PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

2ND QUARTER 2017

DIVE INTO WELLINGTON

"REINVENTING PRACTICE"
MNZ CONFERENCE – AUGUST

DERMONEUROMODULATION • **DELIVERING PAIN EDUCATION** • **VISCERAL EXPLORATION** • SELF-CARE FOR THE HIGH PERFORMING MASSAGE THERAPIST • **UPDATE FROM HIGH PERFORMANCE SPORT NZ** • **BICEP INJURIES** • MNZ SURVEY OF NON AND EX MNZ MEMBERS

DermoNeuroModulating

"Treating the body as if the nervous system really mattered"
Diane Jacobs.

NZCM Continuing Education

International Presenter: Diane Jacobs

Where: NZCM Auckland Campus
When: Thursday 24th August 6pm – 9pm,
Friday 25th – Sunday 27th August 8am-5pm

Venue: Building C, 382-385 Manukau Road, Greenlane, Auckland 1023

Regular Registration: $695.00 NZD
Early Bird (by July 10th): $495.00 NZD
Registration: Phone 09 522 5522 (Auckland) or register online

www.massagecollege.ac.nz
0800 NZCMNOW (69 26 66)

NEW ZEALAND COLLEGE of MASSAGE

OM
ONCOLOGYMASSAGE

Are you turning away clients with cancer?

Don't refer on,
improve your skills.

Get the confidence you need to improve client wellbeing.

Contact
info@oncologymassagetraining.com.au
Enrol NOW!
0416 004 616
www.oncologymassagetraining.com.au

The Wellington School of Massage Therapy

inspiring leaders in health education, more effective skills, better choices

5 Ways You Can Get More Clients

1. Upskill
2. Expand your network
3. Join social media + participate
4. Give clients more than they expect
5. Treat referrals like gold

To help you be successful + busy we help you upskill so you will give clients way more than they expect. Options include:

- Clinical NeuroMuscular Therapy
- Trigger Point Release
- Touch for Health Kinesiology
- Kinergetics
- Bach Remedies
- Ortho-Bionomy®

www.radianthealth.co.nz
jane@radianthealth.co.nz | 04 473 8788 | FB

EDITORIAL

We bring you the MNZ Massage Magazine Q217. It is the second production that is entirely online – this means you can click on any link and be taken directly to the web page. Remember that if you prefer to have a hardcopy for your clinic or to read at your leisure, you can print it out in booklet format.

The MNZ National Massage conference is coming up in Wellington in August and we have featured the key presenters in this issue. Take the time to read of Diane Jacobs (page 10), Paul Lagerman (page 12) and Rosie Greene (page 14) – we hope it peeks your interest. Check out the costs on https://www.massagenewzealand.org.nz/Site/conference/default.aspx where you can also register. Gather a group of you, grab a cheap airfare and "Dive into Wellington" for a great weekend 18th-20th August. We would like to acknowledge RMT Bridie Munro who has been the driving force behind the conference and our great new website so we can become paperless. It is volunteers in the association that keep pushing MNZ forward. It has been a great year with the Executive making real changes to boost membership. Read what was requested on page 23.

We have wonderful articles on Neck and Jaw by Til Luchau (page 20) and Ben Benjamins Bicep injuries (page 29). We are very grateful for permission to reprint these articles.

Local authors have also submitted articles on interesting topics including selfcare and how to support the LGBTQ community in your client history taking. We always appreciate being brought up to date by Pip Charlton on HPSNZ also.

Do take the time to read the 2nd instalment from Ruth Werner on the Research Update (page 37) where she has explained the steps taken in a Systematic Review and Meta-Analysis of Randomized Controlled Trials: in Patients Experiencing Pain in the General Population. The explanation she has given is helpful and very clear to all those trying to understand research. We thank her so much for contributing to our magazine so willingly.

Finally do ensure you have updated your website and cards (page 39) with the new format of your MNZ registration.

See you in August,

Carol Wilson

Find us on MNZ and @Massage_N_Z

MNZ MAGAZINE

Q2 2017 CONTENTS

ADVERTISING RATES AND INFORMATION

ADVERTISING RATES

Valid from Feb 2017. All rates are GST inclusive.

MNZ Magazine: Now ONLINE only

RMT and Affiliate members receive a 15% discount on magazine advertising.

All adverts are in full colour

Casual advertising rates:

Full page	$290
Half page	$160
Quarter page	$90

Package deals (in 4 publications over 12 months):

Full page	$840
Half page	$450
Quarter page	$240
Magazine inserts (per insert)	$0.75c

MNZ Website:

RMT and Affiliate members receive a 15% discount on magazine advertising.

All website advertising is placed for 2 months, unless otherwise stated when booking.

Advertising blocks (6 adverts)	$280
Events/adverts page (one off)	$50

MNZ Magazine and Website Annual Bulk Advertising Packages:

Packages provide magazine and website coverage. A discount is already included in these prices.

Package 1 includes:

Magazine full page advert (x4)	
Website advertising block (6 ads)	$1120

Package 2 includes:

Half page advert (x4)	
Website advertising block (6 ads)	$760

Email Advert to MNZ Members:

Provides a one–off mass email blast to membership.

Members (RMTs & Students)	$25
Non-members + Affiliates	$80

SUBMISSION DEADLINES

The MNZ Magazine will be published:

Q1 2017 (deadline end Jan 2017)
Q2 2017 (deadline May 1st 2017)
Q3 2017 (deadline Aug 1st 2017)
Q4 2017 (deadline Dec 1st 2017)

Note: submission dates may be changed or delayed as deemed necessary by the Editor.

The MNZ Magazine link will be emailed out to all members and placed in the members' only area on the website.

Requirements of advertisements:

Advertisements must have good taste, accuracy and truthful information. It is an offence to publish untruthful, misleading or deceptive advertisements. Advertisements for therapeutic goods and devices must conform to New Zealand therapeutic goods law.

Only a limited number of advertisements can be accepted. Advertising availability closes once the quota has been filled.

ADVERTISING BOOKING AND SPECIFICATIONS

Advertising for magazine, website and email blasts to members should be booked via our online booking form and can be paid online with credit card at www.massagenewzealand.org.nz/about/advertise/advertising-opportunities.aspx

Emailed advertising forms are no longer accepted.

Magazine Page Sizes

- Full page is 180mm wide x 250mm high
- Half page is 180mm wide x 124mm high
- Quarter page is 88mm wide x 120mm high

For any enquiries about advertising with MNZ, please contact advertise@massagenewzealand.org.nz

PAYMENT

FULL PAYMENT MUST ACCOMPANY EACH ADVERTISEMENT

Methods of Payment:

- Credit via our online payment gateway when booking the advertisement online
- Internet banking to ASB A/c 12-3178-0064216-00
  Please include your business name in the 'reference' field when making an internet transfer.

ARTICLES, CONTRIBUTIONS, RESEARCH, COMMENTS AND IDEAS...

ARTICLE SUBMISSION GUIDELINES

- **Word count - Max 1800 words include references**
- **Font - Arial size 12**
- **Pictures - Maximum 4 photos per article, send photo originals separate from article, each photo must be at least 1.0MB**
- **Please use one tab to set indents and avoid using double spacing after fullstops. The magazine team will take care of all formatting**
- **We prefer APA referencing (see http://owll.massey.ac.nz/referencing/apa-interactive.php)**

Editor - Carol Wilson

magazine@massagenewzealand.org.nz

MNZ EXECUTIVE, STAFF AND SUB-COMMITTEES

EXECUTIVE COMMITTEE

President
Helen Smith
president@massagenewzealand.org.nz

Vice-President
Teresa Karam
vice-president@massagenewzealand.org.nz

Treasurer
Reina Reilly
accounts@massagenewzealand.org.nz

Publicity Officer
Karley Skinner
publicity@massagenewzealand.org.nz

Education Officer
Rosie Greene
education@massagenewzealand.org.nz

Regional Liaison Coordinator
Donna Roy
liaisoncoord@massagenewzealand.org.nz

Research Officer
Currently vacant
research@massagenewzealand.org.nz

STAFF

Executive Administrator
For all enquiries about MNZ functions and operations.

Nicole Hedges: 027 778 2954
admin@massagenewzealand.org.nz

General Administrator
For all enquiries about membership and CPD requirements.

Melissa Orchard: 0800 367 669
membership@massagenewzealand.org.nz OR
For enquiries about advertising through MNZ
advertise@massagenewzealand.org.nz

Accounts
Reina Reilly: (09) 432 1846
accounts@massagenewzealand.org.nz

NON EXECUTIVE POSTS

Magazine Editor
Carol Wilson: 027 281 3426
magazine@massagenewzealand.org.nz

Upper Nth Island Regional Coordinator
Annika Leadley: 021 025 79533
upperNIrep@massagenewzealand.org.nz

Lower Nth Island Regional Coordinator
Iselde de Boam: 021 044 8552
lowerNIrep@massagenewzealand.org.nz

South Island Regional Coordinator
Currently vacant

Iwi Liaison
Stanley Williams
iwi@massagenewzealand.org.nz

NZQA Liaison
Currently vacant

Education Sub-Committee
Pip Charlton, Bridie Munro

Publicity Sub-Committee
Natalie Dent, Crystal Golding, Rachel Ah Kit

Conference 2017 Sub Committee
Bridie Munro, Alison Wainscott, Rachel Dickinson, Agnes Sio-Atoa, Trevor Hamilton
conference@massagenewzealand.org.nz

MNZ
PO Box 4131
Hamilton East
Hamilton 3247
Phone: 0800 367 669

PRESIDENT'S AND EXECUTIVE REPORTS

PRESIDENT

This is my first report as President of MNZ and its been an extremely busy time. You'll have heard from me regularly as part of the "President's email" which I instigated at the beginning of the year. I hope you are finding it useful and informative.

I want you all to know about what's going on – I like a "no surprises" approach to matters and I want us all to feel like we're part of a collegial environment even though we usually work apart from one another.

There will be an element of repetition in light of the monthly emails you've been sent but to recap the past few months:-

We've said goodbye to Odette and welcomed Nicole as our new Executive Administrator. A new deal has been instigated with Bizcover replacing our former provider for Indemnity Insurance Cover. A deal with St John has been arranged to provide a small discount for First Aid and Refresher courses. We are working at improving deals with other key providers as well.

Membership renewals can be done online as well as conference registration. These are all as a result of the upgraded website. The magazine is now online with the ability to have links to websites. We are working at streamlining student memberships to make it easier for students to join.

We are in the process of updating our Strategic Plan and one of the key elements of this will be publicising Registered Massage Therapists.

There is a lot to do with just a small team of dedicated volunteers and two hardworking part-time staff. I would like to take this opportunity to thank Nicole and Melissa for their hard work and also to the members of the Executive Committee for stepping up to their tasks.

We will need volunteers to take on roles at our AGM so take this time to consider giving back to the profession of massage therapy by becoming an executive committee member.

Helen Smith

TREASURER

It was a sad occasion to say goodbye to Odette who has kept us on the straight and narrow for 14 months. But with one door closing another door opened and it was my pleasure to team up with our President Helen Smith to interview our shortlisted applicants and we decided on giving the job to Nicole Hedges. Welcome to the team, Nicole! The changeover was seamless and I look forward to working with you.

Our term deposit $15000 matured at the end of March and has been reinvested for 7 months special at 3.7% p.a. with ASB donating $25 to Starship Foundation. The budget is ready for the new financial year and with the lowered subscriptions plus the target to increase membership we will just break even for this coming financial year. That is a good start! With the lowered subscription rate and students renew at no cost we hope to increase our membership and therefore increase your profile in the public eye. It is a win-win.

A big step forward in helping our members to pay for their annual subscriptions, MNZ now offers direct debit payment plans. You can contact me on accounts@massagenewzealand.org.nz to discuss and set these up.

The accounts will shortly go to the Auditor for their yearly audit as per MNZ constitution. There is still a bit of work to be completed for this financial year including the filing of the GST however I endeavour to drop everything off at the beginning of May.

I am looking forward to catching up at the conference this year. It is a great opportunity to learn and network at the conference, so see you there!

Reina Reilly

VICE PRESIDENT

Hi everyone, with the changing of the seasons into Autumn I hope you're all keeping well and helping clients with their aches and pains as the weather cools down. It has been a busy three months since the new Executive Committee was appointed, most of us are new to our roles so it's quite a learning curve. I personally am finding it so rewarding giving back to our industry and continuing on with the work done previously at MNZ. We are really committed to promoting MNZ to massage therapists and students as a credible, professional and worthwhile association to be registered with; and also, to raise awareness of MNZ the massage industry in general.

Best regards,

Teresa Karam

EDUCATION OFFICER

As my first report as Education Officer from Massage New Zealand it is only fair to say that I have been on a very steep learning curve and have the utmost respect for the committee members that have come before. The work that they have done alongside the representatives from the various education providers has been huge and we are now seeing the results of this consultation in the form of the new Level 5, 6 and 7 qualifications. It is an exciting time for our profession as our new graduates are highly skilled which bodes well for continued recognition of the professionalism of the massage industry as a whole.

Over the next couple of months, the Education sub-committee will collaborate with the industry providers to ensure that our "scope of practice" levels are in line with what is being taught. We have also been kept busy with assessing RPL (recognition of prior learning) from applicants from overseas.

Rosie Greene

PUBLICITY OFFICER

The main objectives for the Publicity Sub-Committee are to promote the goals of Massage New Zealand, and strategize on publicising the organisation and the industry. Sub-Committee members are: Rachael Ah Kit, Crystal Golding, Natalie Dent.

SUMMARY OF RECENT ACCOMPLISHMENTS AND CURRENT ACTIVITIES:

We have been increasing the value of our Preferred Suppliers list (found here) to further benefit our members. So far this year, St. John has come aboard as our preferred First Aid provider, and we look forward to a long relationship with them. We believe that their professionalism and excellence in First Aid will continue to greatly benefit massage therapists.

Tui Balms, who have long been on our list, have increased their offer to MNZ members. This includes:

- A free 100g Balm of your choice with every order over $100net
- A 5% bulk discount on wholesale prices for orders above $400net.

To benefit from this deal, remember to quote your membership number and 'MassageNZ' when ordering. An email blast will be sent out shortly to inform members of this development.

We are currently in talks with more potential 'preferred suppliers', to work in closer partnership with, and create cross-promotional activities that benefit both parties, and MNZ members in particular. If you are aware of a massage therapy products-related business who might be interested in becoming a preferred supplier with us, let me know at publicity@massagenewzealand.org.nz.

We are also working on updating our Facebook page so it reaches more people, is more professional, and can synergize with people and groups who remain important to MNZ.

LIST OF ACTIVITIES IN PROGRESS AND UPCOMING EVENTS/ DISCUSSIONS:

I will now be attending the monthly meetings with AHANZ (the Allied Health Association of New Zealand), to further our presence and voice within this group, and to build greater bonds with other allied health professions. The hope is to encourage these professionals to understand the value that massage therapy offers, and how we can work together and promote the greatest health outcomes for our clients. As an affiliate member of this group, we are one of the few health professions who are not required to have mandatory membership, and I believe it is in the interest of the health community to have an alliance of professionals who see the value of having any MT's they work with being members of MNZ.

As the AGM and Annual Conference draw near, the Publicity Sub-Committee and I will be working with the Conference Committee to find methods of promoting the conference and AGM to therapists and other interested parties. There is a wonderful line-up this year, and we hope that we can gain momentum and interest among affiliated groups and other health care professionals, who may have a lot to gain from this experience.

Karley Skinner

REGIONAL LIAISON CO-ORDINATOR

I joined the Executive Committee at the end of last year in the role of Regional Co-ordinator. Since then, it's been a steep learning curve for me to get my head around what the Executive Committee does and all the different things that are going on.

I've had correspondence and phone calls with the two North Island Co-ordinators.

