in 80% of miscarriages) occurs within the first trimester.[7]

Most massage therapists have probably massaged a pregnant person in their first trimester without realising it because the client may not have known they were pregnant.

There is no research-based or clinical reason for not touching a pregnant person during the first trimester.

3. Don't massage during entire pregnancy

This myth is generally grown from fear and may derive from the outdated belief that pregnancy turns a pregnant person into something fragile, where even the slightest touch will cause unknown but horrific outcomes.

Unless a known contraindication is present, such as those listed under "Contraindications for massage during pregnancy" below, there is no evidence to support avoiding treatment.

4. Don't massage over the abdomen

If it's OK for the pregnant person (or their partner) to rub a pregnant abdomen, then why not a massage therapist? Bub may kick back if it doesn't like it (or if it does).

The history of pregnancy is happily littered with supportive partners providing a nice abdomen rub, without the impediment of knowing about all those massage myths.

> **Commonsense test:** Ask a pregnant person with kids how often their kids kick, hit, sit on or cuddle that pregnant belly.

There is no evidence to suggest that massage causes miscarriage.

5. Don't massage over the lumbar region

This myth is sometimes restricted to the first trimester, most likely due to the unproven link to miscarriage. Please refer to "massage does not cause miscarriage" above.

> **Commonsense test:** A pregnant person with low back pain will rub their own back with no fear of harming their baby, so why would a qualified Massage Therapist cause harm?

6. You must have specific pregnancy massage qualifications to treat pregnant people

Massage Therapists are trained to treat clients with a variety of presentations. They don't undertake specialist training before treating a client who has fibromyalgia or Crohn's Disease or Multiple Sclerosis or who is recovering from surgery. Massage Therapists can obviously undertake further study on treating pregnant people, particularly if they would like to specialise in this area, but it is not mandatory or a prerequisite for performing massage on a pregnant person.

7. You must have clearance from the treating medical practitioner before treating pregnant people

The GP, OB/GYN or other treating specialist may have reasons to advise their patient not to have massage and, in that scenario, Massage Therapists should defer to the treating doctor. However, unless there is a contraindication such as those listed overleaf, there's no requirement to get clearance from the treating medical practitioner. Any potential issues should come to light through a thorough pre-treatment intake.

When researchers have tried to use acupuncture on these points to induce labour in women past their due date, they have failed.

8. Massage of the feet and ankles causes miscarriage and/or pre-term labour

There is no evidence that massage of the feet and/or ankles causes any detrimental impact on the pregnant person.

Alice Sanvito's article discusses the reasons behind this myth, and suggests that the information comes from foot reflexologists and acupuncture practitioners. When researchers have tried to use acupuncture on these points to induce labour in women past their due date, they have failed.

A study undertaken by Neri et al[8] supports the assertion, as does a 2017 Cochrane review on reduction of Caesarean rates in post-date pregnancy.[9]

If an acupuncture needle can't find an alleged specific point to induce labour, then how can a Massage Therapist? If acupuncture can't induce labour post-date, then why would massage result in pre-term labour or miscarriage?

> **Commonsense test:** Are partners (and kids) of pregnant people who rub the pregnant person's tired feet causing harm? What about shoes and walking – do they induce labour?

9. You need to pay extra professional indemnity insurance to treat pregnant women

Any insurer that tries to extract extra money from a Massage Therapist for performing massage on a pregnant person needs to be dumped and/or given a stern talking to.

Massage is a low risk activity, that's why our insurance premiums are so low.

10. Don't treat with the pregnant person in the prone position

While pregnant people are told not to lie supine because it may compress the inferior vena cava and potentially harm the mother and starve the baby of oxygen, there is no evidence to support the myth that women can't be massaged while prone and supported by the use of bolsters, pillows, pregnancy cushions or a special treatment table, as long as the client is comfortable and remains comfortable.

Contraindications for Massage During Pregnancy

There are some instances where massage is contraindicated, including:

- Specific advice from treating medical professional.
- Placenta Previa (but not in all cases)
- Some high risk pregnancies (OB/GYN will advise):
  - » Preeclampsia
  - » High blood pressure/PIH (Pregnancy Induced Hypertension)
  - » Previous pre-term labour
  - » Recent bleeding
  - » Pre-term contractions
  - » Sudden severe headache.

Still Not Convinced?

Try this quick exercise. Go to PubMed and enter this search string:

massage + miscarriage

If you thought that was fun, try the search string:

massage + first trimester + adverse effects

Further reading/watching

Newborns of depressed mothers who received moderate versus light pressure massage during pregnancy
https://www.sciencedirect.com/science/article/pii/S0163638305000755?via%3Dihub

Pelvic Physical Therapist Sarah Haag's Pregnancy and Pain talk at the San Diego Pain Summit in February 2018
https://www.pain.education/2018

Dispelling Miscarriage Myths So Women Get the Help They Need
https://www.healthline.com/health-news/women-dispelling-miscarriage-myths-102413#1

Diagnosis and management of first trimester miscarriage
https://www.bmj.com/content/346/bmj.f3676

About the author

Sharon Livingstone is a massage therapist in Sydney, NSW. A love of sport drew her to the industry but discovering job satisfaction came from helping people live with less pain keeps her in it. Sharon is a writer, keen bushwalker and frustrated traveller who is also a coffee snob.

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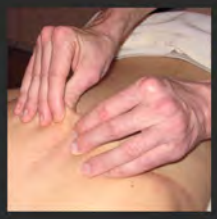

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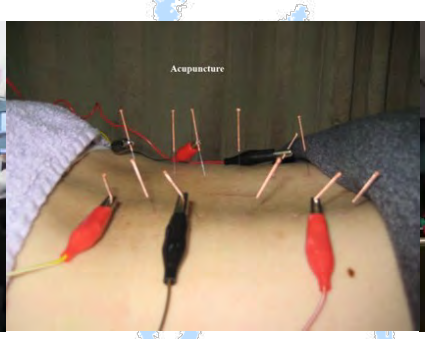

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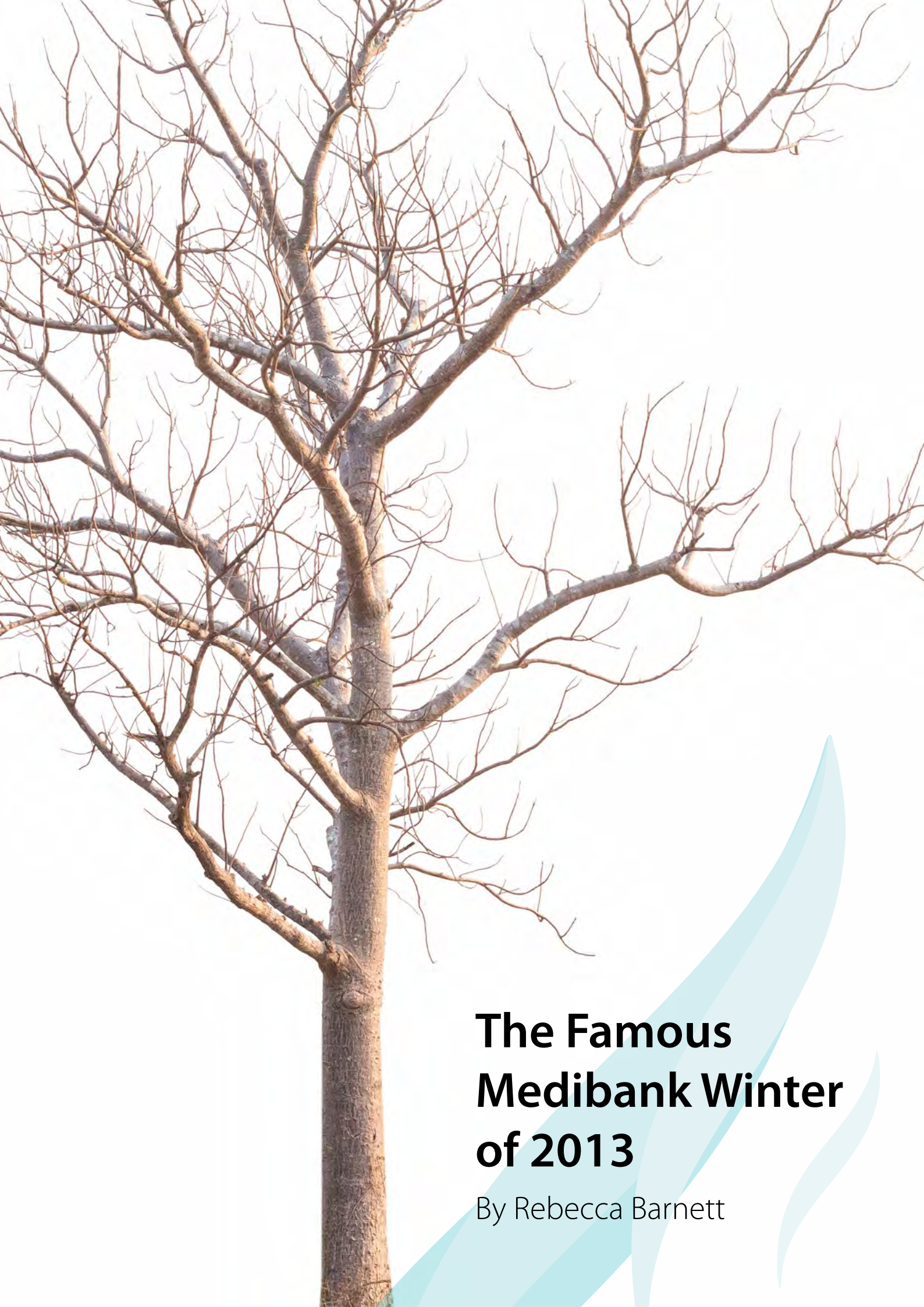


The Famous Medibank Winter of 2013

By Rebecca Barnett

Those of you who have been members of AMT since before the middle of 2013 will recall the dark days of the infamous Medibank provider number freeze. Our membership ranks have swelled by more than 50% since then so that means there are many AMT members, not to mention the general public, who may not know the colourful story of our David and Goliath battle to protect the integrity of our nationally recognised qualifications.

In mid 2013, Medibank announced its plan to revise its criteria for remedial massage therapy providers and to temporarily close its books to new provider numbers on 1 September 2013.

Medibank advised the associations of its intention to introduce minimum education requirements for provider status that were outside the standards of the national training package, including proposed qualification duration requirements for the Diploma of Remedial Massage.

It was a significant move for a number of reasons, not the least of which being that it was a reversal of a decade long trend towards adoption of the National Health Training Package for provider eligibility by all the private health insurance companies.

It didn't make any sense.

A Glimmer of Opportunity to Change Medibank's Mind

However, Medibank had not yet finalised its criteria so there was a window of opportunity to negotiate for changes that would actually address Medibank's concerns about ballooning provider numbers in its system.

Over numerous face-to-face meetings, including a forum organised by AMT with representatives from Medibank, Australian Natural Therapists Association (ANTA), Australian Traditional Medicine Society (ATMS), Australian Association of Massage Therapists (AAMT), Australian Skills Quality Authority (ASQA) and the then Community Services and Health Industry Skills Council, AMT tried to inform and educate Medibank about national competency standards, and explain why having a non-aligned education standard was not a good outcome for either the fund or the industry at large.

The measures Medibank was proposing to improve the quality of providers appeared to be pretty arbitrary and meaningless, and would clearly not address the issues the fund was concerned about.

With the September 1 deadline for the provider number freeze looming, Medibank was inundated with thousands of requests for new numbers, as therapists panicked about the blackout. Ironic?

September 1 arrived and AMT was plunged into a long, dark teatime of the soul. For over a year, we were unable to forward a single new provider or provider location to the fund while we negotiated the terms of their agreement. Imagine that! Twelve months in the Medibank wilderness.

But I am getting ahead of myself …

A United Front From Massage Associations?

Through September and October 2013, we waited nervously for the new Medibank provider agreement to arrive. On a Tuesday evening in November, I met with the CEOs of AAMT and ATMS to discuss a coordinated response to the impending Medibank changes. We agreed to move forward as a united front; a promising but ultimately fragile accord.

Medibank's New Agreement

The new Medibank agreement arrived exactly a week before Christmas 2013.

Merry Christmas massage industry!

All AMT's worst fears were confirmed. Medibank adopted a qualification duration requirement and other criteria we weren't sure how to meaningfully interpret.

We started asking questions to clearly and precisely establish what the terms of the agreement meant for AMT and the industry at large:

What does 12 months Diploma duration mean? Does it include holiday and semester breaks? Does the TAFE February to November academic year meet the duration requirement for example? *Medibank answer: We just want to be treated the same as HCF.*

Does it include time taken to complete the pre-requisite Certificate IV? *Medibank answer: The duration requirement relates to the Diploma course only.*

Does the course duration requirement preclude accepting qualifications via legitimate RPL? Medibank answer: Every effort should be made to establish the time it took the provider to achieve their Diploma.

What are "other associated therapeutics and techniques"? *Medibank answer: Instead of listing every technique in the addendum I went with this wording. I assume you would know them better than I would.*

What is the rationale for surface anatomy to be delivered on campus as opposed to, say, gross anatomy? *Medibank answer: Advice we received suggested it should be on campus.'*

Insert your own exasperated profanity here.

The Darkness Descends

Medibank had us over a barrel – no signed contract meant the freeze on provider numbers persisted. And no Medibank provider number effectively meant no HICAPS. AMT members were getting anxious. At stake, though, was the integrity of our competency standards: AMT could, at best, only identify three RTOs whose delivery may have met the Medibank provider requirements and, even then, we weren't completely certain. As far as we could ascertain, only one dog and his boy were going to be eligible for provider numbers.

Significantly, the two largest private providers of the HLT50307 Diploma of Remedial Massage did not meet the Medibank criteria **including, notably, Endeavour College of Natural Therapies which was frequently cited by Medibank as a compliant provider.** That was both confusing and worrying.

ANTA signed the new Medibank agreement before Christmas 2013 and eagerly shared the news with their members.

Don't Worry, We Still Have Our United Front of Massage Associations …

AMT went into the 2013 Christmas break anticipating some vigorous dialogue with ATMS and AAMT in the new year. As a united force, we still had substantial power to negotiate the terms of the agreement with Medibank. With our combined memberships, we had the potential to display some serious industry muscle, potentially a watershed.

Or Not

In the third week of January 2014, AMT was informed second hand that AAMT had signed the Medibank agreement. The AMT/AAMT/ATMS triumvirate was broken. AMT had only just engaged our law firm to represent us in the anticipated negotiations.

On February 13, AMT's lawyers sent a letter to Medibank requesting some small but significant changes to the agreement. Along with qualification duration requirements, one of the key problems with the agreement was the lack of grandfathering provisions. Once signed, technically AMT would have to cancel all existing providers in our system. Our lawyers advised AMT that this needed to be addressed. Their letter to Medibank stated:

> *"As you are aware, the HLT50307 Diploma of Remedial Massage (the Diploma) is offered in a range of different formats by a number of Registered Training Organisations (RTOs). These organisations are recognised by the Australian Skills Quality Authority as providers of quality-assured and nationally recognised training and qualifications.*
>
> *It is clear from publicly available information that most RTOs do not deliver the Diploma over the course of a standard academic year. This includes many NSW TAFEs. Further, inquiries made to those RTOs, whose published information does not make clear whether the delivery of the HLT50307 Diploma course satisfies the proposed requirements, has put our client in the position where it is unable to identify a single RTO that offers the HLT50307 Diploma course in a manner that satisfies the proposed requirements.*
>
> *The proposed amendment would have, in effect, retrospective effect by causing our client to take action which would result in all existing Medibank IPNs held by members of our client being cancelled.*
>
> *We have accessed the Medibank website at* http://www.medibank.com.au/Visitors-Cover/About-Visitors-Cover/About-Our-Members-Choice-Network.aspx *and note that Medibank offers particular classes of members coverage in respect to Remedial Massage.*
>
> *We invite you to provide to us a list of RTO providers that Medibank considers provides the HLT50307 Diploma course in such a way as to satisfy Medibank's proposed requirements. In the absence of such a list, Medibank's representation referred to above would appear to be misleading and deceptive in view of Medibank's proposed Minimum Education Requirements."*

Shortly after this correspondence was sent to Medibank, we were informed that ATMS was also signing the agreement. To his credit, the then CEO of ATMS called me personally to let AMT know that ATMS had decided to sign. He sounded slightly disappointed.

AMT was effectively now on its own at the negotiation table. This is when things turned decidedly David and Goliathy.