As I live in Christchurch and there's no South Island Co-ordinator at the moment, I rang new members who have joined

since September 2016 and it was encouraging to speak with those I managed to connect with. If you're interested in becoming the South Island Co-ordinator, let me know.

I'm keen for some groups to get up and running, particularly in Christchurch and Dunedin, but also in some of the regional towns. Please let me know if you would like to arrange a regular meet-up, it doesn't have to be every month, it could be a quarterly meeting. If you have a group already and meet regularly, please let us know too (if you haven't already done so). Meeting details can be posted on the MNZ Facebook page and in the quarterly magazine.

For those that live in an area that has regular meetings, I can only encourage you to attend as often as you can. The organisers make a huge effort to find interesting speakers and it's an easy way to accumulate your CPD hours. Its also a time to connect with other therapists and share ideas and experiences, particularly if you are working on your own.

If you have any ideas, concerns or queries, please feel free to contact me.

Donna Roy

EXECUTIVE ADMINISTRATOR

This is my first report in the role of Executive Administrator having taken over from Odette Wood at the end of March. I'm still in the process of familiarising myself with the position but really appreciate everyone's patience, supportive emails and assistance.

My experience is in administration and fundraising having most recently worked for the Cancer Society Otago/Southland Division. Last year I completed my Certificate in Stress Management and Spa Therapies (Level 5) and am continuing my studies this year for my Diploma in Advanced Therapeutic Massage. I have also recently started my own practice at a local gym and have begun building a small client base.

The reward and satisfaction I feel when being able to assist a client have relief from pain and more freedom of movement is one of the key reasons I am wanting to learn more about the benefits of massage.

My first month in my role at MNZ has been very busy with a lot of information and processes to digest. I have really enjoyed navigating around and getting up to speed with the new website and interacting with the Executive Committee members.

Massage New Zealand presents 'Reinventing Practice' at this year's pre-conference and conference on the 18-20th August in Wellington. Our hope is to offer you the chance to reflect, review and ultimately offer some inspiration to 'reinvent your practice'. Check out more details and guest speakers in the magazine or on MNZ website.

I'm sure you will enjoy reading the articles in this Q2 issue which I found very interesting including Timely's article on Self Care Tips for the massage therapist.

Winter has arrived in Dunedin here today and the fire will probably be on all weekend, a good opportunity to get some study done.

I look forward to meeting up with many of you at the Conference and AGM in Wellington on 19th and 20th August.

Nicole Hedges

REGIONAL ROUNDUP

UPPER NORTH ISLAND

Easy CPD hours, interesting topics and friendly faces... you really should go along to your next local MNZ networking meeting!

At Northland's March meeting held in Whangarei members drove from Kerikeri and Warkworth to attend, which was great to see. Louella Wood of Whangarei Natural Health introduced her Whangarei naturopathy practise to the group. She talked about a holistic approach to the body and explained how she works using blood tests, hair analysis and some genealogy training that she has just done. At their April meeting they had a nice get together learning about Subscapularis and at their May meeting the Iliopsoas muscle along with chair massage techniques were up for discussion.

Auckland had a dozen turn up for Dan Archer's talk at their February meeting including members and interested non members. He talked about the results of his research on standing desks and the benefits of working into the deep anterior neck flexors (longus coli and capitis) to help with posture correction and headache relief. Another meeting was held on the 1st of May with a demonstration by Alla Kalinina on 'Facing up to your emotions with Ukrainian Classical Facial Massage'. Classical Facial Massage is a traditional blend of ancient Japanese and Baltic modalities that delivers amazing visual outcomes and some real health benefits for your clients. Thank you to Mark Fewtrell for organising another couple of great talks.

There is a lot to oncology massage they discovered from Michelle Steward at Tauranga's February meeting. Georgia Meichtry mentioned after their meeting that she thought Michelle Stewart was clearly skilled and passionate about her work and after seeing her demonstrate her skills and talk about oncology massage she would be referring to her knowing that whoever was sent her way will be treated with best practice. Unfortunately the March meeting with planned guest speaker Marta Willis talking on pregnancy, birth and postnatal massage/treatments was cancelled due to low attendees. If you are in the Bay of Plenty region come along to the next meeting or get in contact if you have any suggestions or ideas for the meetings. Let's keep the momentum going.

In February, Hamilton had the pleasure of meeting Ros Broome author of "Rest; A Science and an Art" and a physiotherapist who has decades of experience plus medical evidence-based knowledge. She talked about how reducing muscle tension and controlling breathing can help you move from the sympathetic nervous system to parasympathetic nervous system. How 'chest breathers' cause neck and shoulder tension in their bodies and how by adjusting the way we breathe, we can help with that tension. She took everyone through a lovely relaxation and breathing exercise and everyone came out feeling well rested! The March meeting had Dr Steve Joe; GP turned applied kinesiologist and integrative medicine expert talk about his work. He explained about the importance of gut health and the affect of diet and toxins on the body plus the ways in which he tested the body for these.

Everyone who is involved in organising these local meetings and getting people to attend are very passionate and work hard to create a friendly, learning networking opportunity. This is such an easy way to keep informed and to clock up CPD hours, so get involved!

Annika Leadley

LOWER NORTH ISLAND

Wellington has started the year with an excellent interactive workshop run by Laurent Pang. It was sold out and with the enthusiastic direction of Trevor and Rob, the rest of the workshops this year are set up for high attendance, not to mention a perfect opportunity for some live 'social networking' and some delightful nibbles (because who doesn't love a good snack at the end of the day!?)

I've started calling new members in my region, so far having touched base with people in Hawkes Bay and the wider Wellington region but I'm yet to find any established (or would-be) Massage Therapists getting together. I would love to speak to anyone looking to set up activities and wanting some structure or ideas to contact me so I can share some of the secrets of success used here in Wellington. Also if I haven't called you yet but you have some Massage Therapists you are in regular contact with, let me know.

The only other thing I want to say is that there seems to be quite a buzz here in Wellington with a lot of local therapists getting involved in leadership roles within MNZ and a lot of people are either involved with conference organisation or discussing what workshops they'll be attending. In short, the community here seems very 'alive' compared to some previous years. Join us, be part of the buzz, we ARE the massage industry.

All the best

Iselde de Boam

If you have organised or been involved in a MNZ event in your area we would love to hear from you! Please email your Regional Roundup or What's On dates to: magazine@massagenewzealand.org.nz

WHAT'S ON...

DATE	WHERE/HOW TO REGISTER
Northland Massage Group:	**Contact:** Eva Van Gaalen 021 231 4975
Auckland Massage Group:	**Contact:** Mark Fewtrell www.markmassage.co.nz
Tauranga Massage Group	**Contact:** Annika Leadley uppernirep@massagenewzealand.org.nz for info
Hamilton Massage Group	**Contact:** uppernirep@massagenewzealand.org.nz
Wellington Massage Group	**Contact:** Iselde de Boam 021 044 8552 lowernirep@massagenewzealand.org.nz
Christchurch Massage Group	**Contact:** Volunteer required
Christchurch Foot Joint Mobilisation Course 30th June – 2 July	**Maree Gifkins** http://footjointmobile.co.nz/nz_courses.html
Wellington MNZ Preconference workshops Friday 18th August	**NZ College of Massage**, Manners St, Wellington https://www.massagenewzealand.org.nz/Site/conference/default.aspx
Wellington MNZ Conference workshops & AGM 19th - 20th August	**NZ Institute of Sport**, Westpac Stadium, Wellington https://www.massagenewzealand.org.nz/Site/conference/default.aspx
Auckland DermoNeuroModulation 24 – 27 August	**Diane Jacobs,** Canadian International Presenter 382-385 Manukau Road, Greenlane, Auckland 1023 https://www.massagecollege.ac.nz/courses-study/continuing-education-courses/
Auckland Dry Needling Course for RMTs August 25-27, 2017	**Dr Wayne Mahmoud,** Osteopath and Acupuncturist http://www.cpdhealthcourses.com

WHO'S WHERE

WELLINGTON

Absolute Therapy has moved to a new permanent home after the earthquakes at:

Level 1
36 Allen Street
above BNZ on Courtenay Place
Wellington CBD

Hours

MON – FRI: 8.00am to 8.00pm

SAT & SUN: 9.30am to 6.30pm

Phone: 04 801 8284

http://www.absolutetherapy.co.nz/

Our new signage should be up within the next month or so which will make us unmissable to anyone strolling down Courtney Place. Come and try our wide range of services.

Her Absolute Awesomeness
Ms Iselde de Boam

If you would like your profile and location advertised contact:

Carol Wilson
EDITOR
magazine@
massagenewzealand.org.nz

2017 MNZ ANNUAL **GENERAL MEETING**

massage new zealand

We are pleased to announce preliminary details of the AGM to be held in Wellington.

Please mark your calendars!

Please keep an eye out for more information about the AGM that we will be sending out.

DATE AND TIME: Saturday 19th August 2017 at 4.00 pm
VENUE AND LOCATION: Westpac Stadium (105 Waterloo Quay, Pipitea, Wellington 6140)

For any enquiries, please contact Nicole Hedges,
Executive Adminstrator admin@massagenewzealand.org.nz

DERMONEUROMODULATION: DEVELOPED BY DIANE JACOBS

By Jason Erickson, BCTMB, CPT, CES, CAIST, BBA, BA, AA

Dermo (skin) + neuro (nervous system) + modulation (change) = dermoneuromodulation (skin is a medium to interact with the nervous system and effect change).

The term "dermoneuromodulation" (DNM) was developed by Diane Jacobs, a Canadian physiotherapist specialising in pain science and the treatment of painful conditions. She was influenced by Dr. Ronald Melzack, who developed the "Neuromatrix" model that is now central to modern pain science, and by physiotherapist Michael Shacklock's work with the movement of nerves and nerve trunks. In 2007, Diane did a cadaver study that revealed how peripheral cutaneous nerves divide into rami connecting into the underside of skin. This suggested a new conceptual model for all approaches to manual therapy for people in pain:

For massage therapists, learning DNM is a paradigm change. It's not a modality based on a specific set of techniques, but rather a way of thinking more flexibly (and critically) about how to use the techniques we already know. The learner gains an updated knowledge of the nervous system, what causes pain, how to apply that knowledge in hands-on work, and better ways to educate our clients.

Pain may persist long after injury or danger have passed. If the nervous system relaxes, it may abandon these protective responses. This way of thinking encourages gentle approaches to help clients resolve pain, regain function, and feel better. It should be pain-free for client and therapist. It promotes relaxation, informs therapeutic work, and can be applied to all kinds of specific modalities.

From the spinal cord to the skin, nerves pass through small contiguous gaps, or "tunnels" through many tissue layers. These layers move and shift. Where nerves pass from one layer into the next, shear forces may impinge nerves to cause localized ischemia and nociception, often called tunnel syndromes. This may lead to pain, increased muscle tension, and other protective responses.

Moving nerves (neurodynamics) helps restore nerve health and function. Since tunnel syndromes often involve cutaneous nerves (found throughout the skin and subcutis), it should be possible to resolve most musculoskeletal pain by moving nerves attached to skin, i.e., by moving skin into which they are embedded from beneath. This may be done without pressure sufficient to deform or damage the underlying muscle, fascia or other soft tissues. Body positioning, skin stretching/gathering, and gentle movement may resolve discomfort from tunnel syndromes.

HOW DOES THIS WORK?

The skin layer is full of innervation, much of it right at the skin surface. Hilton's Law states: "The nerve supplying a joint supplies also the muscles that move the joint and the skin covering the articular insertion of those muscles." (Stedman's Medical Dictionary).

Mechanoreceptors adapt at different speeds and in different ways. Fast adaptors fire when they detect movement, then shut off until new movement restimulates them (e.g. motion detector). Slow adaptors remain turned on, transducing information and firing action potentials into the spinal cord the whole time a stimulus is operating, regardless of whether it moves or doesn't (e.g., bathroom scales).

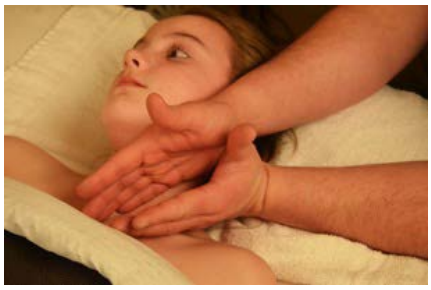
KEY IDEA: Use touch strategically. As therapist, give the skin's mechanoreceptor system as much slow, gentle, and continuous stimulation as possible without adding any more nociceptive input. This may alter the brain's perception of what is happening in that area of the body and stimulate a downregulation of pain/bracing protective responses. One simple way to do this is with skin stretch.

BASICS OF SKIN STRETCH

When we stretch skin, we are shifting tissue layers, the nerves embedded within them, and stimulating mechanoreceptors. Ruffini corpuscles are slow-adapting mechanoreceptors sensitive to skin stretch; their input to the brain may trigger a positive response: reductions in discomfort and excess muscular contraction.

The basic process:

1. Find a tender point.
2. Slowly draw the skin away from the tender point.
3. Multiple stretch vectors may be used as necessary.



Anterior Neck DNM

The concept of dermoneuromodulation informs my work with people suffering from chronic and/or complex pain problems, sports performance concerns, and chronic tension patterns. Educating people helps them manage their concerns and take steps towards improvement. We talk about it during intakes, and during sessions if

they wish. Many report a deep sense of relaxation. Most love how quickly pain and tension may dissipate. Athletes are pleased when their flexibility and strength improve. Clients for whom "regular" massage is contraindicated are happy when there are other approaches that may be safe and effective for them.

Dermoneuromodulation training is a great fit for massage therapists that wish to improve their understanding of pain and tension patterns and conditions. Spa-oriented massage therapists may find DNM to be a profoundly relaxing addition to their skill set, particularly for challenging clients.

For those who specialise in "medical", "orthopaedic", "sports", or other massage niche markets, DNM provides a powerful means of leveraging knowledge into real results, even with stubborn cases that previously failed to respond.

Diane Jacobs the founder of DNM will be at the preconference and conference workshops in Wellington 18-20 August 2017.

Jason Erickson has been part of the San Diego Pain Summit (SDPS), the International Massage Therapy Research Conference (IMTRC), and the AMTA National Conference.

His web site is www.HealthArtes.com, and he can be reached via JasonEseminars@gmail.com

massage new zealand

MASSAGE NEW ZEALAND'S 2017 CONFERENCE **"REINVENTING PRACTICE"** IS FAST APPROACHING!

Put the dates in your diary for Wellington:

Friday 18th August – Pre-conference (CBD).

Saturday/Sunday 19th and 20th August – Conference and AGM (Westpac Trust Stadium).

KEY PRESENTERS

Paul Lagerman – "Know Pain"

Diane Jacobs (Canada) – Dermo Neuro Modulation

Rosie Greene – Visceral Manipulation

TICKETS

Members: $450 for 2 day conference, $230 for pre conference workshop. See https://www.massagenewzealand.org.nz/Site/conference/default.aspx for more information.

CPD HOURS

Pre-conference 6 hrs, Conference 10 hrs, AGM 2 hrs (TBC).

See www.**massagenewzealand.co.nz** for more information as it becomes available.

Local Volunteers appreciated for support roles – contact **conference@massagenewzealand.org.nz**

DELIVERING PAIN EDUCATION

Paul Lagerman BSc NZRP MNZPS

INTRODUCTION

The clinical landscape regarding the management of persistent pain has changed. No longer can we understand pain as purely a physical sensation, as for several years now it has been classified as a sensory and emotional experience[1]. Yet many clinicians continue to treat pain as an input with the premise that treating the tissues will elicit change. Unfortunately, this often provides only a short-term result for people living with pain, resulting in feeling better but not actually getting better. Therefore, a contemporary paradigm shift in the understanding of pain from biomedical to biopsychosocial thinking is required. However, this carries many personal and professional challenges for individuals and clinicians[2].

People who live with pain present to a variety of healthcare professionals looking for the 'off switch'. A removal of the pain by treating the pathology. This draws comparisons from the infectious disease model – ridding the body of the infecting agent. Something like the common cold or bacteria. Unfortunately, pain is inherently more complex than this, and it does not necessarily present as a causal link to the injury. Therefore, it is important to provide a shared understanding of pain that supports the practice of all health professionals that have exposure to those who live with pain.

THE PRACTICE-BASED EDUCATOR AND COLLABORATIVE LEARNING

Due to the enormity of the biopsychosocial model and the complexity of pain there is a need for advanced communication skills. This allows clinicians to identify when medical language and metaphors may be confusing or potentially threatening[3, 4], and to use language that encourages individuals to engage in a "safe" movement program and/or learn to live well with pain[5].

Barker et al[3] identify several aspects of the communication exchange process that creates difficulties between clinicians and patients, including:

- Understanding the clinician and medical literature
- The use of jargon and medical models rather than patient-centered lay models
- Patients and clinicians appearing to define terms differently
- Misunderstandings amongst healthcare professionals that can arise

Therefore, there is a need to shift from medical and scientific terminology to a more simplified language that is understood by the person living with pain. This enables an enhanced collaborative learning dialogue between the clinician and individual, therefore facilitating the opportunity to make sense of persistent pain[6].

This is vital when we consider the unhelpful role that healthcare professionals often play in both the instigation and perpetuation of downward spirals into disability, anxiety and pain within our local population. Complex terminology and language explaining anatomy and pathoanatomy is usually a main culprit for this, and studies have shown that this is not an effective method for reducing pain and disability. Conversely this may have the opposite effect, increasing fear and perpetuating pain [9, 10].

In order to bring about a meaningful change in the way that we think about and explain pain to our patients, we must first focus on the education of clinicians from all backgrounds. Dreeben[7] highlights that patient education forms a 'significant component of modern healthcare'. Yet, Bolton[8] argues that 'educational skills are merely assumed in both practice and research.'

PERSISTENT PAIN IN NEW ZEALAND

We know that persistent pain is a real problem, and many people can't access help for it. In NZ, one in six adults have ongoing pain[11].

There is compelling evidence to show that both people living with pain and clinicians display an outdated and unhelpful understanding of pain. Unfortunately, this knowledge gap is one of the driving forces behind the current epidemic growth of persistent pain in western societies. This is further compounded by the poor clinical outcomes that conventional, passive interventions so often provide[12].

Within New Zealand and other western societies, we routinely see patients who have repeatedly and unsuccessfully used healthcare resources in an attempt to 'fix' their pain. Current models of treatment based upon outdated biomedical evidence continue to be a driving force for the perpetuation of persistent pain states.

People living with long term pain are often unable to make sense of pain and withhold themselves from participating in familial and social pleasures. As a clinician, it is vital to adopt a collaborative and

integrated approach to provide a reduction in an individual's sense of suffering and to facilitate a reconnection with life's pleasures.

The application of massage therapy has been shown to provide short-term effects for acute, sub-acute and persistent back pain[14]. Yet massage is an incredibly personal, social and mindful experience for the person living with pain. Massage has been shown to reduce pain and anxiety in cancer patients[15], ease pain in knee osteoarthritis[16] and reduce low back pain[17]. Moreover, Massage Therapists require a competent knowledge of anatomy and physiology, pathoanatomy and disease processes[13]. With a solid grounding in the biopsychosocial (BPS) model, and in partnership with other clinicians, Massage Therapists are in a strong position to create a shift in focus for the individual that lives with persistent pain.

The combination of the San Diego pain summit experience, my interest in pain, rehabilitation and communication has sparked a new drive to reach out and collaborate with clinicians inspired to make a difference with sufferers.

CONCLUSION

Collaborative pain education provides a means for all clinicians to effectively meet the demands of the biopsychosocial model, and more importantly, the needs of people living with persistent pain. Furthermore, it provides a sense of uniformity for the patient that could otherwise be confused by multiple opinions and mixed messages regarding the origin and treatment of their pain. A simplified approach to pain education delivery will prevent individuals from becoming disengaged and provide them with an opportunity to make sense of pain, thus promoting a sense of hope and restoring an internal locus of control. Through understanding an individual's coping style and educating in a way that is non-threatening, clinicians would be better equipped to respond to and deliver the evolving demands of the biopsychosocial model and contemporary pain science.

Paul Lagerman will be at the Preconference and conference workshops in Wellington 18-20 August 2017.

He is an Auckland based Physiotherapist working in pain management at Active +. He is an advocate of practice-based education and collaborative learning and provides education courses and seminars in pain management for all clinical disciplines.

He is the creator of the Naked Physio blog and Naked Physio podcast, and the course tutor of Know Pain NZ. Contact Paul on thenakedphysio@gmail.com

REFERENCES

1. Pain Taxonomy (2014). International Association for the study of Pain. Retrieved from www.iasp.org
2. Stewart, M. (2015). The assumption dilemma: do healthcare professionals have the teaching skills to meet the demands of therapeutic neuroscience education. Pain News. 13. (1).
3. Barker et al., (2009). Divided by a lack of common language? – a qualitative study exploring the use of language by health professionals treating back pain. BMC Musculoskeletal Disorders. 10:123
4. Greville-Harris, M & Dieppe, P. (2015). Bad is more powerful than good: The nocebo response in medical consultations. The American Journal of Medicine. 128, 126-129
5. Thompson, B.L. (2015). Living well with chronic pain : A classical grounded theory.
6. Cross V, Moore A, Morris J, et al. (2006). The Practice- Based Educator: A Reflective Tool for CPD and Accreditation. Chichester: John Wiley & Sons.
7. Dreeben O. (2010). Patient Education in Rehabilitation. Sudbury, MA: Jones & Bartlett.
8. Bolton G. (2010) Reflective Practice: Writing & Professional Development, 3rd edn. London: SAGE.
9. Morr S, Shanti N, Carrer A, Kubeck J, Gerling MC. (2010)Quality of information concerning cervical disc herniation on the internet. Spine J 10:350-4.
10. Greene DL, Appel AJ, Reinert SE, Palumbo MA. (2005). Lumbar disc herniation: evaluation of information on the internet. Spine. 30:826-9.
11. Dominick C, Blyth F, Nicholas M. (2011) Patterns of chronic pain in the New Zealand population. N Z Med J;124(1337)
12. Eccleston, C, Crombez, G. (2007). Worry and chronic pain: A misdirected problem solving model. Pain. 132 (3) 233-236.
13. Degree Course Programme (2016). New Zealand College of Massage. Retrieved from http://www.massagecollege.ac.nz
14. Furlan, A.D. et al., 2008. Massage for low-back pain. Cochrane Database Syst Rev, (4), p.CD001929. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=18843627.
15. Hughes, D. et al., 2008. Massage therapy as a supportive care intervention for children with cancer. Oncology nursing forum, 35(3), pp.431–42. Available at: http://www.ncbi.nlm.nih.gov/pubmed/18467292.
16. Perlman, A.I. et al., 2006. Massage therapy for osteoarthritis of the knee: a randomized controlled trial. Archives of internal medicine, 166(22), pp.2533–2538. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17159021.
17. Netchanok, S. et al., 2012. The effectiveness of Swedish massage and traditional Thai massage in treating chronic low back pain: A review of the literature. Complementary Therapies in Clinical Practice, 18(4), pp.227–234.

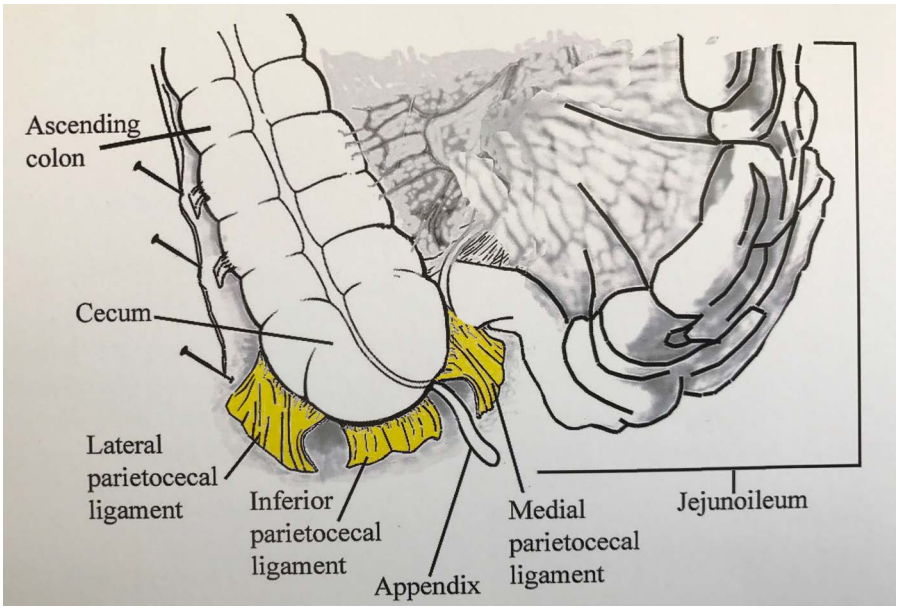
VISCERAL EXPLORATION
–LEARN MORE AT WELLINGTON CONFERENCE

by Rosie Greene RMT

Let us look under the skin, past the muscular layers that we are so familiar with and delve into the world that is governed by the autonomic system, the organ system – the lungs, heart, stomach, liver, kidneys and the intestines. This is the world that is constantly monitoring every part of our being - adapting and compensating. It is a world of which we are completely unaware until it stops functioning in an optimal fashion. It is a world that can be the cause of many common symptoms that we treat on a daily basis - chronic lower back pain, neck and shoulder issues. Visceral Manipulation is a therapy that can access this world and make profound changes to the musculoskeletal system.

There are many reasons for an organ to lose its mobility, such as physical trauma, surgeries, infections, sedentary lifestyle, pregnancy, or a poor diet. When an organ is no longer freely mobile, but is fixed to another structure, the body is forced to compensate. This disharmony creates fixed, abnormal points of tension and the chronic irritation gives way to functional and structural problems throughout the body. As therapists we may focus on the container without giving thought to the contents or how they can impact the structures of the container.

If we consider the large intestine – the beginning of the large intestine is the caecum – which is located just above the ASIS on the right in the lower right quadrant of the abdomen. The ascending colon runs from here to its attachment point on the 10th rib on the right and then becomes the transverse colon. which loops across the abdomen to be attached at the splenic flexure on the 8th rib on left. It then continues inferior as the descending colon on the left lateral aspect of the abdomen, to be renamed as the sigmoid colon at about the level of the ASIS before becoming the rectum.



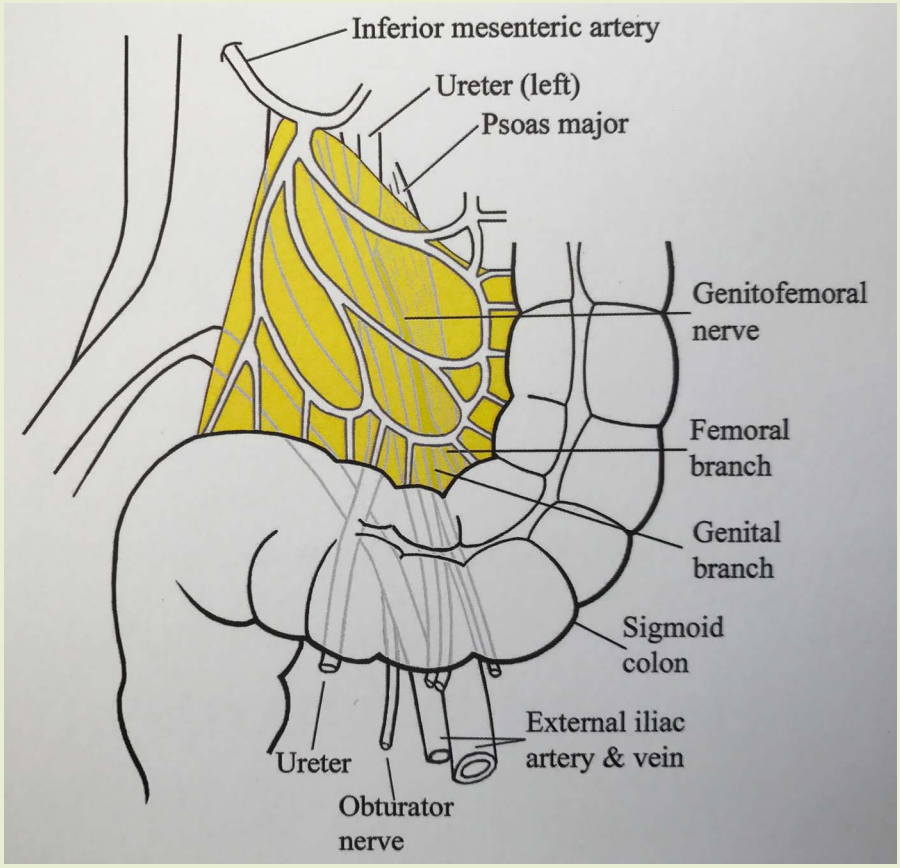
Caecum and associated structures (Barral & Mercier, 2005)

Any time there is a spasm in the large intestine it may affect the structures with which it comes into contact. As Massage Therapists, the symptoms we could encounter if there is tension within the large intestine, include an adaptive shortening of the psoas, tension in the quadratus lumborum and the lower ribs, right sacroiliac issues or left sacral torsion. Due to the neurovascular structure that passes directly posterior to the large intestine there may also be issues with the hip, knee or foot. These may not be fully resolved until the mobility of the large intestine is restored.

When participating in post-mortems, Barral was able to follow patterns of stress in the tissues of his former patients as he studied their biomechanics whilst they were still living. This introduced him to the visceral system, its potential to promote lines of tension within the body. This led to his development of the form of manual therapy, which focuses on the internal organs, their fascial environment and the potential influence on structural and physiological dysfunctions. The term he coined for his therapy was "Visceral Manipulation".

In our training as Massage Therapists, the focus of our education is on the musculoskeletal system – often the structures posterior to the spine. Visceral manipulation offers a method for assessing and treating structures anterior to the spine that may have a profound effect on reducing muscular tension. Barral has found with his 40 years of clinical experience that a majority of musculoskeletal problems have a visceral component (Barral & Mercier 2007).

The initial training I had at the Canterbury College of Natural Medicine gave me the tools, both academic and palpation, to be able to embark on my journey with Visceral Manipulation. I cannot imagine my practice without this treatment method. I hope that some of you are inspired to study this work as it does have some amazing results. The people who benefit are our patients and they are our biggest teachers. The



Sigmoid colon area (Barral & Mercier, 2005)

profound changes I see in my patients are the driving force behind my ongoing quest for knowledge and understanding of the complexities of the human body. The last two years has seen me undertake a grueling apprenticeship program to become the first Australasian Instructor and one of only three instructors in the southern hemisphere.

I am passionate about my work and see people of all ages, from newborns with reflux, to my loyal octagenerians, teenage boys with their love of all things physical, women dealing with a myriad of pelvic issues, people who have suffered from whiplash or concussion, to people with chronic digestive issues or post surgical complications and everything in between.

Every body has tissues that deserve to be 'listened' to and gently encouraged back to homeostasis.

Rosie Greene will be at the preconference workshops and the conference in Wellington 18-20 August 2017.

She is a Visceral Manipulation Instructor for the Barral Institute, and now teaches both in New Zealand and internationally. She is the Education Officer for Massage NZ.

Her website is www.rosiegreene.co.nz and can be contacted at rosie@rosiegreene.co.nz

REFERENCE LIST

Barral, J. P. (1991). The thorax. Seattle: Eastland Press.