So AMT Fights Medibank Alone

Our legal negotiations with Medibank continued. The fund cheerfully pointed out AMT's lonesome status in correspondence to our lawyers dated May 2:

> *"In respect of the amendments to the Deed proposed in your letter of 2 April 2014, I am instructed that Medibank is not agreeable to these. I note that Medibank has reached agreement on these terms with all other provider associations, and is not prepared to negotiate the terms of the Deed."*

AMT Staff Bear the Disgruntled Brunt

Eight months had elapsed since AMT had sent a single new provider location to Medibank. Head Office staff were copping a battering from frustrated and disgruntled AMT members. We wrote a standard but sincere telephone script to deal with these angry calls that in essence said "Sorry. We're still negotiating the terms of the agreement with Medibank. We understand if you have to jump ship to another association that can issue you with a Medibank provider number. We'll be sad to see you go but we understand that you may need to."

It was proving hard to explain to disgruntled members what was at stake. We were officially under siege.

AMT Board Stand Firm, With Moral Support

The AMT Board remained resolute. AMT also had the passionate support of hundreds of disaffected recent graduates who were negatively impacted by the lack of transitional arrangements in the Medibank agreement. We also had RTOs across Australia quietly rooting for us. A number of RTOs even offered financial support to establish a legal fighting fund. While this would have been wonderful in theory, it was not possible for AMT to accept the offers of financial assistance, as it would have created a conflict of interest.

AMT went back to our law firm for advice. We were asked, *"How much do you want to spend fighting this?"* Our lawyers aren't greedy but they wanted us to be realistic about how prodigiously expensive taking the case to the ACCC could become. They drafted a final advice to the AMT Board in July 2014 which stated:

> *"We note that we have had extensive correspondence with Medibank's National Ancillary Services Manager and in-house legal counsel concerning the proposed amendments.*
>
> *In particular, we note that AMT has sought amendments to the deed designed to clarify how the minimum education requirement is to apply, as there is considerable room as to how the drafting proposed by Medibank will operate in practice.*
>
> *We consider that the amendments sought by AMT were reasonable and consistent with the overall purpose of the Medibank amendments.*
>
> *However, Medibank has refused to negotiate in relation to AMT's request for amendments on the ground that the deed has been accepted by all other provider associations. Medibank's refusal to engage substantively with AMT's request suggest that further correspondence with Medibank will not alter its position."*

Counting the Cost of Medibank's Stance

There was no Erin Brockovich style victory in sight. Or, at least, not one that AMT could afford. We fired the slingshot but failed to bring the monster down. Our 15-month campaign to defend the integrity of industry-developed competency standards was over. RTOs had already spent much of 2014 hastily re-jigging training and delivery schedules to ensure their diplomas were "Medibank compliant". RTOs were also forced to absorb a massive administrative burden in reporting compliance and providing letters to associations.

Even now, it's hard to estimate the costs of this fairly meaningless process to the industry as a whole.

The extent to which AMT's final sorrow-laden capitulation to Medibank's requirements in August 2014 has shaped the industry over the past four years is hard to overstate. It provided the backdrop to many of the changes in the HLT52015 training package, leaving RTOs to battle with unhelpfully prescriptive assessment requirements, none of which contribute to better educational outcomes.

It takes a bit longer to get a Diploma of Remedial Massage now but not because there's more time invested in training but rather because assessment is now so ludicrously burdensome, labour-intensive and unrelenting. Students are assessed to within an inch of their lives.

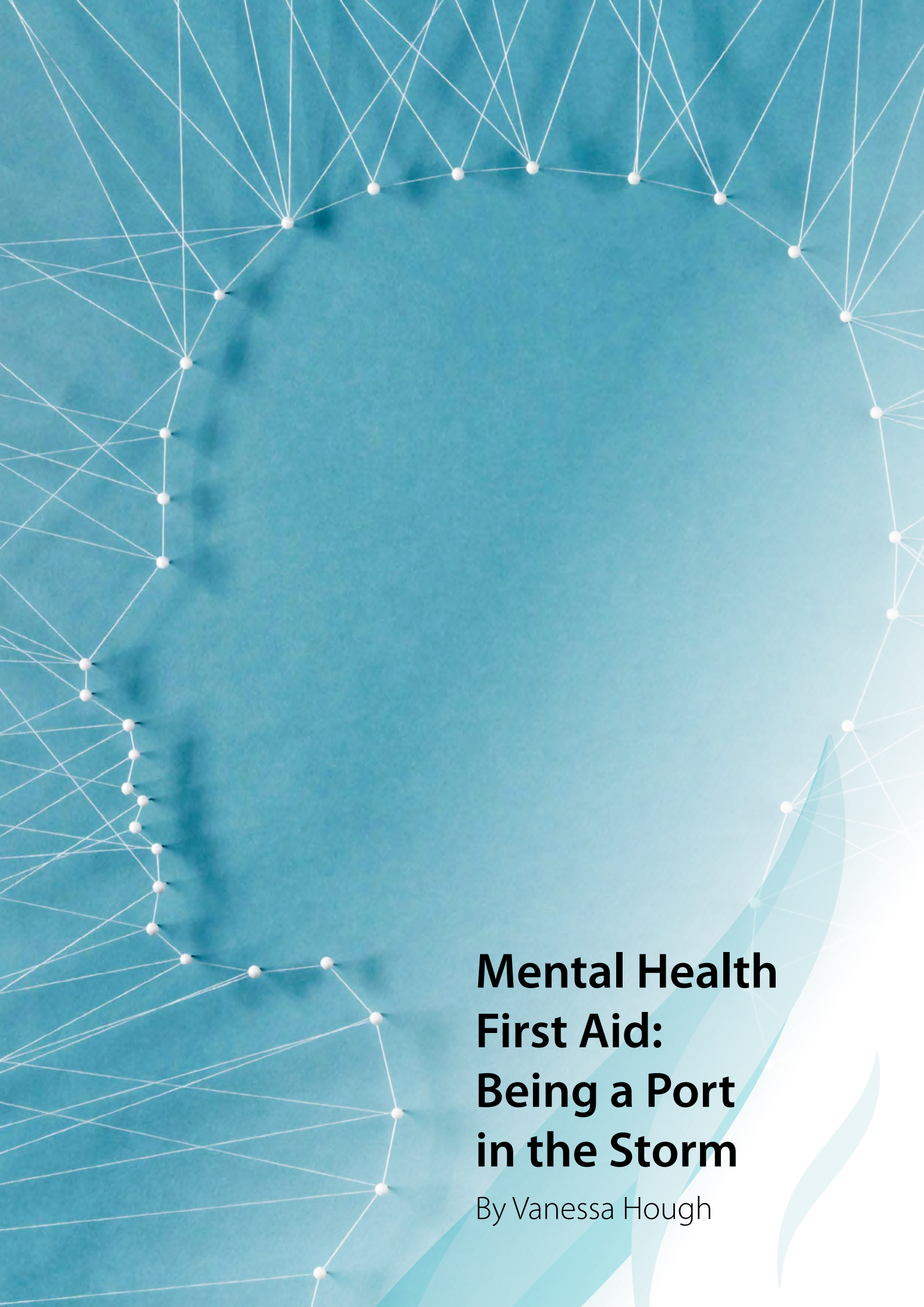
What Does the Massage Industry's Capitulation to Medibank Mean?

If I was asked to pick a moment when the industry's relationship with health funds jumped the shark, then this negotiation with Medibank in 2013/14 would be it. It was an opportunity for the profession to unify around a common cause but we were atomised by the pursuit of the god almighty provider number.

The saddest realisation of all was the extent to which the pressure for numbers wasn't even ultimately coming from AMT members or massage therapists in general but, rather, was being brought to bear by the demands of clinic owners who had built their businesses around point of sale claims. The majority of these people were not even massage therapists. Whose agenda are we serving, using precious membership funds and administration resources?

About the author

Rebecca Barnett has been at the coalface of professional advocacy for 12 years. Her proudest achievements include the release of the AMT Code of Practice in 2013 and the establishment of AMT's classified massage therapy research database. She's still not sure whether to be proud of, or horrified by, those nine stressful months of negotiation with Medibank Private back in 2014. The resulting baby was one that only a private health insurer could love.



Mental Health First Aid: Being a Port in the Storm

By Vanessa Hough

Massage and mental health

Studies show that massage therapy can have a profound affect on mood, with anxiety reduction being one of the most well established effects. Evidence for the effectiveness of massage in promoting mental health crosses multiple presenting conditions and populations.