Barral, J. P. (1993). Urogenital manipulation. Seattle: Eastland Press.

Barral, J. P., & Croibier, A. (1999). Trauma: An osteopathic approach. Seattle: Eastland Press.

Barral, J. P. (2005). Manual thermal evaluation. Seattle: Eastland Press.

Barral, J., & Mercier, P. (2005). Visceral manipulation. Seattle: Eastland Press.

Barral, J. P., & Mercier, P. (2007). Visceral manipulation II. Seattle: Eastland Press.

Barral Institute (2016) Visceral connective tissue support system pocket guide, Barral Productions, Florida

SELF-CARE FOR THE HIGH PERFORMING MASSAGE THERAPIST

by Hanna Morley and Theo Wallis

Like athletes whose sport is their livelihood, Massage Therapists rely on high-performing bodies. We might not be sprinting around or ducking any punches, but to do our job efficiently, enjoyably and without injury, we still need to think of our bodies as athletic tools, and care for them accordingly.

Integrating a warm-up, a cool-down, the principles of progressive loading, and resetting your mechanics throughout the day will give you great return on investment. If you want to do a physical job like massage for the long term (and love it) you need to focus back in on yourself and start making self-care a habit, not a treat.

WHY WARM UP?

Realistically, we may not need to warm up as thoroughly or for as long as Serena Williams or Misty Copeland, but the core principles are still the same.

There are quite a few benefits to warming up. We consider it an important preparation to our day because it may allow us to:

- get our tissues gliding
- make sure we are operating at our full range of motion
- check our joint positioning for the upcoming activities

This increases the efficiency of our body while we work, and reduces risk of injury[4]. Ultimately, warming up thoroughly will result in being able to work harder, for longer.

As Massage Therapists, we must take care of our hands and forearms. We should also be checking that our shoulders and upper body are well-positioned. Hip and lower body mobility is also vital. You want to ensure your pelvis has the ability to maintain a balanced, strong position while we work.

There are lots of postural adjustment and stretching options that are useful to integrate into your warm up. It's important to do your own research and construct a warmup that works for you.

Theo demonstrates self massage for the forearms, as well as the "Superman Adjustment" a postural corrective exercise for shoulder positioning and pelvic tilt in this link.

https://www.youtube.com/embed/iZmaYqeAbZo

RESET BETWEEN CLIENTS

It's easy to want to squeeze in clients back-to-back – we get it! We all have bills to pay. However, giving yourself a few opportunities to re-set throughout each day is vital for the longevity of your career. Resetting your body between sessions will help you to maintain strong positioning, and good posture. Good posture and strong positioning will in turn allow you to do your job better, and more comfortably.

Schedule in enough breaks throughout the day to unwind, reset and refuel your body – you want to be a role model to your clients, not the Massage Therapist that needs a massage! If you can, build a few extra minutes at the beginning and end of each appointment slot for your reset. The core principles of resetting between clients are the same as your initial warm-up, so you should notice results using the same exercises.

COOLING DOWN

If you've had a full schedule, you know how physically exhausted your body can be. Cooling down is just as important as your warm up, and re-setting exercises. Don't shoot out the door towards home before you've gotten your cool-down in! The idea of cooling down is to reset your body back to a good position after a day under load. Your muscles will be less likely to tighten up and stagnate. Paterson and Renstrom (2016) discuss that stretching after exercise is an effective way to increase flexibility, which reduces tension and resistance in muscle tissue. We might know all of these things – but we still need to practise what we preach.

Spend time winding down at the end of your treatments with a few well targeted static stretches, postural adjustment exercises and flush your forearms with self-massage. This is the perfect opportunity to include some preventative exercises. A consistent exercise programme will enable you to deliver the very best treatment without the risk of developing an overuse injury. Take the time to strengthen the wrists and forearms with a combination of heavy slow resistance training and eccentric exercises[1,2,8,14]. Try including 3 sets of 15 repetitions in your cool-down routine and see if you notice results[14]. Overall, a smart cool-down routine will prep your body for the next day, so you're ready to take on another full calendar of clients. Give it a try!

PROGRESSIVE LOADING AND REST DAYS:

It is important to keep your workload tolerable. You will burn out if you go too hard too fast (without warming up your own body), and if you schedule in back-to-back appointments. Remember to match any increase in loading with an increase in rest and recovery [8,9]. If you are new to massage, or have had a break from work, build your endurance slowly by spacing out appointments intelligently, as well as taking rest days every week – two in a row if possible. Build the break time in your schedule, so that you're not accidentally taking too many bookings.

Progressive loading will give your body time to adapt to stresses without the risk of overuse injuries[8,9]. If your forearms are

feeling sore get immediate relief with mid-range isometric holds to soothe painful tendons[3,13].

A NOTE ON HYDRATION

As a therapist, your attitude, mood and energy levels have a direct impact on your clients – if you're feeling tired, they will feel it. Staying well hydrated throughout the day aims to keep you feeling fresh and help you stay positive. There are proven benefits to staying hydrated, and many of these are vital for us massage therapists[6]:

- water transports nutrients to your cells and waste products out of the body – this will keep your tissue healthy.
- Hydration ensures good joint health, as the cartilage lining these is made up of 65-80% water[11].
- Staying hydrated may help combat fatigue. If your cells are dehydrated, they may not have energy to function.
- Hydration may also improves cognitive function, keeping you focussed and alert[10].

Alert, full of energy, mobile and healthy: making sure you're drinking water regularly is definitely worth the effort.

CONCLUSION

Self-care is vital in massage therapy. Being smart about taking care of yourself is not only vital for your own well-being, but it's vital for the wellbeing of your business. An unhappy, worn-out therapist is unable to effectively treat clients. At The Muscle Mechanics, we work hard to practice self-care. Because of this, we're able to comfortably perform upwards of 30 hours of deep tissue and sports massage, over 5 days a week.

Practising self-care makes for a happier workplace, and a more lucrative business. Good self care gives you longevity, meaning you can treat more patients to the best of your ability. Clients know when you are putting in your best effort, and when you're not. Be sure that part of that effort is going towards yourself.

Hanna Morley and Theo Wallis are Timely Ambassadors and Sports Massage Therapists based at The Muscle Mechanics in Dunedin. They share a passion for improving how humans feel and perform through restoring functional movement and rehabilitating soft tissues.
www.themusclemechanics.co.nz

REFERENCES:

1. Stasinopoulos, D. and Stasinopoulos, I., 2017. Comparison of effects of eccentric training, eccentric-concentric training, and eccentric-concentric training combined with isometric contraction in the treatment of lateral elbow tendinopathy. Journal of Hand Therapy, 30(1), pp.13-19.
2. Cullinane, F.L., Boocock, M.G. and Trevelyan, F.C., 2014. Is eccentric exercise an effective treatment for lateral epicondylitis? A systematic review. Clinical rehabilitation, 28(1), pp.3-19.
3. Rio, E., Kidgell, D., Purdam, C., Gaida, J., Moseley, G.L., Pearce, A.J. and Cook, J., 2015. Isometric exercise induces analgesia and reduces inhibition in patellar tendinopathy. British journal of sports medicine, 49(19), pp.1277-1283.
4. Peterson, L. and Renstrom, P.A., 2016. Sports Injuries: Prevention, Treatment and Rehabilitation. CRC Press.
5. Page, P. (2010). A NEW EXERCISE FOR TENNIS ELBOW THAT WORKS! North American Journal of Sports Physical Therapy : NAJSPT, 5(3), 189–193.
6. Potgieter, S., 2013. Sport nutrition: A review of the latest guidelines for exercise and sport nutrition from the American College of Sport Nutrition, the International Olympic Committee and the International Society for Sports Nutrition. South African journal of clinical nutrition, 26(1), pp.6-16.
7. McCrary, J.M., Ackermann, B.J. and Halaki, M., 2015. A systematic review of the effects of upper body warm-up on performance and injury. British journal of sports medicine, 49(14), pp.935-942.
8. Harris-Love, M., Seamon, B.A., Gonzales, T.I., Hernandez, H.J., Pennington, D. and Hoover, B.M., 2017. Eccentric Exercise Program Design: A Periodization Model for Rehabilitation Applications. Frontiers in Physiology, 8, p.112.
9. Hough, P., 2016. Long-term training programme design (periodisation). Advanced Personal Training: Science to practice.
10. Masento, N.A., Golightly, M., Field, D.T., Butler, L.T. and van Reekum, C.M., 2014. Effects of hydration status on cognitive performance and mood. British Journal of Nutrition, 111(10), pp.1841-1852.
11. Popkin, B. M., D'Anci, K. E., & Rosenberg, I. H. (2010). Water, Hydration and Health. Nutrition Reviews, 68(8), 439–458. http://doi.org/10.1111/j.1753-4887.2010.00304.x
12. NICE:The National Institute for Health and Care Excellence (2015) NHS England Guidance. Commissioning Excellent Nutrition and Hydration. Accessed 28th February 2017: https://www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf
13. van Ark, M., Cook, J.L., Docking, S.I., Zwerver, J., Gaida, J.E., van den Akker-Scheek, I. and Rio, E., 2016. Do isometric and isotonic exercise programs reduce pain in athletes with patellar tendinopathy in-season? A randomised clinical trial. Journal of Science and Medicine in Sport, 19(9), pp.702-706.
14. Beyer, R., Kongsgaard, M., Hougs Kjær, B., Øhlenschlæger, T., Kjær, M. and Magnusson, S.P., 2015. Heavy slow resistance versus eccentric training as treatment for Achilles tendinopathy: a randomized controlled trial. The American journal of sports medicine, 43(7), pp.1704-1711.
15. Kongsgaard M, Qvortrup K, Larsen J, Aagaard P, Doessing S, Hansen P, Kjaer M, Magnusson SP. Fibril morphology and tendon mechanical properties in patellar tendinopathy: effects of heavy slow resistance training. Am J Sports Med. 2010 Apr;38(4):749-56

SUPPORTING THE LGBTQ COMMUNITY THROUGH MASSAGE PRACTICE

by Karley Skinner

It was recently bought to my attention that massage therapy Client Information forms can be tricky to navigate for some members of the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community, particularly for transgender or gender non-conforming clientele. This issue was raised to me by a client (a spokesperson for the Public Service Association), in response to my own client forms which ask a person to circle 'M' or 'F'.

This client pointed out several points:

- Information that is not specifically needed should not be collected;
- "We have always done this" is not a good enough reason to collect this information;
- 'M' or 'F' is too narrow and ignores those whose gender identity is neither of those options.

This matters specifically in the massage therapy profession as we are uniquely positioned as a touch therapy that usually requires people to undress. A few reasons to pay attention to this issue are:

- Massage puts people in a vulnerable position, where they are in underwear or naked, and are usually in pain, and we need to be compassionate and proficient when dealing with clients' vulnerabilities.
- Transgender members of the community are hurt by sincere people with unaddressed assumptions about gender just as often as open hostility.
- The LGBTQ community face high rates of discrimination and harassment, even from health practitioners.
- More people should benefit from massage therapy; removing barriers between potential clients and the wonderful skills of massage, is a benefit to our community and our profession (Haines, 2016).

It is recommended for health forms to only collect information that is being used for something, and it may be time for all MNZ therapists to analyse their intake forms for unnecessary questions.

If you do believe the question of gender is necessary for your practice (i.e, for marketing purposes, you work at a medical practice, or your client management system requires the information) a more appropriate question is to ask for Gender Identity, as opposed to Sex or simply Gender. This will also identify to clients that your practice has some awareness of the issues with collecting the information.

A more comprehensive list could be:

What is your gender identity? (please tick all that apply)

Female ☐

Male ☐

Transgender man / Transman ☐

Transgender woman / Transwoman ☐

Genderqueer / Genderdiverse ☐

Additional identity (fill in)

.....

However, unless there is a real need to collect this information, it may be best not to request it at all. As a professional body, MNZ aims to support the LGBTQ community by ensuring that our members are aware of best practices and potential areas of discrimination, and to avoid the repercussions of accidentally or deliberately discriminating against clientele.

By eliminating barriers to massage therapy as a treatment, the LGBTQ community can rest assured that MNZ practitioners will not offer up judgement, or pursue probing or uncomfortable questioning.

For clarification, below are some commonly used terms, as outlined by the Centre of Excellence for Transgender Health (2017):

- **GENDER IDENTITY:** A person's internal sense of self from a gender perspective.
- **SEX:** The assigned sex at birth, based on genitalia, chromosomes and gonads (Female, Male or Intersex). This is often used interchangeably with Gender, however the differences become important in the context of transgender people.
- **GENDER EXPRESSION:** The visible way in which a person displays their gender. Gender identity and gender expression may differ; e.g. a woman (transgender or non-transgender) may have an androgynous appearance, or a man (transgender or non-transgender) may have a feminine form of self-expression.
- **TRANSGENDER:** A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to trans. A transgender man is someone with a male gender identity and a female birth assigned sex; a transgender woman is someone with a female gender identity and a male birth assigned sex. A non-transgender person may be referred to as cisgender (cis=same side in Latin).
- **GENDER NONCONFORMING:** A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person. Genderqueer is another term used by some with this range of identities.
- **NONBINARY:** transgender or gender nonconforming person who identifies as neither male nor female.
- **TRANS-MASCULINE/ TRANS-FEMININE:** Terms to describe gender nonconforming or nonbinary persons, based on the directionality of their gender identity. A trans-masculine

person has a masculine spectrum gender identity, with the sex of female listed on their original birth certificate. A trans-feminine person has a feminine spectrum gender identity, the sex of male listed on their original birth certificate.

- **THEY/THEM/THEIR:** Neutral pronouns used by some who have a nonbinary or nonconforming gender identity.
- **TRANSSEXUAL:** A more clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation. Term is less commonly presently.
- **CROSS DRESSER / DRAG QUEEN / DRAG KING:** These terms generally refer to those who may wear the clothing of a gender that differs from the sex which they were assigned at birth for entertainment, self-expression, or sexual pleasure. Some cross dressers and people who dress in drag may exhibit an overlap with components of a transgender identity. The term transvestite is no longer used in the English language and is considered insulting.
- **SEXUAL ORIENTATION:** Describes sexual attraction only, and is not directly related to gender identity. The sexual orientation of transgender people should be defined by the individual. It is often described based on the lived gender; a transgender woman attracted to other women would be a lesbian, and a transgender man attracted to other men would be a gay man.

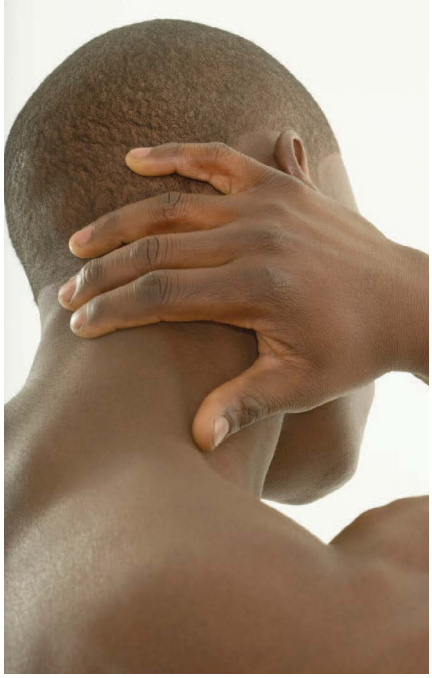
REFERENCES

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People: Terminology and definitions. (2017). Transhealth.ucsf.edu. Retrieved 2 May 2017, from http://transhealth.ucsf.edu/trans?page=guidelines-terminology

Haines, A. (2017). Supporting Transgender Clients, Part 2: Doing Better. Massage Business Blueprint. Retrieved 2 May 2017, from https://www.massagebusinessblueprint.com/supporting-transgender-clients-part-2-better/

UNCOUPLING THE NECK AND JAW

By Til Luchau



If you place your hand on the back of your neck and open your jaw wide, what do you feel? Does your neck extend slightly? Do your neck muscles contract a bit when your jaw drops?

If so, you're likely feeling what Moshé Feldenkrais called "parasitic contraction"—habitual muscle activity and tension not necessary for the movement being performed[1]. Of course, I wouldn't suggest using the term "parasitic" when talking to your clients about their movement (it's a creepy word, and as therapists, it's good to remember that our language has the power to shape our clients' body sense, in both helpful and unhelpful ways). The point is, in normal circumstances you don't need to tighten or extend your neck in order to open the jaw. Using these extra muscles actually takes more effort, and just adds tension to an area that usually has plenty of that already. There are many examples of these unnecessary and inefficiently paired movements in the body—the shoulder might lift when the arm reaches; the eyebrows arch when singing loudly; the jaw clenches when opening a jar. There may be a reason for these pairings, in certain situations—extending your neck when opening the jaw can help you open a bit wider, for example; but to the extent that these patterns become unconscious, automatic, and habitual, they can cost us in lost movement efficiency and ease.

Paired movements of the jaw and cervicals are very common—in one small but often-cited study, all participants' necks extended with jaw opening (and to a lesser extent, flexed with jaw closing).[2] That study's authors speculated that this coupling was related to the jaw and neck's shared innervation via the trigeminocervical nucleus in the upper cervical spine. But we should be clear that shared innervation doesn't have to mean "automatically and always linked"; we differentiate the movements of structures with shared innervation whenever we refine our movement skill. For example, the thumb, and the first, and second fingers are all innervated by the median nerve, but can easily learn to operate independently in complex and refined ways, such as in typing, playing a musical instrument, or performing a manual therapy technique. Likewise, we can also learn to move our jaw independently of our neck; the posterior cervical muscles do not need to contract in order to open the jaw. Try it yourself: return your hand to the back of your neck, and practise letting your jaw gently fall open while your neck stays relaxed and long. Allow your tongue to soften (because interestingly, cervical motion can be inhibited by tongue position)[3] Make sure your shoulders are relaxed, and your breathing is easy. Most people find it is much easier to open the jaw when these other structures are relaxed.

THE JAW/CERVICAL TECHNIQUE

We use the Jaw/Cervical Technique as a way for clients with neck or jaw issues to practise new movement options. This technique uses gentle pressure to increase awareness of the muscles and deepest structures of the posterior neck and since neck tension, jaw tension, and the above mentioned trigeminocervical nucleus are each implicated in cervicogenic (neckrelated) headaches, migraine headaches, and temporomandibular joint disorders.[4] This technique can be a useful and relevant self-care tool for clients dealing with any of these common complaints, or for each of us whose necks or jaws are sometimes more tense than needed. Why not take another second right now to let your own jaw gently fall open once more, as the back of your neck remains long, easy, and relaxed.

Indications

- Cervical extension or muscular contraction with jaw opening, especially when accompanied by
- Neck tension, pain, or movement restriction
- Jaw tension or pain; temporomandibular joint dysfunction (TMD)
- Headaches (both tension and migraine)

Purpose

- Refine proprioceptive awareness of any jaw/neck movement coupling
- Increase self-care options for practicing relaxed and easy jaw movement

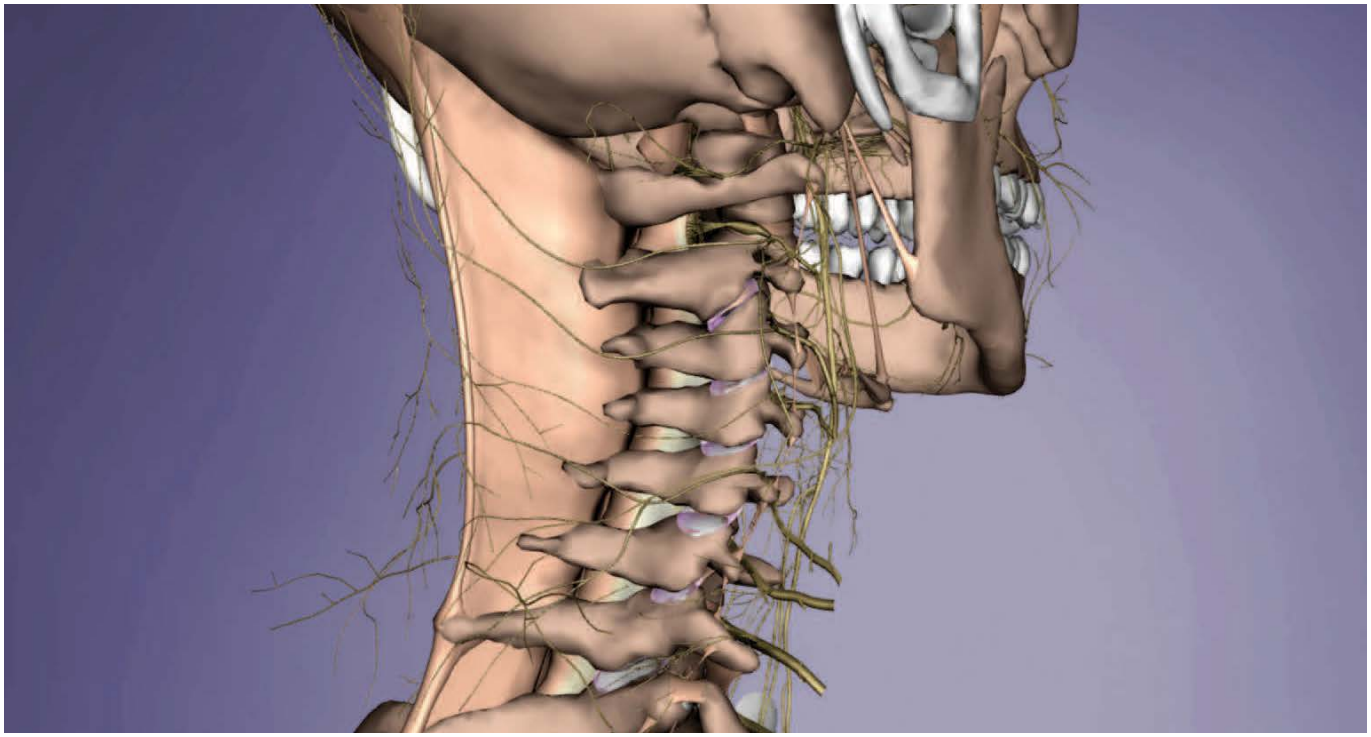


Image 2 The ligaments and facet joint capsules of the posterior neck can also be gently palpated during active jaw depression, helping clients feel any movement at the deepest and most subtle levels. Image courtesy Primal Pictures, used by permission from Til Luchau to reprint in NZ

Instructions

- Use your fingertips to gently feel for any posterior neck involvement in slow, active jaw opening (see images below).

In the Jaw/Cervical Technique, gentle,

Images courtesy Advanced-Trainings.com.

specific touch is used to help refine the client's proprioception. When your client opens their jaw, feel for contraction or extension in the posterior neck. Use verbal and tactile cues to help the client discover a way to let the jaw open without cervical extension or contraction.

- Check movement with the client's head and neck in a neutral position, as well as in fully rotated positions.
- If you find neck extension or contraction with jaw depression, help your client feel this, too, by directing their attention to these sensations with your words and your touch. Use gentle, but specific pressure into any areas of contraction or extension in order to further increase your client's proprioception.
- Offer proprioceptive cues such as: "Just allow your jaw to fall open as your neck stays relaxed," "Let your shoulders, tongue, and neck soften as you move," "Let it move even less. Can your jaw move a little before your neck tightens?"
- Repeat in a seated or standing position; offer as client self-care homework and practice.

Considerations

- Keep jaw-opening within the client's comfort range.
- Use your touch to help the client feel their unneeded movement or tension, rather than trying to rub or manipulate any tight muscles you find. Keep in mind that this is a reeducation technique, rather than tissue manipulation.
- Slow, focused, small, active movements will often be more effective than large, fast movements.
- Not everyone has coupled jaw/neck motion. Repeat the test in various positions, but if no coupling is found, this technique is not indicated.
- Many jaw problems resolve on their own after a few months of stress reduction and self-care. (5) Chronic or severe temporomandibular joint disorder (TMD) sufferers can benefit from a combination of methods, which together offer physical, educational, psychological, and social support.

For More Learning

- "Neck, Jaw & Head," "TMJ & Jaw Issues," or "Whiplash" in the Advanced Myofascial Techniques series of workshops and video courses.
- Advanced Myofascial Techniques, Vol. 2, chapters 11–13, "Cervical Issues." (Handspring, 2016)

BIO

Til Luchau is a Certified Advanced Rolfer, the author of Advanced Myofascial Techniques (Handspring Publishing, 2016) and a member of the Advanced-Trainings.com faculty, which offers distance learning and in-person seminars throughout the United States and abroad. He welcomes questions or comments via info@advanced-trainings.com and AdvancedTrainings.com's Facebook page.

Watch Til Luchau's technique videos and read his past articles in Massage & Bodywork's digital edition, available at www.massageandbodyworkdigital.com, www.abmp.com, and on Advanced-Trainings.com's Facebook page.

Originally published in Massage & Bodywork magazine, reprinted by permission of the author.

REFERENCES/NOTES

1. Todd Hargrove, Better Movement, "The Skill of Relaxation," September 23, 2008, accessed March 2017, www.bettermovement.org/blog/2008/ the-skill-of-relaxation. www.bettermovement.org/blog/2008/the-skill-of-relaxation.
2. P. O. Eriksson, H. Zafar, E. Nordh, "Concomitant Mandibular and Head-Neck Movements During Jaw Opening-Closing in Man," Journal of Oral Rehabilitation 25, no. 11 (November 1998): 859–70.
3. J. Chew (Producer), "Cervicogenic Headache with Toby Hall," audio podcast, October 2, 2016, http:// chewshealth.co.uk/tpmpsession34/; M. J. Ellis, J. J. Leddy, and B. Willer, "Physiological, Vestibulo-Ocular and Cervicogenic Post-Concussion Disorders: An Evidence-Based Classification System with Directions for Treatment," Brain Injury 29, no. 2 (2015): 238–48; D. M. Biondi, "Cervicogenic Headache: A Review of Diagnostic and Treatment Strategies," The Journal of the American Osteopathic Association 105 (April 2005): 16S–22S.
4. Prin Chitsantikul and Werner J. Becker, "Treatment of Cervicogenic Headache: New Insights on the Treatment of Pain in the Neck," Canadian Journal of Neurological Sciences 42, no. 6 (2015): 357–359; Simon Akerman, Bruce Simon, Marcela RomeroReyes, "Vagus Nerve Stimulation Suppresses Acute Noxious Activation of Trigeminocervical Neurons in Animal Models of Primary Headache," Neurobiology of Disease 102 (2017): 96–104; José G. Speciali and Fabíolam Dach, "Temporomandibular Dysfunction and Headache Disorder," Headache: The Journal of Head and Face Pain 55, no. 1 (2015): 72–83.
5. TMJ Association, "TMJ Science Overview," January 7, 2016, accessed March 2017, www.tmj.org/Page/51/32.

CALL FOR REMITS

Massage New Zealand is now calling for remits to be tabled at the Annual General Meeting to be held in Wellington on Saturday 19th August 2017.

If you would like to request a change to the Constitution please submit your request as outlined below, including a rationale.

REMIT: That Clause (give clause number) of the Constitution be amended to read as follows:

"GIVE YOUR SUGGESTED NEW WORDING FOR THE CLAUSE".

Rationale:

Give the reason you feel the existing Clause needs changing and the reason your suggested new clause will be an improvement.

Due date: All remits must be received by 17th June, 2017.

Sending remits: Remits must be sent to the Executive Administrator at: admin@massagenewzealand.org.nz

Or if you are posting a remit please send it to:

Executive Administrator
Massage New Zealand
PO Box 4131
Hamilton East 3247
HAMILTON

MNZ SURVEY OF NON AND EX-MNZ MEMBERS

by Helen Smith, President MNZ

Thank you very much to Karley Skinner, our Publicity Officer, who organised the survey of non and ex-MNZ members and collated the information gathered from 100 responders. The results of the survey are an interesting mix of opinions with some misunderstandings and misinformation evident.

The primary barriers to joining Massage New Zealand (MNZ) were cost and Continuing Professional Development (CPD) requirements – MNZ has already attempted to address this by lowering the joining fee and making it easier to fulfil CPD requirements.

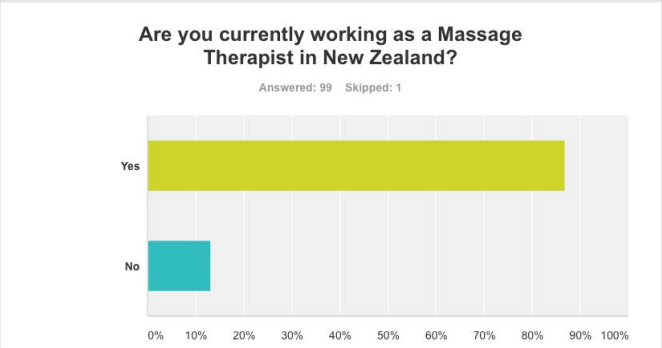
Another point raised is that those with a degree level qualification didn't feel sufficiently recognised. MNZ has to balance this with the skills and expertise gained by those who have worked in the industry for a long time and have acquired a lot of knowledge which they bring to their practice. MNZ will be looking into how to give recognition to those with 'speciality' training.

Some non and ex-MNZ members didn't realise that we have a vibrant Facebook page which connects everyone who follows us with information about what's happening at MNZ. This includes research undertaken, changes to member benefits such as monthly payment options now being available for membership renewal, changes to CPD requirements to make it easier for those working part time and reducing student membership rates to $0 with a reduced rate for the first year of practise. You don't have to be a member to "like" us on Facebook and this will keep you in touch with what's happening.

Many of the points raised are issues that MNZ is fully aware of and is endeavouring to address. Thanks to everyone who took the time to respond. We will be contacting those shortly who asked for more information.

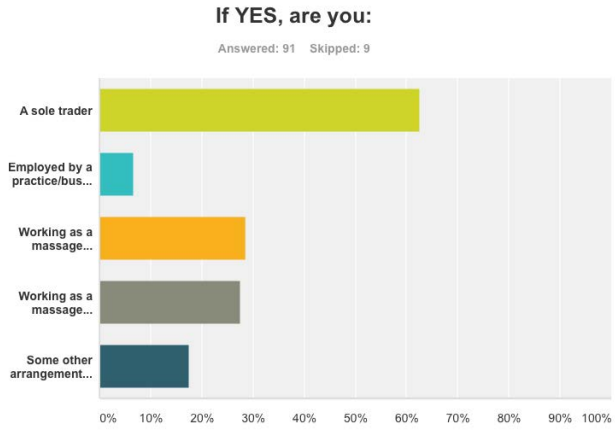
See below for specific replies

Q1.



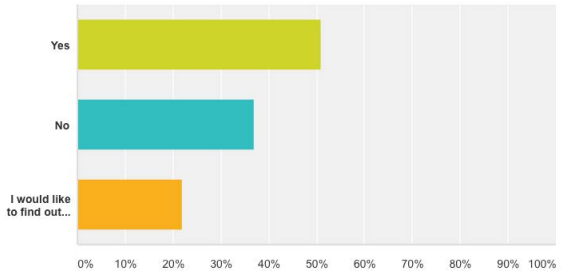
Answer Choices	Responses	
Yes	86.87%	86
No	13.13%	13
Total		99

Q2.