TRAIT ANXIETY AND DEPRESSION

Reductions of trait anxiety and depression were identified as the largest effects of massage in a 2004 meta-analysis of massage therapy research. A course of treatment provided benefits similar in magnitude to those of psychotherapy, according to this study published in *Psychological Bulletin*.

DEPRESSION

According to a 2010 meta-analysis published in the *Journal of Clinical Psychiatry*, massage is associated with alleviated symptoms in depressed people.

DEPRESSION IN CANCER PATIENTS

There is a vast body of evidence showing the positive effects of massage in cancer palliation. According to a study published in *Support Care Cancer*, massage therapy is an efficient treatment for reducing depression in breast cancer patients. A 2009 systematic review also suggested that massage can alleviate a wide range of symptoms including pain, nausea, anxiety, depression, anger, stress and fatigue.

MENOPAUSE

A study of 87 women in *Complementary Therapies in Medicine* concluded that massage was effective in reducing the psychological symptoms of menopause.

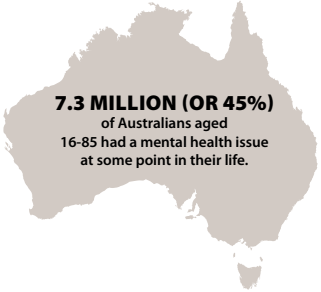
ANOREXIA AND BULIMIA

Massage, aerobic exercise and yoga may improve mental and physical quality of life in patients with an eating disorder, according to a 2014 systematic review of physical therapy interventions published in *Disability and Rehabilitation*.

OCCUPATIONAL STRESS

A 2015 study of intensive care nurses showed that massage was an effective, non-invasive way to reduce stress, promote mental health and prevent the decrease in quality of work life.

According to the 2007 National Survey of Mental Health and Wellbeing



7.3 MILLION (OR 45%)
of Australians aged 16-85 had a mental health issue at some point in their life.

ONE IN FIVE (20% OR 3.2 MILLION)
had a mental health issue lasting 12 months.

There was also **4.1 MILLION PEOPLE** who had experienced a mental health issue at some point in their life but did not have symptoms in the 12 months prior to the survey interview.

To find your local AMT-accredited massage therapist please visit:
www.amt.org.au or call **02 9211 2441**

Some years ago, I worked in the student residences of a public university in the US. I was a Resident Advisor: the go-to person for between 35-50 resident students on my floor from my second to sixth year of study. It was a great job and we were given very thorough training in the weeks leading up to semester one of each academic year before students moved into the residences. At that time, we were taught to deal with circumstances like fire, roommate disputes, body fluids, first aid for injuries and suicide.

Whenever we role played the suicide scenario, everyone's anxiety levels would go up. Nobody ever wanted to be confronted with this issue, but we had to prepare for it. We talked about behavioural changes to watch for as well as changes in communication. Today, we would call it Mental Health First Aid training.

So here's the thing: all manner of occupations train in Basic First Aid and CPR. Only a few specific occupations like Doctors and Mental Health Professionals, even Police and Paramedics are given Mental Health First Aid training. The broader population is increasingly exposed to mental health issues on a significant scale, and people who are dealing with varying degrees of mental health issues are seeking out help in non-traditional ways because of a delay or lack of availability and accessibility to mental healthcare professionals.

My remedial massage clients often find their sessions an opportunity to unload their minds and hearts. While I am not a psychologist and have never claimed to be, I have had a lot of training in active listening. My clients know that I am a "captive audience" for an hour or so and feel safe confiding in me. For some, it takes a while to open up and others let the floodgates go. Although I am quite comfortable in this role as confidante during our sessions, there have been times when the talk is much heavier than the pressure exerted through my elbows.

I have listened to many a heavy heart and weighty shoulders. Some of the topics have ranged from relationship splits, abusive situations, parental stress, drug rehabilitation, job loss and just last year, I had a client come to see me just a few days after he attempted suicide.

This young man, mid 20s, was a labourer. He worked long, hard hours, and came to me through his partner several months prior to this attempt. He often spoke of his work-related stress and sometimes relationship woes.

More so, he had chronic back pain. He wasn't sleeping well and was often grumpy when he got to my clinic after a full day of work. I pride myself on having my clients laugh during treatment. It really is good medicine for the soul and a great ab workout, and he did laugh. There had only been a short break between our weekly sessions but he had cancelled the week before due to work. Then a message came to me from his partner begging me to see him. She said he just got home from seeing the doctor at the hospital after attempting suicide. I was overwhelmed in that moment, to say the least. I was overwhelmed by the feeling of sadness at this news; overwhelmed by the guilt that I didn't see this coming; overwhelmed by the fear of assuming I was going to be seen as his "counsellor".

How is it I was the first person called to help him, and not the psychologist or counsellor he had been referred to? His partner sent multiple messages and rang several times insisting that he needed to see me as he was physically in pain. I knew I had to help, but I also had to establish some parameters for his treatment.

I insisted that he see a Mental Health professional before seeing me. After he had a few sessions with his counsellor, he came for a massage. From the time of his suicide attempt to his massage session was one week. I was nervous. So was he. Not surprisingly, he didn't want to talk about what happened. He just said that his whole body hurt and he would love nothing more than one of my usual "pummelling" treatments. In his words, "make me feel every sore spot so I know I am still here". Whoa! Took everything to choke back a few tears. At the end of our session that day, I said to him, "I am glad you are still here. This massage wouldn't have been the same without you." It got a little chuckle from him. He said it felt good to laugh.

When I look back on this moment, I realise just how much massage therapists are sounding boards for their clients. We don't just hear about physical aches and pains, we are privileged to the emotional and mental ones, too. So where is the training for this in our education packages at TAFE or massage colleges or university?

Due to a lack of funding in most cases, we are left to seek this kind of training on our own. I know I would have felt better equipped if I had a bit more training in this area. I would have felt better if I had had a resources pack at hand to refer to, not just a list of phone numbers to hotlines. I am not saying those numbers are not valuable, quite the opposite. In that moment, certain communication skills, a way of making sure I could support him and his partner would have been beneficial. Let's not forget her in this. She is the one who found him after all. Fortunately, Mental Health First Aid is a thing now. Yes, a thing!

With mental health care professionals stretched to the max in the greater metropolitan areas and in dire need of help in bush areas, we need to add this to our First Aid tool kit.

There are a lot of courses available around the country and even some online courses. I took a look at a few options, including those offered through Mental Health First Aid Australia. As they say on their home page, "You don't have to be a doctor. You don't have to be a psychologist. Anyone can do Mental Health First Aid by signing up." We will not be a replacement for these professionals, but we will be able to be a port in the storm.

About the author

Vanessa Hough owns and operates Purple Sister Massage and Wollongong Frozen Shoulder Clinic in Wollongong, NSW. She has taken a special interest in persistent pain as it relates to mental health in recent months; "Where chronic pain is involved, the mind and body cannot be treated separately but rather the treatment plan must involve a combination of efforts to bring about a positive change for the client", according to Vanessa.

Resources

Crisis Help:

Lifeline: 13 11 14

Beyond Blue: 1300 224 636

Suicide Call Back Service: 1300 659 467

Kids Helpline:
1800 55 1800 (people aged 5-25)

Information on mental health:

RUOK: https://www.ruok.org.au/

Black Dog Institute:
https://www.blackdoginstitute.org.au/

SANE Australia: https://www.sane.org/

Mental Health in Multicultural Australia:
http://www.mhima.org.au/

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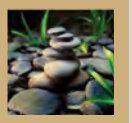