Answer Choices	Responses	
A sole trader	62.64%	57
Employed by a practice/business	6.59%	6
Working as a massage therapist on average <10 hrs a week	28.57%	26
Working as a massage therapist on average >10 hrs/week	27.47%	25
Some other arrangement (please specify) Responses	17.58%	16
Total Respondents: 91		

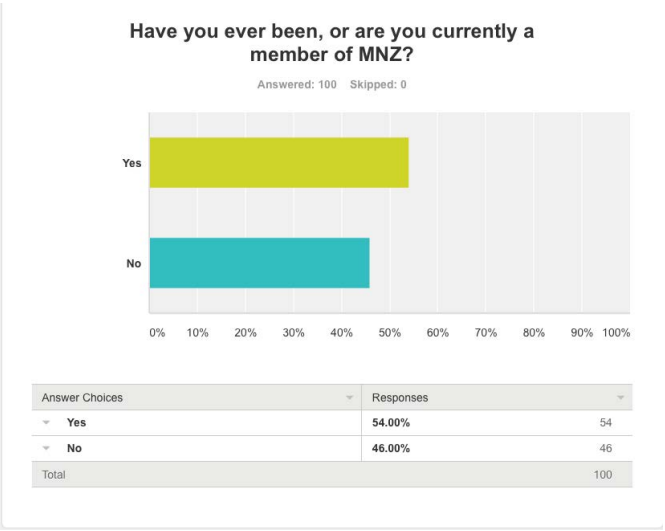
Q3.



Answer Choices	Responses	
Yes	51.00%	51
No	37.00%	37
I would like to find out more	22.00%	22
Total Respondents: 100		

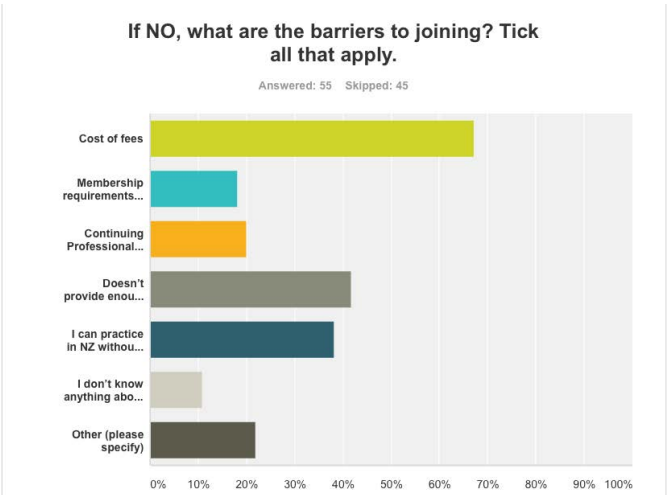
Comments (22)

Q4.



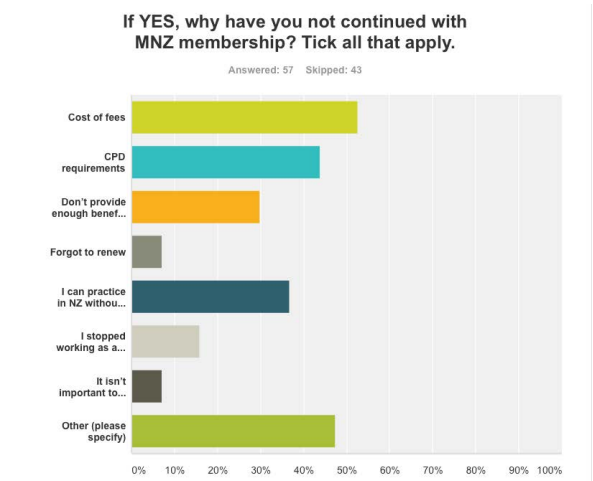
Answer Choices	Responses	
Yes	54.00%	54
No	46.00%	46
Total		100

Q5.



Answer Choices	Responses	
Cost of fees	67.27%	37
Membership requirements – my level/type of qualification isn't recognised by MNZ	18.18%	10
Continuing Professional Development (CPD) requirements	20.00%	11
Doesn't provide enough benefits for me	41.82%	23
I can practice in NZ without it	38.18%	21
I don't know anything about MNZ	10.91%	6
Other (please specify) Responses	21.82%	12
Total Respondents: 55		

Q6.

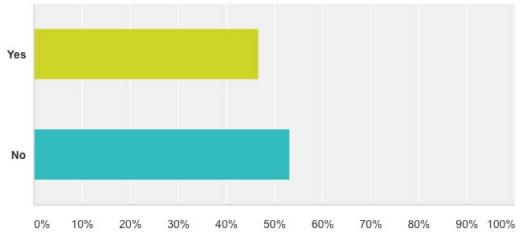


Answer Choices	Responses	
Cost of fees	52.63%	30
CPD requirements	43.86%	25
Don't provide enough benefits for me	29.82%	17
Forgot to renew	7.02%	4
I can practice in NZ without it	36.84%	21
I stopped working as a massage therapist for personal/career/family reasons	15.79%	9
It isn't important to me to be part of a professional association of massage therapists	7.02%	4
Other (please specify) Responses	47.37%	27
Total Respondents: 57		

Q7.

If the cost is a barrier to membership, would you prefer a monthly fee structure as opposed to yearly lump sum?

Answered: 79 Skipped: 21

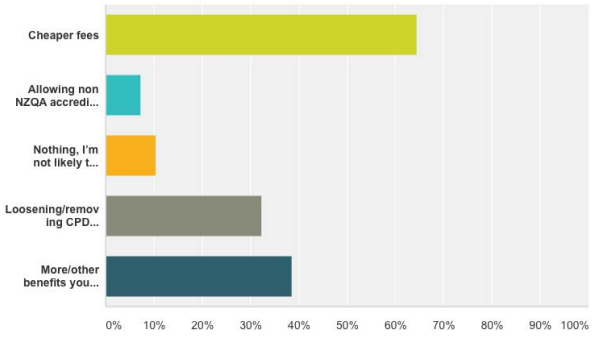


Answer Choices	Responses	
Yes	46.84%	37
No	53.16%	42
Total		79

Q8.

What would encourage you to join/re-join MNZ?

Answered: 96 Skipped: 4

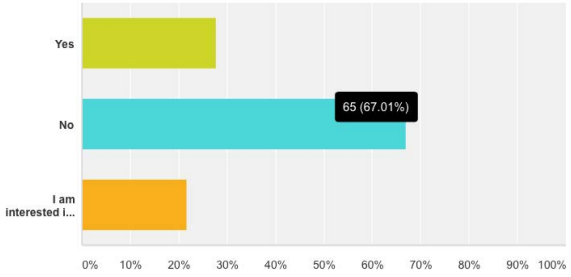


Answer Choices	Responses	
Cheaper fees	64.58%	62
Allowing non NZQA accredited trained massage therapists to join	7.29%	7
Nothing, I'm not likely to join/rejoin regardless	10.42%	10
Loosening/removing CPD requirements	32.29%	31
More/other benefits you would like to see us provide	38.54%	37
Total Respondents: 96		

Q9.

Do you currently have professional indemnity insurance for your practice?

Answered: 97 Skipped: 3



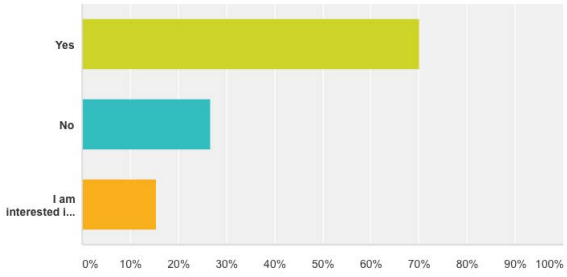
Answer Choices	Responses	
Yes	27.84%	27
No	67.01%	65
I am interested in finding out exclusive MNZ deals for Indemnity Insurance	21.65%	21
Total Respondents: 97		

Comments (13)

Q10.

Do you have a current first aid certificate?

Answered: 97 Skipped: 3



Answer Choices	Responses	
Yes	70.10%	68
No	26.80%	26
I am interested in finding out exclusive MNZ deals for First Aid	15.46%	15
Total Respondents: 97		

Comments (15)

UPDATE FROM HIGH PERFORMANCE SPORT NEW ZEALAND

Pip Charlton, RMT (MNZ) HPSNZ Massage Provider and Advisor

High Performance Sport NZ's (HPSNZ) mission is to create a world leading , sustainable high performance sport system that ensures resources are targeted and prioritised to deliver performance outcomes with National Sporting Organisations (NSO's). Massage is one of the support services that is provided to HPSNZ carded athletes by an approved group of massage providers around the country. Massage Therapists are key members of the performance health team and below are some of their key functions in delivery to athletes.

- Support athletes' physical preparation to cope with demands of daily training/ competition (performance optimisation)
- To optimise soft tissue health following training (performance optimisation/ recovery)
- Minimise risk of injury and movement dysfunction through management of soft tissue restrictions (injury prevention)
- To support ongoing rehabilitation following injury (injury management)

For optimal benefit, massage is delivered according to the individuals' needs and aligned to their performance requirement, which varies through the year according to fluctuations in training/competition demands or the presence of injury.

The provision of massage has changed over the last 5-6 years with most of the work now happening at one of the HPSNZ regional training centres: National Training Centre (Auckland), regional training centres (Cambridge, Karapiro, Christchurch, Wellington, Dunedin and Wanaka). HPSNZ have prioritised the support from regional training centres to optimise the integration within the health team and to interact with other disciplines such as strength and conditioning, physiology, and most importantly coaching.

For the last two years, massage within HPSNZ has been led by Fiona Mather, Physiotherapist and Head of Performance Therapies. She has shown great commitment in moving massage forward collectively as a group within the organisation and has initiated group meetings which have seen some robust discussions and new delivery initiatives take place.

At a recent massage group meeting, discussion took place around the establishment of a new pathway for bringing new therapists on and consolidation of the criteria required by prospective applicants. I will report back in the next MNZ Magazine as to how these areas in particular are progressing.

Finally in this update it is with great pleasure to announce that Clint Knox, Hans Lutters and Annette O'Connor (and Seah Taylor reserve) will be the NZ Health Team Massage Therapists at the Gold Coast Commonwealth Games in April 2018. These three therapists were all in Glasgow and Rio at the last Commonwealth and Olympic games respectively. We wish them and all the athletes chosen to compete, all the very best.

GET REGISTERED AS A SOUTHERN **CROSS EASY CLAIM PROVIDER**

By Annika Leadley RMT

As you may be aware, Southern Cross recognises MNZ Massage Therapists (RMT levels 6 and 7 only) as healthcare providers therefore their members with eligible policies can claim part or all of their treatment with you. Up until recently, to do this your client required a receipt for the session from you as part of the paperwork required by Southern Cross. However it is now possible to register with Southern Cross Health Society Easy-claim.

What does this mean? Well, Southern Cross Health Society Easy-claim ("Easy-claim") is a convenient way for Southern Cross members to claim for eligible healthcare services at the time of purchase, without completing a claim form. Clients can use Easy-claim at participating healthcare providers by simply presenting their Member card or app at the counter when they are purchasing eligible healthcare products and services.

If their plan covers the product or service and it qualifies, Southern Cross will reimburse the provider directly and the client only pays any remaining contribution they are responsible for if any, so they don't have to worry about receipts, filling out claim forms or waiting for a refund.

As a RMT level 6 or 7 MNZ Massage Therapist you can register as a Southern Cross Easy-claim provider. Benefits for a registered practitioner include:

- Easy-claim increases patient loyalty due to a quick and easy claiming experience.
- Easy-claim is free to set up and very easy to use
- You get an instant response confirming payment from Southern Cross, and any member contributions if applicable
- Payments to your practice are processed overnight
- Training, support and Easy-claim posters for your reception are provided free of charge

If you'd like to find out more about offering Easy-claim to clients who are Southern Cross members, you can call Southern Cross on 0800 700 053 or email easy-claim@southerncross.co.nz.

I've been registered for three months now and have already made three regular clients who are Southern Cross members very happy and gained three further clients who were specifically looking for a Massage Therapist that was registered with Southern Cross Easy-claim. It was straightforward to register with, the website through which you process your client claims is simple to use and I find the claims are paid within 24-48 hours. I definitely recommend looking into it!

BENEFIC THAI HERBAL COMPRESS TECHNIQUE

A TRADITIONAL HEALING TREATMENT

Known in Thailand as "Luk Pra Kob" meaning 'herbal pressing sphere' the Thai Herbal Compress massage therapy is an ancient healing technique that is suitable for qualified professional massage, beauty, spa, wellness, natural and alternative therapists/practitioners.

The origins of the herbal compress dates back to the Ayutthaya period which ran from the 14th to 18th century when the compress was developed and mainly administered to soldiers returning home from wars with neighbouring countries. These soldiers suffered from a variety of maladies including back pain, sprains, inflammations and skin disorders.

It has long been a common belief among the Thai people that the human touch and gifts of Mother Nature are the best ways to heal the body and cure minor ailments, as opposed to the intake of medicines and other modern invasive treatments. Interestingly, this product is integrated into the public health system in Thailand so everyone there gets to benefit from it.

THE POWERFUL EFFECTS OF COMBINING: HEAT THERAPY, HERBAL THERAPY, AROMATHERAPY AND MASSAGE THERAPY IN ONE TREATMENT

Benefic Thai Herbal Compress Therapy allows you to provide 4 therapies all at once in a modality that is new and unique.

Once the compresses are steamed they release their wonderful aromatics which permeate the room and have a two-fold action. Firstly, you and your client inhale the aromas via the olfactory which are absorbed through the mucous membranes of the respiratory tract and lungs. Secondly, when the compress is applied topically the transfer of medicinal moist heat to our biggest organ, the skin, may travel into the lymphatic system and could be circulated into the blood stream.

These authentic Thai herbs are bundled together in accordance with ancient recipes and are handmade, wrapped in cotton and traditionally consist of several curative herbs such as; prai (or plai), turmeric, camphor, kaffir lime, lemongrass, eucalyptus, galangal and tamarind. These traditional herbs possess properties that may be anti-inflammatory, analgesic, antispasmodic, antiseptic, sedative, bronchodilator, astringent and antioxidant which makes them very effective in treating ailments like: stress and anxiety, sprains, bruises and sore muscles, upper respiratory ailments such as bronchitis, asthma, sinus congestion, migraines, and the common cold - as well as cleansing and healing the skin by promoting cell growth. (Tewtrakul, S., Subhadrisakul, S., 2007)

THE APPLICATION TECHNIQUE

Although Benefic has been designed as a stand-alone treatment, it can be incorporated into other massage modalities, such as complementing a lymphatic drainage massage or deep tissue massage. The compress can serve as a fantastic way to warm hyper-irritable trigger points within a taut band of muscle fiber prior to manual release work or manual massage. A cold herbal compress application can be applied in a treatment and/or can alternate with a hot herbal compress.

Treatments can be customized to the needs of the individual and therapists may wish to treat specific areas of the body or treat areas that are deemed important for the clients' pain condition.

Thai Herbal compress has gained popularity and stood the test of time due to the adaptability of this multi-faceted treatment, which is simple yet effective and boosted by a multitude of benefits. (Dhippayom et al, 2015)

A GREAT ADDITION TO YOUR TOOLBOX

Incorporating Benefic Thai Herbal Compress Technique into an established massage practice can be a good addition to your suite of services due to the fact that working with the compress is ergonomically easier on your body, alleviating much of the physical stress of the job and increasing the longevity of your career. This holistic one-of-a-kind treatment allows therapists to work deeper into the client's muscles without as much wear and tear on their own body and hands.

Benefic Thai herbal compress is truly a unique treatment providing benefits for the therapist while at the same time ensuring a client experience that is both therapeutic and relaxing.

WHAT ARE YOU LOOKING FOR IN A TREATMENT?

Would you like something exotic and yet highly therapeutic to offer your massage clients?

Would you prefer that this technique be based on centuries of traditional use in a culture famed for its hands-on healing techniques?

Would you like your therapy to feature all-natural products?

How about if this technique was easy on your hands and body?

If you are interested in training in this new, unique treatment and growing your business by offering its many benefits to your customers - you can find out more at www.benefic.co.nz

REFERENCES:

Dhippayom, T., Kongkaew, C., Chaiyakunapruk, N., Dilokthornsakul, P., Sruamsiri, R., Saokaew, S., & Chuthaputti, A. (2015). Clinical Effects of Thai Herbal Compress: A Systematic Review and Meta-Analysis. Evidence-Based Complementary and Alternative Medicine : eCAM, 2015, 942378.

Tewtrakul, S., Subhadrisakul, S., (2007). Anti-Allergic Activity of Some Selected Plants in the Zingiberaceae Family; Journal of Ethnopharmacoly 12; 109(3):535-8

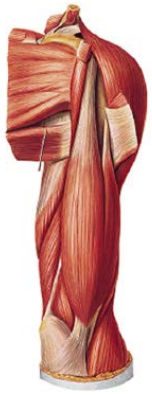
BICEPS INJURIES

By Ben Benjamin, PhD

While most muscles cross over only one joint, the biceps crosses two joints: the elbow and the shoulder. Injuries to lower biceps causes lots of elbow pain.

The biceps muscle helps to flex the elbow (as in lifting your massage table), but more importantly, it supinates the forearm (as in using a screwdriver). It has the greatest mechanical advantage when the elbow is bent at about 90 degrees, and is more likely to be injured when the elbow is almost straight. Biceps injuries often result when people attempt to lift objects that are heavier than they realize – for example, when someone tries to move a big piece of furniture for the first time.

At its distal end, the biceps has two insertion points. One is a tendon attachment at the radial tuberosity, a rounded projection on the radius located just inferior to the elbow. The other is the bicipital aponeurosis (a fibrous sheet of connective tissue) that fuses into the deep fascia of the forearm on the ulnar side. Injury at either of these locations will cause elbow pain.



Biceps Anatomy

BICEPS ASSESSMENT

Verifying a biceps injury involves two separate tests; both are crucial to making the correct assessment.

First is resisted flexion of the elbow. With the client standing, have the person hold the elbow of the injured arm at a right angle, with the palm or the thumb facing the ceiling. Now, place one or both of your hands on the wrist and ask the client to flex the elbow as you apply an equal and opposite downward pressure.

Fig.1: Resisted Flexion of the Elbow

One word of caution: in some clients, flexion is very strong. If the client is much stronger than you are, there is a risk of injury to you as the therapist. Also, if you can't hold the arm still in such a way that there is no movement through space, the test will be inaccurate. You can minimize both of these risks by doing the biceps test with the person lying supine. In this position you can use your full body weight. Lace your fingers together, wrap them around the radial side of the forearm just above the wrist, and lean back. This way the client would have to pull your entire body weight to overpower you.

Pain on resisted flexion tells you that either the biceps and or the brachialis muscle is injured. To differentiate between the two, you need to perform one additional test: resisted supination of the forearm. Again, have the client standing with the elbow at a right angle. With both of your hands just superior to the wrist, grip the forearm to hold it in place. Lacing your fingers helps. Now ask the client to try to supinate (outwardly rotate) the forearm, so that the palm faces the ceiling. Apply an equal and opposite force, not allowing the wrist to rotate at all. Anterior elbow pain felt on both this test and resisted elbow flexion indicates that the lower biceps is injured.

Fig. 2: Resisted Supination of the Forearm

TREATMENT

The most effective treatment approach for the biceps is a combination of friction therapy, massage therapy, and exercise therapy. The injured portion of the tendon will be painful on palpation. If you have difficulty pinpointing the precise site of injury, try having the person flex their arm against resistance – so the tendon tightens and pops up – and then palpate again in that position.

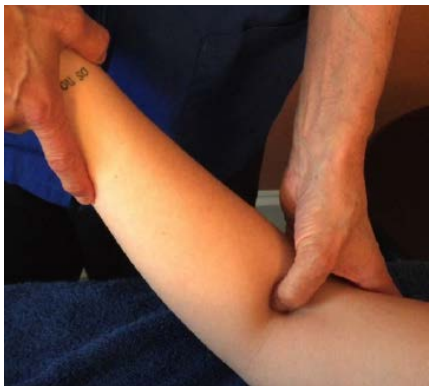


Fig. 3: Friction Therapy of the Biceps Tendon

Friction therapy is done with no lubricant so you can pin the injured fibers against the bone and perform a friction motion against that resistance to break up the adhesive scar tissue. Be careful to take the skin with you, rather than rubbing over it. When performing this technique, work for 10 to 12 minutes at a time, taking breaks as necessary. Remember to change hands frequently so you don't strain yourself. Follow the friction with deep massage to the upper arm, lower arm, and shoulder, and repeat twice a week for four to six weeks.

Printed with permission from Massage Today, August, 2016, Vol. 16, Issue 08

MYTHS AND MISCONCEPTIONS IN PHYSIO

by Thomas Jesson

Welcome to our list of myths and misconceptions in physio[1]! This list is designed for students, but it might be useful for qualified physios, too. There are seven sections of myths and misconceptions: assessment, treatment, clinical reasoning, condition-specific, exercise, pain science, and evidence based practice.

Why did I write this list? Well, as students, my friends and I spent a lot of time and energy working this stuff out. I want to save future students from having to do all that frustrating work, so they can concentrate on learning new things.

Editor's note: MNZ doesn't necessarily support/agree with all these myth busters but it is good food for thought and challenges Massage Therapists to read, think, question, create and report knowledge, with reference to literature.

1.This article was written by a Physiotherapist for Physiotherapists but has relevance to massage therapy. When reading the article, substitute the terms "physiotherapy" and "Physiotherapist" with "massage therapy" and "Massage Therapist".

ASSESSMENT MYTHS AND MISCONCEPTIONS

Myth	Explanation
POSTURAL, STRUCTURAL AND BIOMECHANICAL QUIRKS SHOW YOU THE CAUSE OF PAIN	Structure is not destiny! Pelvic tilt, lordosis, kyphosis, 'over' pronation, weak muscles, tight muscles, bulging discs, asymmetries, mild scoliosis: these things do not explain pain and worrying about can feed into more pain.
POSTURAL TYPES ARE SCIENTIFIC	They're really pseudo-scientific, and posture correction has a long and ignoble history. The idea that we should sit and stand up straight is simply made up.
SCANS SHOW YOU THE CAUSE OF PAIN	Treat the man, not the scan! Brinjikji et al found that people with no pain have all sorts of things going on in their spines. This doesn't mean the scan is irrelevant, just that it is part of a complex picture.
CORE INSTABILITY CAUSES BACK PAIN	The one myth to rule them all. Peter O'Sullivan produced some of the research that started the core stability myth, and now totally refutes its value as an explanation of LBP. His youtube videos show his new approach. Ben Smith's systematic review is the most recent of many to indicate that core stability training is no better than any other exercise for LBP. This podcast is a nice intro to his work. Telling someone their core needs stabilising is just plain mean.
OVERPRONATION CAUSES (INSERT PAIN HERE)	"Overpronation" is everywhere, although there's not really a consensus about what it is. Once spotted, it's easy to follow a spurious line of reasoning to identify it as the cause of someone's pain. But there are a lot of holes in this approach.
PALPATION IS A SUPER-SKILL	Gone are the days when physios believed we could detect meaningful information about the state of soft tissues or the 'alignment' of the body with our super-sensitive, magic hands. It seems our sense of touch is particularly vulnerable to over-interpretation.
PALPATION IS AN ILLUSION	Is this in danger of becoming a new myth? Good hands are important for performing certain special tests, for manual therapy, and for communicating with your patient and making them feel safe. We are one of the only professions that gets to use touch to reduce people's pain, help them move and build their strength and confidence. (substitute Physio for Massage Therapist – Ed)
DERMATOMES ARE STRICT AND PREDICTABLE	Dermatome maps don't properly show the variation and overlap of our dermatomes.
TRIGGER POINTS ARE (INSERT EXPLANATION HERE)	No doubt something is there, and it's a bit implausible that they are what many people think they are. Stay sceptical.

TREATMENT MYTHS AND MISCONCEPTIONS

Myth	Explanation
MASSAGE INCREASES BLOOD FLOW AND HAS ALL SORTS OF EFFECTS ON SOFT TISSUES	Massage probably does increase superficial, cutaneous blood flow (making skin look red). But it's unlikely it does anything to the blood flow of deeper tissues.
MANUAL THERAPY WORKS BY "PAIN GATE" THEORY	This theory was put forward by Melzack and Wall in 1965 and is very significant in the history of pain science because it was the first theory to account for top-down modulation of pain (ironically the bit that is most forgotten when people think of Pain Gate now). But it is such a small part of a complex picture that some time ago Melzack and Wall encouraged people to move on.
JOINT MOBILISATIONS/ MANIPULATIONS PUT THE JOINT BACK IN PLACE	The mechanisms of manual therapy are mostly "neurophysiological". Whether or not "neurophysiological" mechanisms are specific to manual therapy is up for debate.
MANUAL THERAPY IS DIRECTION SPECIFIC	All pressure applied onto the skin is transferred perpendicularly through bone and soft tissue because the skin-fascia interface is frictionless. Here is an adorable video to explain this.
TREATMENTS WORK BY CAUSING SOFT TISSUE CHANGES	People often get better, but tissue stays the same. People who improve after core stability exercises, for example, don't show any actual increased "core stability". When tendon pain goes, the tendon has not "healed". This is no surprise: loading is important but works in many ways, not just by causing structural changes. This is a good thing, it means exercise works in more ways than we think.
PEOPLE WITH PERSISTENT PAIN SHOULD "PACE THEMSELVES"	Sometimes we tell people in pain to "pace yourself". Often, this is heard as "do what you feel able to do". In fact, pacing is about doing the same, manageable amount daily, regardless of how you feel, and increasing over time.

CLINICAL REASONING MYTHS AND MISCONCEPTIONS

Myth	Explanation
If the patient got better, the treatment worked	Why do ineffective treatments seem helpful? Natural history, regression to the mean, placebo, confirmation bias...
PAIN IS COMPLICATED	Pain isn't complicated, like a machine, where causation is predictable and knowable; it's complex, like a **city or an ecosystem**, where causation is unpredictable and hard to trace. If one thing changes we don't know what else will change and in what way. This means often we are fooling ourselves when we identify one or two original causes.
SPECIAL TESTS ARE SPECIAL	Special tests are not litmus tests: they don't give yes or no answers. Not many have great sensitivity or specificity, and these values are merely estimates anyway.
ANYTHING YOU CAN TRY TO HELP THE PATIENT IS GOOD	It is human nature to want to try every tool in the toolkit to help someone in pain. But often this approach forgets that as well as potential benefits, all treatments have costs. This may be in terms of time and money, which is an important consideration. All treatments have the potential to rob patients of their self-efficacy and to encourage maladaptive beliefs and behaviour.
THERE ARE RESPONDERS AND NON-RESPONDERS TO TREATMENTS	The idea that certain people "respond" to certain treatments is appealing, and it is nice to think that there is a perfect patient for each tool in your toolkit. Unfortunately, data suggest that for our underwhelming pain treatments, including exercise, there is no hidden group of responders.
PLACEBO IS A POWERFUL FORCE THAT WE NEED TO LEVERAGE	The debates about placebo are endless but it is sufficient to say that we should be wary of anyone saying that placebo is 1) powerful or 2) something we need to "leverage" with complicated extra interventions. The fact is that placebo is 1) a limited, unreliable, unpredictable thing and 2) the best part of placebo can be obtained through patient therapist interaction without the need for needles or machines.

CONDITION-SPECIFIC MYTHS AND MISCONCEPTIONS

Myth	Explanation
OA IS WEAR AND TEAR	OA is a metabolically active process, so telling a patient they have "wear and repair" rather than "wear and tear" is not only less fear inducing but more truthful.
BACK PAIN INCREASES WITH AGE	Back pain does not become more prevalent after middle age, and may even decrease in the very elderly.
FOR PATIENT WHO NEEDS TO HYDRATE, TEA AND JUICE ARE NOT GOOD OPTIONS	Tea and juice are in fact more hydrating than water, so it's okay for people to drink these.
SHOULDER IMPINGEMENT IS A THING	It's not a thing. Neer's model of shoulder impingement doesn't really hold up and might be fear-inducing for patients. Is it better to say that weak and painful shoulders have "rotator cuff tendinopathy"? Any 'impingement', in this case, is secondary and not a diagnosis.

RUNNING CAUSES OA	Evidence is conflicting and common sense suggests that well-managed loading is good for joints, so we can challenge patients' beliefs that running causes "wear and tear".
TENDINOPATHY HAS AN INFLAMMATORY COMPONENT	It's no longer appropriate to say "tendinitis", or to manage tendinopathies like they are inflammatory.
TENDINOPATHY DOESN'T HAVE AN INFLAMMATORY COMPONENT	Ok, there is some inflammation in tendinopathy!
THERE ARE ADHESIONS IN ADHESIVE CAPSULITIS	There aren't articular adhesions, so some say it might be better to call this condition "frozen shoulder contracture syndrome". And since there are no adhesions to break down, it makes little sense to bring patients in for aggressive range-of-motion exercises.

EXERCISE MYTHS AND MISCONCEPTIONS

Myth	**Explanation**
STRETCHING CAUSES MUSCLES TO LENGTHEN	This is possible but takes a lot of force and time, and it's unlikely that even a good long yoga session is enough to stimulate actual tissue changes – even in terms of tissue flexibility. Instead what is likely to be adapting is the nervous system, which is 'reassured' by stretching that the end range of motion is safe, and therefore 'allows' the muscle to lengthen a bit more next time.
STRETCHING IS GOOD FOR TENDINOPATHY	Compression is a big factor in tendinopathy and many stretches compress tendons, if not against nearby bone then at least within their tendinous sheaths. So stretching may exacerbate tendinopathies.
STRETCHING REDUCES INJURY	Stretching does not reduce sports injuries.
YOU CAN STRETCH ITB	ITB is tough and firmly attached to the femur.
YOU SHOULDN'T SQUAT KNEES OVER TOES	Unless there is a compelling reason, it's fine for knees to go over toes, and for many squat patterns it's essential. It's going to happen when someone walks upstairs anyway!
VMO ISOLATION EXERCISES ARE USEFUL FOR PFP	All four quads are innervated by one nerve, so preferential activation for VMO is very unlikely and has never been shown before.
"GLUTES NOT FIRING" AS A CAUSE OF WHATEVER PROBLEM	It's a bit mysterious where this idea comes from. Bits of your body don't just fall asleep?

PAIN SCIENCE MYTHS AND MISCONCEPTIONS

Myth	Explanation
PAIN IS AN ISSUE IN THE TISSUES	The now well-established disconnect between "hurt" and "harm" tells us that pain does not "come from" the tissues, and nor is it a good measure of the state of the tissues. Pain is an output of the brain, which scrutinizes many inputs, internal and external, including but not limited to nociception.
PAIN IS IN THE BRAIN	Some physios have accepted that pain isn't in the tissues and decided it must be in the brain instead. But, it's not there either. Whether or not saying "pain is in the brain" is a helpful thing to say to patients is debatable.
THERE ARE "PAIN SIGNALS" THAT TRAVEL ALONG "PAIN FIBERS"	"Eyes have light receptors, not vision. Ears have vibration receptors, not hearing. Tissue has danger receptors, not pain" – Adrian Louw. Pain is an output of the brain.
PEOPLE IN PERSISTENT PAIN HAVE GOT CENTRAL SENSITISATION	Central sensitisation, the long-term potentiation of pain in the spinal cord and brain, is often assumed to be inevitable if someone has been in pain for a long time. But central sensitisation isn't just another word for persistent pain, it's its own particular thing. So, someone with chronic low back pain may or may not have central sensitization. This story illustrates one unexpected danger of assuming persistent pain is centrally driven.
EXPLAINING PAIN IS ABOUT TEACHING PEOPLE TO MANAGE PAIN	There are many educational interventions that help people to cope with pain, but pain neuroscience education is about reducing pain.
PAIN SCIENCE RELEGATES THE "BIO" FROM THE "BIOPSYCHOSOCIAL".	Pain science does not imply that bio-factors, including biomechanics, are irrelevant – it just puts them in a better context. Indeed, pain neuroscience education has not yet been shown in an RCT to reduce pain without some kind of exercise or manual therapy intervention to go with it.
PAIN SCIENCE IS FOR PERSISTENT PAIN.	Many patients can benefit from the message that hurt does not equal harm.