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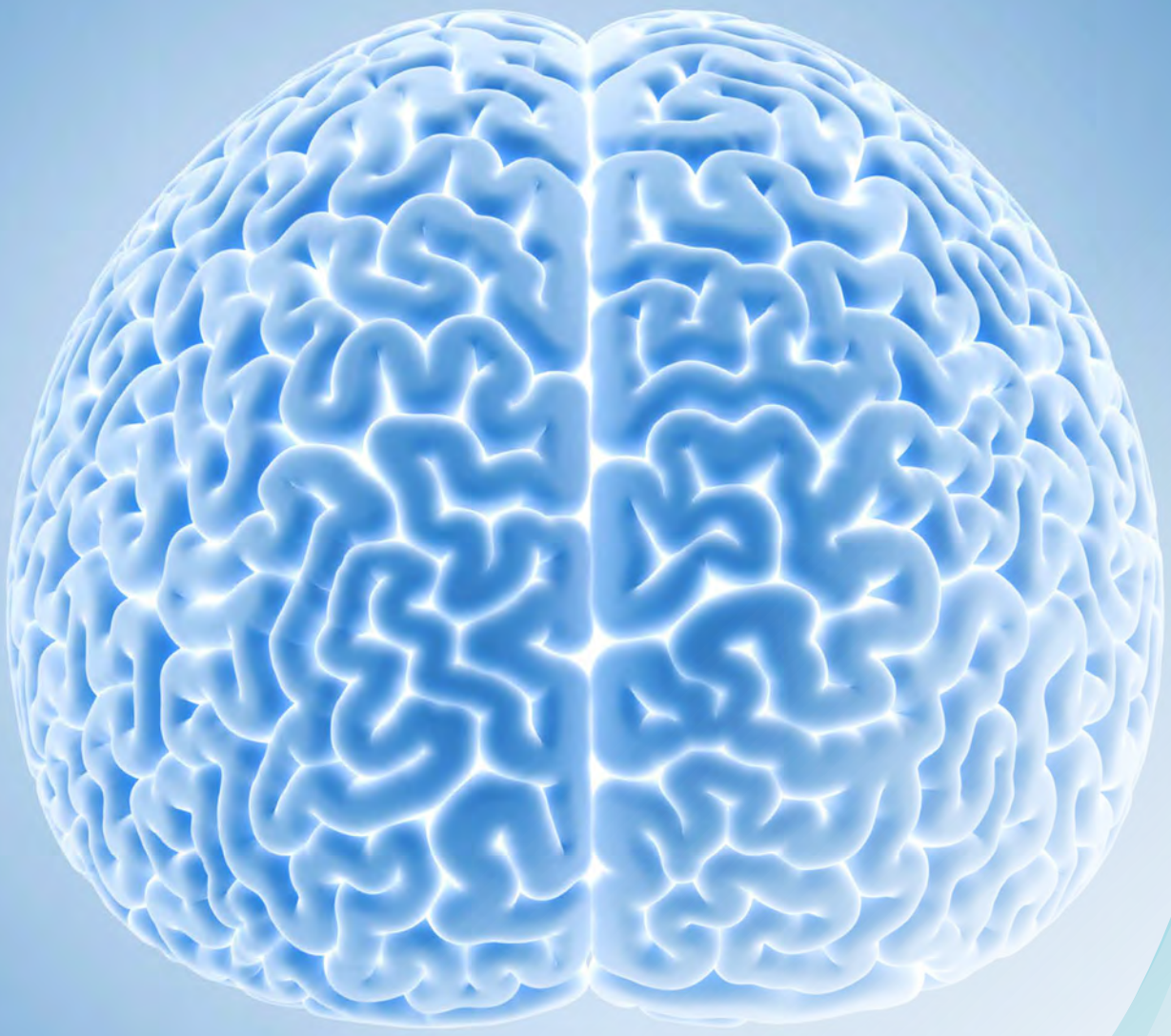

Neural Plasticity

By Joe Muscolino

Learning and Memory

Neural plasticity is the term that describes the brain's ability to be formed or moulded; the term *plastic* comes from the Greek word *plastikos*, which relates to moulding.

The process of learning is the acquisition of knowledge and ability; memory is the retention and storage of knowledge and ability. Memory is stored in the central nervous system by the creation of memory *engrams*, also called memory *patterns*, which are, in effect, recordings of what we have learned. Memory storage is usually divided into short-term memory, which lasts for only a few moments; and long-term memory, which can last indefinitely. Whenever any type of long-term memory occurs, whether it is cognitive, kinesthetic, emotional, or even pain sensitivity, the concept of neural plasticity is involved.

Hence, memory is a recording within the nervous system of our experiences. If the experience is purely intellectual, we form a cognitive memory; if the experience is a physical posture or movement pattern, we form a motor skill memory; if the experience is emotional, we form an emotional memory; and if the experience involves processing sensory pain signals, we can create a memory of pain sensitisation.

Most memory patterns are a combination of cognitive, motor, sensory, and emotion. In each case, the memory pattern is encoded by the activation/firing of neuronal pathways in a specific sequence.

Memory is a recording within the nervous system of our experiences

Creating Memory Patterns

The creation of a memory pattern occurs by encoding the activation/firing of specific pathways of neurons in a specific timed sequence. A simple memory pattern might involve only a few neuronal pathways. A more involved pattern might involve many, many neuronal pathways, with a precise interplay of timing.

For example, the motor skill memory pattern to play a simple song on the piano would involve learning to successively flex the metacarpophalangeal and proximal interphalangeal joints of the fingers in a certain sequence, with a specific timing.

Review of Nervous System Function:

The nervous system is composed of neurons and neuroglial cells (also known simply as glial cells). Neurons comprise 15% of the cells of the brain; glial cells comprise the other 85%.

Neurons are linked together by synaptic connections, and are named for their positions relative to the synapse located between them: the pre-synaptic neuron is located before the synapse; the post-synaptic neuron is located after it (the post-synaptic neuron would then be a pre-synaptic neuron relative to the next synapse along the pathway of neurons).

At a synaptic connection, the regions of the membranes where neurotransmitters are released by the pre-synaptic neuron and picked up by the post-synaptic neuron are called active zones.

When a neuron is sufficiently stimulated to reach action potential, an electrical impulse occurs within the neuron. This impulse travels in one direction, from the dendrites/cell body end of the (pre-synaptic) neuron to the ends of the terminal branches of the neuronal axon located at the synapse with the next (post-synaptic) neuron. Because the electrical impulse cannot cross the synaptic connection, the pre-synaptic neuron releases chemical neurotransmitter molecules that cross the synapse to the post-synaptic neuron. These neurotransmitters can either facilitate or inhibit the creation of an action potential (nerve impulse) in the post-synaptic neuron. Because many thousands of pre-synaptic neurons converge on a post-synaptic neuron, whether the post-synaptic neuron is sufficiently facilitated/stimulated to action potential depends on the summation of all facilitatory and inhibitory pre-synaptic neuron's neurotransmitters. If the post-synaptic neuron is sufficiently stimulated, a nerve impulse will be initiated that can then travel to the axonal end of that neuron and synapse with the next post-synaptic neuron. In this manner, impulses travel throughout the neuronal network. In effect, the presence or absence of impulses translates into binary-code information, just as a computer carries 1s and 0s.

This understanding of nervous system function is called the *neuron doctrine* because it holds that neurons are principally important for nervous system functioning. Although current research does not contradict our knowledge of neuronal functioning, it is beginning to show us that neurons are not the only important actors on the stage when it comes to impulse transmission. We are finding out that glial cells are far more important than previously thought. Glial cells were once thought to provide support functions and be little more than putty that held the neurons together (the term *glia* literally means glue). They are now becoming understood to be integral to the functional ability of neurons to carry their electrical impulses and transmit their chemical synaptic messages.

If it is a simple song such as *Mary Had a Little Lamb*, the sequence of fingers would be 3-2-1-2-3-3-3, 2-2-2, 3-5-5, 3-2-1-2-3-3-3, 2-2-3-2-1 (3, middle finger; 2, index finger; 1, thumb; and each comma represents a pause). At the same time, the nervous system would have to simultaneously isometrically contract extensor muscles of the wrist joint and flexor muscles of the elbow joint so that the hand and forearm would be positioned for the fingers to strike the keys, as well as core muscles to hold the trunk and neck in position, while seated to play. If expression is added to the song, then cognitive and/or emotive (limbic system) pathways would be involved, as well as possible other upper extremity joint motions to allow the pianist to strike the keys harder or softer as desired. A memory pattern for this song would involve all these neuronal pathways to engage musculature spatially throughout the body, as well as temporally in sequence and timing to hit the proper order of notes to play the song. And this is a simple song. Imagine if the piece being played is a Beethoven Sonata!

A similar process occurs with a more complicated motor skill, such as hitting a forehand stoke in tennis. Neuronal pathways that encode for hip, knee, and ankle joint motions to place the feet in the right position; elbow, shoulder, shoulder girdle, and spinal joint motions to bring the racquet back; and then swinging the racquet forward with a concerted coordination of all the upper extremity; spinal, and lower extremity joints for balance and to rotate the body to swing through the ball; all the time tracking the ball with the eyes, cognitively remembering the usual court position of the opponent to determine in which direction to hit the ball, and experiencing the psychological/emotional feelings that are involved in competition.

Given that pain alerts us to physical damage that is occurring or is likely to occur, increased pain sensitisation could be viewed as an effective and vigilant warning system that might prevent further damage.

Long-Term Memory and Neural Plasticity

Every experience results in the formation of an encoded neuronal memory pattern. When first created, this memory pattern is unstable and located in short-term memory. As such, it can usually be accessed for only a few moments. If we want to place a memory into long-term memory, we need to stabilise/consolidate it. The key is repetition. The consolidation of a memory pattern results from the repetitive firing of the neurons within the pathways of the memory pattern. With repetition, comes the functional and structural changes in the neuronal pathways that are the hallmark of neuronal plasticity. Shorter-term changes are functional; longer-term changes are structural.

Pain Sensitisation

Facilitation of pain pathways is termed *central sensitisation* or *simply sensitisation*. If a client has experienced chronic pain then, even if the physical cause of the pain is removed, the facilitation of the pain pathways can create a sensitisation of pain in this pathway: the degree of pain experienced will be out of proportion with the degree of physical damage. In these cases, neural plasticity has created a learned pattern of pain that may last for months, years or indefinitely.

The function of sensitisation is debated but it is likely that it acts to heighten the client's awareness of pain stimuli in a vulnerable region of the body. Given that pain alerts us to physical damage that is occurring or is likely to occur, increased pain sensitisation could be viewed as an effective and vigilant warning system that might prevent further damage. The reality is that the pain is overly vigilant and, to the client experiencing sensitisation, the chronic pain is not appreciated.

Interestingly, the reverse of sensitisation is also possible. Suppression of pain, termed *habituation*, can also occur. This results in a lessened degree of pain relative to physical damage that is present.

Emotional Plasticity

Pathways for emotions and psychology have also been shown to be plastic. Indeed, the entire field of talk therapy could be viewed as a means of becoming aware of unhealthy memory patterns and learning how to change them. The limbic system of the brain is a group of brain structures that are generally considered to be important for emotions. Neuronal emotional plasticity is one reason why a client might have a difficult time letting go of negative feelings. Given the interplay between the motor and limbic systems, emotional plasticity memory patterns also explain why body armoring occurs and why clients may have emotional releases when certain areas of the body are touched.

Neuronal Plasticity

With early repetition, as a synapse is repetitively fired, the first neural change is functional strengthening of the synapses. This occurs for two reasons. One is that the conductance of potassium (K+) ions within the pre-synaptic neuron is changed; this causes the action potential to lengthen in time, resulting in more neurotransmitter being released. The second functional change is that the transport of the neurotransmitter within the pre-synaptic neuron is increased, making it more available for release.

The sum of these two functional changes is that more neurotransmitter is released by the pre-synaptic neuron and therefore picked up by the post-synaptic neuron, increasing the likelihood that the post-synaptic neuron will fire and continue the impulse down the memory pattern's neuronal pathway. (Figure 1)

With continued/later repetition, structural changes begin to occur in both the pre- and post-synaptic neurons. The number of active zones present at the synapses of the pathway increases. In addition, the post-synaptic neuron begins to proliferate its dendritic tree by increasing the number of its dendrites. (Figure 2)

Emotional plasticity memory patterns also explain why body armoring occurs and why clients may have emotional releases when certain areas of the body are touched.

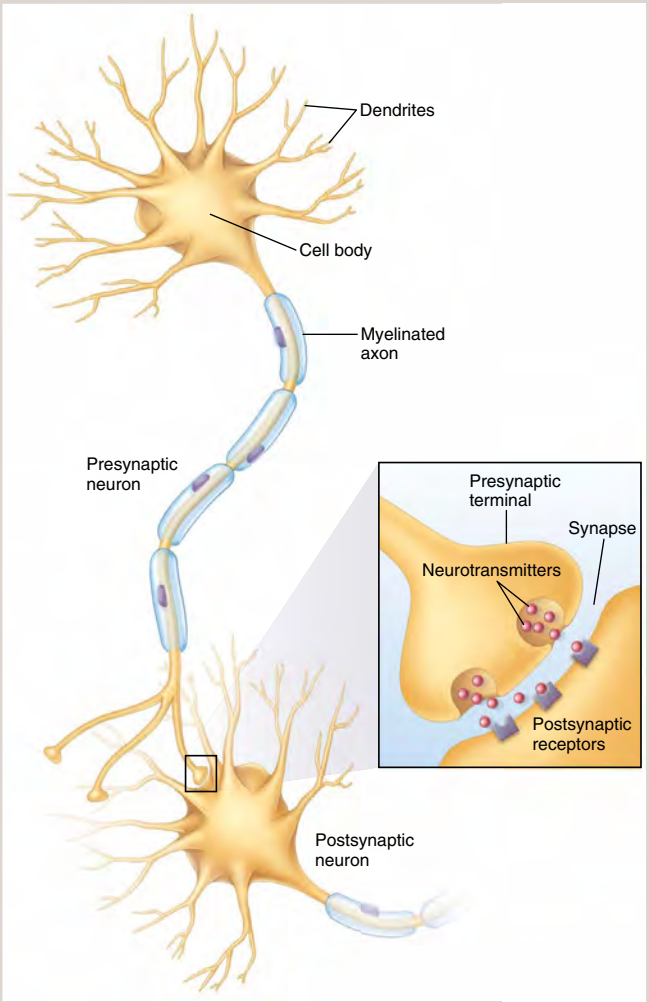

Figure 1: Neurotransmitters are released from the presynaptic neuron, cross the synapse, and are picked up by the postsynaptic neuron.

This then allows for the third change, which is that new functional synapses are formed between the pre- and post-synaptic neurons. The result of these structural changes, as with the functional changes, is that more neurotransmitter is picked up by the post-synaptic neuron, increasing the likelihood that it will fire, continuing the impulse down the memory pattern's neuronal pathway. There is a saying in the world of neurology: "Neurons that fire together wire together."

This describes the concept that when two neurons fire simultaneously, they undergo the functional and structural changes that have been described here as plasticity.

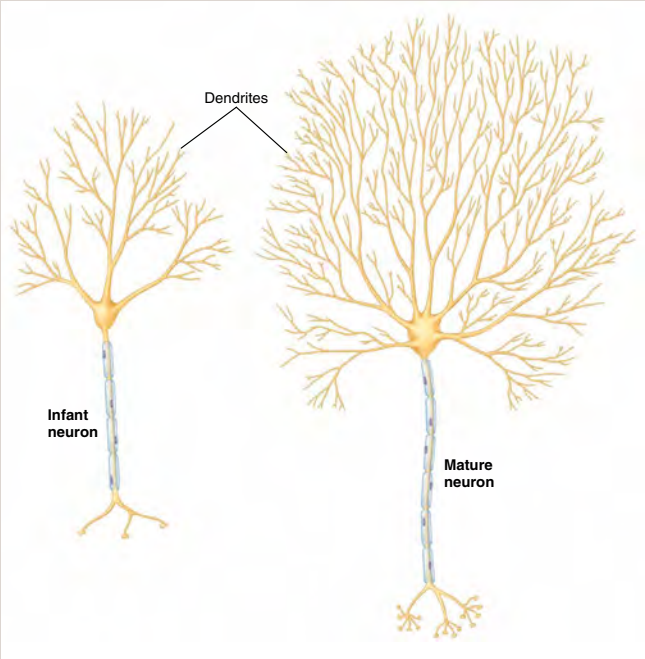

Figure 2: Maturation of a neuron involves proliferation of its dendritic tree

Neurons that fire together wire together.

Neuroglial Plasticity

In addition to neuronal plasticity, neuroglial (glial) cells also exhibit changes with learning and memory. One type of glial plasticity is manifested by oligodendrocytes. Oligodendrocytes function to insulate neuronal axons in the central nervous system by wrapping layers of myelin around them. As a neuron repetitively fires, the oligodendrocyte that myelinates it senses this and responds by increasing the number of myelin layers that ensheath it. This results in greater speed and efficiency of the neuron's impulse conduction, which can contribute to the efficiency of a learned memory pattern.