EVIDENCE BASED PRACTICE MYTHS AND MISCONCEPTIONS

Myth	Explanation
LEVEL I EVIDENCE TELLS US WHAT WE SHOULD OR SHOULDN'T DO	It would be nice to think that an RCT has the authority to tell us the truth about our practice. But research evidence is deeply messy and flawed. Most people are aware of this to a certain extent, but probably not the whole story. About half of published physiotherapy trials are false, and most of the quality indicators we learn about in textbooks – such as ITT analysis, sample size and blinding – don't actually predict which ones. This is true for medical research, too. Not to mention the many ways bias can seep in to a trial.
THERE IS A PYRAMIDAL HIERARCHY OF EVIDENCE, WITH RCTS AT THE TOP	EBM has moved on from the pyramid of evidence and developed more sophisticated models like GRADE. Good cohort and case-control studies can be as useful as a flawed RCT.
A SYSTEMATIC REVIEW IS AS GOOD AS IT GETS	Garbage in, garbage out. If a SR uses bad primary research, the SR is bad. Same goes for meta-analyses.
STATISTICAL SIGNIFICANCE IS IMPORTANT FOR THE CLINIC	A result can be statistically significant but meaningless for your patient. Look at the raw data, the effect size, minimal clinically important difference, and so on. And raise an eyebrow whenever a trial's results are simply reported in, say, a facebook post as "significant".
THE P-VALUE IS THE PROBABILITY THAT YOUR RESULTS OCCURRED BY CHANCE	The P-value is the likelihood that chance could throw up your results even if there was no difference between treatments. The problem with this is that, in most things, it's far more likely that there is indeed no difference than a real difference, meaning that you get a lot more false positives than you might expect. Add to this the fact that most studies are powered to find only 80% of true positives anyway, and false-positives hugely outweigh true ones. This is called the base rate fallacy. For example, even in a trial where the probability of there being a real effect is 50:50, a very high estimate, "P=<0.05" means that the false-positive rate is 26%.
A SAMPLE NEEDS TO BE REPRESENTATIVE FOR A STUDY TO BE RELEVANT	Commonly, you will hear results of trials dismissed because the sample does not represent a clinical population. While it is true that a representative sample helps to generalise findings, it can also undermine them. Representative samples have lots of confounding variables that reduce the internal validity of a trial. This means that external validity and internal validity become a see-saw. If a trial appears weak because its sample is not representative, it may be that its greater internal validity more than makes up for this.
CORRELATION IMPLIES CAUSATION	The number of people who drown by falling into a swimming pool correlates with Nicholas Cage movie releases.
EVIDENCE-BASED PRACTICE IS LIKE A STOOL	The stool metaphor implies that all three legs – research, clinical experience and patient preference – have equal value when making clinical decisions. But they don't.
SMALL STUDIES ARE UNLIKELY TO HAVE FALSE POSITIVES.	It is well known that small studies are worse at detecting true effects; that is, they make more type II errors. Often people take this to mean that if small studies do show an effect then that effect is more likely to be real. In fact, small studies are also more likely to show a false effect; that is, they make more type I errors, proportionately, than large studies, because there aren't as many real effects to water them down.

Thomas Jesson is a final year Physiotherapy student in Newcastle, England. Before studying physio, Tom was an English teacher in Seoul, South Korea. He likes hiking, climbing and travelling as much as he can. He can be contacted on tjessson6@gmail.com

May 2017

Welcome to Massage Therapy Research Update. In this edition we will look at a recent systematic review and meta-analysis that asks about the relationships between massage, pain, and function. This is a nice fit with the upcoming Massage New Zealand conference, Reinventing Practice (click **here** for more information), where several speakers will be bringing information and a perspective from the biopsychosocial model of pain management.

A biopsychosocial model of pain means looking at the person in pain with the understanding that pain is a multifactoral phenomenon that is influenced by what happens in the body (bio); what happens in the mind and emotions (psycho); and what happens in the patient's broader contexts of life (social). It presents pain not as a sensation, but as a response to a stimulus, and that response is influenced by many things.

In other words, when we experience pain—say, from twisting an ankle—then our nociceptors (our "harm alarms") carry a message to the brain about the potential for damage. The brain then determines how much pain we feel, based on many different factors. So if we're taking a leisurely stroll and our foot comes down wrong, we may feel a lot of pain, and we'll limp all the way home. But if we twist our ankle as we are running away from a burning building, then we may not sense much pain at all in that moment—but it may catch up with us later, when we have the time and safety to pay attention to it.

The key point here is that our awareness of pain is a response, not a sensation. The severity and duration of that response can be influenced by setting, history, mood, and many other factors that go beyond a biomechanical injury. This is true with an acute injury, like the sprained ankle we just described, but it is also true with chronic pain.

The project that is the focus of this edition of Massage Therapy Research Update describes a large systematic review and meta-analysis of research about massage therapy and pain. And because pain and function are inextricably linked together—that's all part of the biopsychosocial approach—it also considers the role of massage in the context of improved function.

This goal of reporting on what the research says about massage + pain + function turned out to be much more challenging than anyone expected, and ultimately it was published as a series of three papers: one focused on pain in general populations, one on pain in the context of surgery, and one on pain in the context of cancer.

The project was commissioned from the Samueli Institute, a research institute specializing in complementary and integrative health, by the Massage Therapy Foundation, with financial support from the American Massage Therapy Association. In the interest of full disclosure, I was serving as the President of the Massage Therapy Foundation while the project was ongoing, and I served as one of the subject matter experts who provided some background and context to the analysts who compiled the data.

PAIN MEDICINE: THE OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PAIN MEDICINE. 2016;17(7):1353-1375. DOI:10.1093/PM/PNW099.

The Impact of Massage Therapy on Function in Pain Populations—A Systematic Review and Meta-Analysis of Randomized Controlled Trials: Part I, Patients Experiencing Pain in the General Population

Cindy Crawford, BA, Courtney Boyd, MA, Charmagne F. Paat, BS, Ashley Price, BS, Lea Xenakis, MPA, EunMee Yang, MA, Weimin Zhang, PhD, and the Evidence for Massage Therapy (EMT) Working Group

Abstract

Purpose. Pain is multi-dimensional and may be better addressed through a holistic, biopsychosocial approach. Massage therapy is commonly practiced among patients seeking pain management; however, its efficacy is unclear. This systematic review and meta-analysis is the first to rigorously assess the quality of massage therapy research and evidence for its efficacy in treating pain, function-related and health-related quality of life outcomes across all pain populations.

Methods. Key databases were searched from inception through February 2014. Eligible randomized controlled trials were assessed for methodological quality using SIGN 50 Checklist. Meta-analysis was applied at the outcome level. A diverse steering committee interpreted the results to develop recommendations.

Results. Sixty high quality and seven low quality studies were included in the review. Results demonstrate massage therapy effectively treats pain compared to sham [standardized mean difference (SMD) = −.44], no treatment (SMD = −1.14), and active (SMD = −0.26) comparators. Compared to active comparators, massage therapy was also beneficial for treating anxiety (SMD = −0.57) and health-related quality of life (SMD = 0.14).

Conclusion. Based on the evidence, massage therapy, compared to no treatment, should be strongly recommended as a pain management option. Massage therapy is weakly recommended for reducing pain, compared to other sham or active comparators, and improving mood and health-related quality of life, compared to other active comparators. Massage therapy safety, research challenges, how to address identified research gaps, and necessary next steps for implementing massage therapy as a viable pain management option are discussed.

Keywords: Systematic Review, Meta-Analysis, Massage Therapy, Pain, Function, Health-Related Quality of Life

The full article is available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4925170/

I was pleased to be a part of this project, and I am happy to explain the steps involved in this huge undertaking.

STEP 1: GATHER THE EXPERTS

This project began with a team of subject matter experts with representation from the research field, massage therapy, and conventional medicine (with emphasis on application for military veterans). We convened to do two jobs: to define a research question, and to create definitions that would guide that research.

The research question:

What is the state of the science regarding the impact of massage therapy on function for those experiencing pain?

The definitions:

Pain: "An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is always subjective. Pain can be acute or chronic." (from the Pain Management Task Force, International Association for the Study of Pain).

Massage: "The systematic manipulation of soft tissue with the hands that positively affects and promotes healing, reduces stress, enhances muscle relaxation, improves local circulation and creates a sense of well-being."

In addition, for the purposes of this project, we included papers in which massage was performed by providers who had been trained within the scope of massage practice. Providers in the included studies were either massage therapists or people who have been trained by massage therapists.

We excluded studies that addressed modalities that do not self-identify as massage therapy. For that reason, studies on reflexology, shiatsu, and some other types of bodywork were not part of this review. We also excluded any studies that addressed "prostate massage" (a diagnostic procedure for prostate problems), and "cardiac massage" (a way of talking about cardiopulmonary resuscitation).

STEP 2: IDENTIFY AND RATE THE STUDIES

To identify which studies to include in the review, we set these parameters:

The populations included anyone using massage in the context of pain (excluding cancer and surgical issues, as they were each addressed separately). Massage therapy had to be at least one of the interventions, but any control or comparison was acceptable. And we looked for functional outcomes, including how participants rated their pain, activity, sleep, mood, stress, quality of life, and other factors.

With these parameters, the original literary search generated 4,099 studies. These were eventually honed to 67 studies for the general populations group, 16 studies for the cancer pain group, and 16 studies for the surgical pain group.

(An aside: for those (like me) who are not familiar with the process of creating a systematic review, here's a reality check: 16 studies in a systematic review is very strong. 67 studies in a systematic review is gargantuan.)

Then the analysts had the nonstop fun of reading and rating the included studies for quality and freedom from bias. There is a well-accepted method for doing this, called the SIGN 50 grading system. When this was done to the 67 included studies, 10 of them were evaluated as high quality, 50 were acceptable, and 7 were low quality.

(Another aside: why didn't we throw out the 7 low quality studies? Because they had valuable findings that were not tainted by their methodology.)

The analysts compiled all the data from the studies, and looked at effect size—that is, how much (if any) impact massage had on pain and function. Then the subject matter experts reconvened to discuss recommendations about massage based on these findings and variables. We rated conclusions in these ways:

- Strong in favour of MT
- Weak in favour of MT
- No recommendation for MT

At this point it's very important to define these terms.

"Strong in favour" means that the findings are so clear and consistent that we don't think any future research will change this outcome.

"Weak in favour" means that the findings have a clear trend, but more research is needed to solidify that trend.

"No recommendation" means that massage could be helpful, but not enough data has been accrued to draw a clear conclusion.

STEP 3: WHAT HAPPENED?

Here is a snapshot of the results:

FOR PAIN:

MASSAGE VS. ACTIVE CONTROL	Weak in favour
MASSAGE VS. SHAM	Weak in favour
MASSAGE VS. NO TREATMENT	STRONG in favour

FOR FUNCTION:

ANXIETY	Weak in favour
HEALTH-RELATED QUALITY OF LIFE	Weak in favour
OTHER ACTIVITIES	No recommendation

AGAIN: "weak in favour" means a clear trend is evident, but more data is likely to make that trend stronger. And "no recommendation" means that we don't have enough data to draw a conclusion.

But notice the STRONG if favour line in the "massage vs. no treatment" comparison: this means that for pain patients who wish to avoid surgery, opioid drugs, or other interventions, massage therapy is very likely to have a positive effect on pain levels. This is a BIG FINDING.

Another significant finding, that you will discover when you read the whole paper, is that massage therapy is generally a consistently safe intervention. This is important, because this is not true of many other conventional options that people may consider for dealing with pain.

And a final important conclusion is that we don't have consistent reporting practices in research about massage. If we did, then systematic reviews like this would be much richer, because it would be easier to compare apples to apples, and oranges to oranges. So—and this might make the researchers among us smile—we also produced a STRICT-M document: this stands for Standards for Reporting Interventions in Clinical Trials of Massage.

This short synopsis only gives a glimpse at the scope of the full project: the original article is 23 pages long, and of course there are two companion pieces with the cancer and surgical pain groups. But I hope this piques your interest into what the research says about our potential to help people who live with pain. We have a lot of good work to do here, and research like this helps to clear the way.

Ruth Werner, BCTMB is an educator, writer, and retired massage therapist with a passionate interest in massage therapy research and the role of bodywork for people who struggle with health. Her groundbreaking textbook, A Massage Therapist's Guide to Pathology was first published in 1998, and is now in its 6th edition and used all over the globe. She writes a column for Massage and Bodywork magazine, serves on several national and international volunteer committees, and teaches national and international continuing education workshops in research and pathology. Ruth was honored with the AMTA Council of Schools Teacher of the Year Award for 2005. She was also proud to serve as President of the Massage Therapy Foundation from 2010-2014, and she retains a seat as an MTF Trustee.

Ruth Werner
Massage Therapist
author ~ educator ~ artist

UPGRADE YOUR WEBSITES AND BUSINESS CARDS

As of 1st April 2017, MNZ Certified Massage Therapist (CMT) and Remedial Massage Therapist (RMT) designations ceased to exist. Existing memberships WILL NOT be terminated, members are simply now required to include their NZQA level qualification.

The term 'Certified Massage Therapist' no longer exists in New Zealand from 2107, as the qualification level for this scope of practice has now been raised to a Level 5 Diploma, due to changes to the NZQA framework.

THIS MEANS:

- CMT level members with a Certificate in Relaxation Massage or equivalent:

  Have been re-designated as "Registered Massage Therapist – Level 4 (MNZ)"

- CMT members with a Level 5 Diploma in Wellness & Relaxation Massage or equivalent:

  Will be designated as "Registered Massage Therapist – Level 5 (MNZ)"

- RMT level members who have a Diploma level qualification in Massage Therapy or equivalent:

  Have been re-designated as "Registered Massage Therapist – Level 6 (MNZ)"

- RMT level members who have a Bachelors degree qualification in Massage Therapy or equivalent:

  Have been re-designated as "Registered Massage Therapist – Level 7 (MNZ)".

MASSAGE & MYOTHERAPY

JOURNAL

Towards excellence!

Subscribe now to define your future with the *Massage & Myotherapy Journal*

Stay ahead of the industry by subscribing to Australia's leading journal for Massage Therapists and Myotherapists.

Recent topics include:

- Professional boundaries and standards
- MT and Myotherapy in sports preparation, performance and recovery
- Marketing and PR Guide
- Practice Management Ideas Centre
- Massage in paediatric massage
- Massage in Palliative care.

CONTACT MASSAGE NEW ZEALAND

Or subscribe directly at www.massagemyotherapy.com.au before 30/6/17 and receive access to free online learning modules. (T&Cs apply).

Massage & Myotherapy Australia
Level 8, 53, Queen Street
Melbourne 3000
Tel: +61 3 9602 7300
E: info@massagemyotherapy.com.au
www.massagemyotherapy.com.au

MASSAGE & MYOTHERAPY AUSTRALIA

The Association for Professional Therapists