Astrocytes and microglial cells can also be involved in neural plasticity. These glial cells have been found to contribute to activity in neuronal pain pathways by secreting substances that help to heal the physical damage of the injury. These substances also stimulate the neurons involved, resulting in greater sensitivity to pain. Unfortunately, it has been found that they continue to secrete these substances even after the physical damage is healed. In this manner, glia are implicated in the process of central sensitisation to pain.

Brain Mapping Plasticity

The geographic mapping of the cerebral cortex of the brain can also exhibit neural plasticity. With experience, neurons are reapportioned in relation to the areas of the body that are preferentially used. For example, one study involving the primary sensory cortex showed that, after amputation of a digit of the hand, the region of the sensory cortex that had represented that digit was now reapportioned to represent adjacent digits that remained.

This concept has also been shown to exist with other sensory regions of the brain. In another study involving the primary motor cortex, if an animal was trained to repeatedly use a specific finger, the region of the motor cortex that represented that finger expanded.

Reapportioning brain regions also occurs with long-term learning. One of the hallmarks of long-term learning, especially of a motor skill, is that it can be performed in an automatic manner. This occurs by preferentially shifting the command of the motor skill from being seated in the cerebral cortex to being seated primarily in subcortical regions, for example the basal ganglia, situated more deeply in the brain. The advantage is that it frees up conscious attention space of the cortex to be devoted to other tasks. This is why a person can perform a motor task in an automatic fashion while thinking about something else entirely. A common example is driving home from work in "auto-drive mode" while lost in thought about the events of the day, only to realise that you have been driving without any conscious attention.

Finally, as Charles Leonard, professor of neuroscience of motor control, states in *The Neuroscience of Human Movement:* "Learning is not all in your head." (Leonard 1998). The spinal cord of the central nervous system can also exhibit neural plasticity. Sensory-motor stretch reflex synaptic connections can also be changed based upon experience.

Learning Through Repetition

The key to neural plasticity is repetition. With each repetition of a cognitive, motor, emotional, or sensory experience, the central nervous system becomes sensitised to that experience and encodes it into a memory pattern via functional and structural changes of neurons and glia. With greater repetition, comes more deeply embedded etching of the pattern. A useful analogy is to compare the neuronal pathway of a memory pattern to water etching a deeper and deeper pathway into the side of a mountain over a period of time. (Figure 3) Interestingly, repetition does not have to occur only during our waking hours. When we sleep at night, the brain has been shown to reactivate neuronal pathways of thought and motor patterns that were experienced during the day, thereby strengthening them. It is also during sleep that we move our memory patterns from regions of the cerebral cortex to subcortical regions. This has led some researchers to posit that the primary function of sleep might actually be to use neural plasticity to prioritise and order the events and experiences of the day into the memory patterns needed for learning.

The key to neural plasticity is repetition.

Figure 3: Consolidation of a neural pathway memory pattern is analogous to water etching a deeper and deeper pathway into the side of a mountain over time.

Application of Neural Plasticity to Massage Therapy Practice

The concept of neural plasticity is critically important to massage practice. Beyond local effects on tissues, massage therapy is largely geared toward addressing dysfunctional muscle memory patterns located within the nervous system. The difficulty is that these dysfunctional patterns are plastically moulded/embedded and become entrenched and difficult to change. This is why the client often experiences a positive temporary effect from the treatment, only to have their symptoms return a short time later.

The concept of neural plasticity is critically important to massage practice.

For this reason, it is necessary to create a treatment care and self-care plan for the client that is frequent enough to reverse the embedded pattern. In effect, we are looking to return the client via neural plasticity back to the healthy muscle memory pattern that they once possessed.

Conclusion

The concept of neural plasticity has been demonstrated in multiple research studies involving cognitive learning, motor learning and sensory learning. We now understand that, far from being a static system, our nervous system is a dynamic *plastic* system that is constantly forming, reforming and moulding based upon the experiences in our life. Through multifaceted functional and structural changes, neural plasticity integrates these experiences and encodes them into learned memory patterns. We use these memory patterns to understand our world, process pain and other feelings, and to move our bodies in a fluid, graceful, and efficient manner.

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Leonard, C. (1998) The Neuroscience of Human Movement. St Louis: Mosby.

About the author

Dr. Joe Muscolino is a global lecturer and author, and has been a manual therapy educator for more than 30 years. His ability to apply anatomy to manual and movement therapy is exceptional. He is the author of numerous publications on kinesiology, palpation assessment, body mechanics, and manual and movement therapy techniques.

Does That Feel Tight?

By Sam McCracken

The question I face most often in the clinic and that I imagine most therapists are asked multiple times a day is "Does that feel tight to you?" Given that this is such a common question, we would do well to analyse why we are being asked and what the most appropriate response is.

One reason we are being asked is that the client is seeking validation for what they are feeling. But are we as therapists able to confirm that feeling? Are we truly able to feel the same thing?

At the 2016 AMT annual conference we were fortunate to have Dr Tasha Stanton as keynote speaker.[1]

Dr Stanton shared her research investigating if the *feeling* of back stiffness actually reflects *having* a stiff back? Her research concluded that:

> *"feelings of back stiffness are a protective perceptual construct, rather than reflecting biomechanical properties of the back. This has far-reaching implications for treatment of pain/stiffness but also for our understanding of bodily feelings. Over three experiments, we challenge the prevailing view by showing that feeling stiff does not relate to objective spinal measures of stiffness and objective back stiffness does not differ between those who report feeling stiff and those who do not. Rather, those who report feeling stiff exhibit self-protective responses: they significantly overestimate force applied to their spine yet are better at detecting changes in this force than those who do not report feeling stiff."*[2]

If we were to try to measure tightness, we would invariably run into confounding factors with our assessment. Varied kinematics and ratios of collagen fibre types would only lead us to the conclusion that variation is normal and, as for inter-rater reliability, we find that even the experts fail miserably when trying to gauge tight muscles or taut bands of muscle fibres.[3]

Before we go any further examining what we as therapists are feeling, we need to ask if it is the same thing the patient/client is feeling. The answer is 'probably not'. In fact, they might as well be asking "does my nose feel itchy to you?" My exteroception is not the same as the client's interoception. This is not to say that the physical exam is not important. Indeed, it is essential, but we must exercise awareness that it may be illusory.

We have all heard people proclaiming "it's this muscle here" while pointing to an area of the body. When I ask why a client thinks it's the muscle that's problematic, I usually get a confused look and the reply of "well I don't think it's the bone, so it must be the muscle". The general public are pretty well versed in major muscle groups: lats, traps, glutes, quads and hammies can all be easily identified.

However, any mention of our physical nervous system usually draws a blank, even though we have an estimated 72 kilometres of nerves running through our bodies and that all pain is neurogenic. The public's ignorance of the role of the nervous system can be excused but what about massage therapists? By not acknowledging the role of the nervous system, have we set ourselves up to blame and even punish innocent muscles? If we were to disable the nervous system by administering a general anaesthetic, we can temporarily eliminate pain, but we can also often observe complete restoration of restricted range of motion.[4]

Reported tightness is an emotional and sensory experience related to unpleasant bodily sensations and as such can be classed as a pain descriptor. The renowned pain scientist Ronald Melzack began collecting the words that patients used most frequently to describe pain, organising this vocabulary into categories to capture pain's temporal, sensory and affective dimensions, as well as its intensity. The result was the McGill Pain Questionnaire, a scale comprising some eighty descriptors, including tight, stabbing, burning, and heavy. The descriptors fall into four major groups: sensory; affective; evaluative and miscellaneous.

A muscle that is reported as feeling tight is not necessarily biomechanically tight, just as a report of a leg feeling heavy does not weigh more, or a burning sensation is not associated with heat.

I don't think we should discourage people from using these terms because they are wonderfully informative descriptions.

When someone tells me they feel "tight", I may or may not be able to feel that tightness but I have a good idea what they are talking about. In fact, that is the same word I would use to describe that sensation. I may not literally have knots in my muscles but I can feel all knotted up. My back may not be "out" but it doesn't feel right, it doesn't feel like everything is in order, it feels "out". A discussion about these reported sensations combined with some open-ended questions and a thorough physical examination can streamline the formation of a treatment plan.

In her conference presentation, Dr Stanton also spoke about the importance of explaining pain and how it can be empowering to have a greater understanding of pain, and how massage therapists are exceptionally well placed to provide this information. Massage therapists are generally more affordable, more accessible and many have advanced pain content knowledge and, critically, they know how the musculoskeletal system works.

The question "Does that feel tight to you?" is sometimes asked mid treatment with the patient lying face down. Since this may not be an opportune time for complex explanations, I would like to share a method used by Dr David Butler, co-author of Explain Pain.[5] While he is taking a history or doing an assessment, he places what he refers to as an E flag in his notes, this serves as a reminder to come back to this later to offer more "explanation". Similarly, we can make a mental note, an E flag, to explain things further at a more opportune time.

Conclusion

It is possible to offer validation of peoples lived sensory experiences, in this case the feeling of "tightness", by demonstrating an understanding of the science and using metaphors and storytelling that gives meaning to the subjective nature of pain and discomfort, and moving to a form of discourse that might be called the intersubjective that emphasises negotiation towards shared meaning.

About the author

Sam McCracken is a remedial massage therapist on Brisbane's north side. Sam qualified in traditional Thai massage in 2006 from the world's oldest massage school (Wat Po Traditional Medicine School) and with the benefit of over 30 years of daily Tai Chi practice, he believes he is on track to achieving his goal of becoming the world's oldest massage therapist. Sam has a keen interest in modern understandings of traditional massage methods. He has studied many lineages of massage, mostly from Asian traditions.

1 Tasha's conference presentation can be viewed on AMT's YouTube channel https://www.youtube.com/watch?time_continue=3&v=ZWvyLJkBrLY

2 Tasha Stanton, Lorimer Moseley, Arnold Wong and Gregory Kawchuk; Feeling Stiffness in the Back: a protective perceptual inference in chronic back pain, *Scientific Reports*. 2017;7(1):9681.

3 Fred Wolfe, Travell, Simons and Cargo Cult Science http://www.fmperplex.com/2013/02/14/travell-simons-and-cargo-cult-science/ accessed 16 November 2018.

4 Luise Hollmann, Mark Halaki, Steve Kamper, Mark Haber & Karen Ginn; Does muscle guarding play a role in range of motion loss in patients with frozen shoulder? *Musculoskeletal Science and Practice.* 37. 10.1016/j.msksp.2018.07.001.

5 David Butler and Lorimer Moseley, *Explain Pain,* 2013 (2nd edition) Adelaide: Noigroup Publications

Pleasure is not a dirty word

By Tim Clark

Generally speaking, an hour of massage flies whereas an hour in a dentist's chair can seem endless. A massage can be enjoyed immediately, in the moment, whereas in other modalities pleasure is, if anything, a delayed by-product of symptom relief.

Despite this, there seems to be so many reasons for us to avoid invoking pleasurable states in our clients – not to mention taking pleasure in giving a massage – that it feels a little dangerous to even raise the topic, where 'pleasure' may be loaded with a culturally entrenched association of massage with sex work and the more overt sexual connotations of the verb 'to pleasure'.

It makes sense that some massage therapists (and others) feel uncomfortable about equating massage and pleasure. Wanting to be taken seriously by the medical profession doesn't really lend itself to the spreading of 'good vibes', and this has been accepted by some clients who see medicine as gospel and pleasure as an indulgence.

How often do we hear clients intone some variation on 'no pain, no gain'?

Then there is the ethical responsibility for us as therapists to avoid fostering dependence, or exploiting clients by satisfying our own need to please others. There are undoubtedly more reasons, but do any of them justify us worrying about clients enjoying their massage?

On the contrary, we can use pleasure to harness the physical and mental health benefits of massage, and we have an opportunity to educate clients experientially about the pleasure of safe, non-erotic touch. Of course, this requires clear boundaries and definitions. We need to be very clear about what constitutes pleasure in massage and what can facilitate it.

Three prerequisites for us to consider (and there are undoubtedly more) are:

- Safety
- Comfort
- Communication.

Safety

Massage can affirm or destroy a client's belief that the world is a safe place, depending on how the therapist approaches their work. We have an opportunity to give every client an experience of safety that not only brings relief in the moment but reinforces their trust in the world. In a successful therapeutic massage, the client's willingness to be vulnerable is not only respected but rewarded.

It is not just that the client is safe but that the client feels safe that is central to their ability to enjoy the experience.

Rather than being a source of pleasure in and of itself, safety is a precursor to the client's experience of pleasure.

So, safety is about more than just infection control and work health safety practices. It requires that the therapist holds beneficence and non-maleficence as key personal and professional values. It requires that the therapist is clear with clients about what treatment will entail and delivers, as much as possible, what is agreed at the outset. It requires that the therapist knows their own boundaries and how to respond when a client knowingly or unknowingly tests those boundaries. (AMT sets out the requirements for Professional Boundaries in the Code of Practice.)

Of course, these are issues for us all to grapple with in our own ways, and we may never feel that we succeed perfectly. We need to accept that and then strive for our ideals.

Comfort

Imagine the ultimate uncomfortable massage experience: the face cradle feels like a vice, your feet are frozen, the towels are like sandpaper, the radio is blasting the traffic report and you can smell baby oil and the therapist's halitosis. It would all be okay if you thought the therapist would be receptive and responsive to your feedback, but they've given no indication of caring about your comfort. You put up with it, hoping that things might get better but they don't. When it's over, you quietly resent handing over your money but you have no choice.

Now imagine that this is typical of your life experience: that although you give generously of your kindness, the world seems perpetually hostile and others routinely fail to respond to your needs. For some of us this will require little imagination, while even those of us with a more affirming experience of life may recognise in it some of the quiet desperation of day-to-day existence.

We all experience the world's hostility to some degree and have moments of feeling overwhelmed by negativity, anger, hopelessness and isolation. One of massage's gifts is a moment's respite from this, an opportunity to relearn that others can and want to offer solace.

Failure to keep our clients comfortable can rupture the therapeutic relationship, denying the client of the human connection that massage can offer. It might convey to them that they are not deserving of careful attention and that their needs don't need to be met, exacerbating low self-worth and reinforcing patterns of poor self-care. Reassuring clients that it's okay to voice needs and then being responsive without interpreting requests as criticisms, can offer clients a new experience of relationships and the world in general.

It makes sense that some massage therapists (and others) feel uncomfortable about equating massage and pleasure. Wanting to be taken seriously by the medical profession doesn't really lend itself to the spreading of 'good vibes', and this has been accepted by some clients who see medicine as gospel and pleasure as an indulgence

Communication

I once got into a spirited discussion with an older client of mine after I observed that he liked to talk throughout his massages. "Why shouldn't I?" he responded. "I spend most of my days in silence at home, sometimes not talking to anyone for days at a time. Silence stresses me out more than anything."

It was a great way to learn that how and what we choose to communicate can impact on our clients' ability to enjoy their massage. Talking during the massage can feel intrusive to some, while others feel liberated and soothed by the opportunity to just converse in an easy way with another human being for a little while.

Of course, communication isn't just about talking. Everything we do as massage therapists communicates something to our clients. We communicate with our voices, bodies and faces and, of course, through the environment we set up.

Perhaps most uniquely for us, though, we communicate with our hands. When I'm massaging, I often think about what my hands would be saying if they could speak. Is it, "I care," or is it, "I'm distracted"? Are they giving away that I've had a bad day, or are they responding to the client's needs in the moment?

In this way, communication is the same as connection, and we need to wonder if our clients are receiving our messages across a crystal clear, high definition line or if they're struggling on the other end of a tin-can telephone.

It's the nature of human communication that we might never know for sure, but never wondering is the best way to ensure we never know.

Conclusion

To think more about the role of pleasure in massage, it might be helpful to bring in Paul Dolan's 2014 book *Happiness by Design: Finding pleasure and purpose in everyday life*. Dolan suggests that happiness in life requires a balance between our sense of purpose and our experience of pleasure. Massage is one of the few healthcare modalities that offers people an experience of pleasure that is also purposeful. Let's embrace that.

About the author

If you'd told Tim Clark five years ago that he would be a massage therapist and psychotherapist in five years' time he would have laughed in your face. But in spite of that, he completed his massage training in 2017 and has just finished the Master of Counselling and Psychotherapy. His Master's thesis examines the relationship between a massage therapist and her client through the lens of psychotherapy.

Office Location:
Suite 3.02, 22-36 Mountain Street
Ultimo NSW 2007

Mailing Address:
PO Box 826
Broadway NSW 2007

Phone: 02 9211 2441
Fax: 02 9211 2281
E-mail: info@amt.org.au

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