PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

# MNZ MAGAZINE

massage new zealand

ISSUE 1 2019

# MOVING IS MEDICINE

PEDIROLLER AND SHAKTI MAT GIVEAWAYS IN THIS ISSUE!

- 2018 MNZ CASE REPORT CONTEST – TUI BALMS BRONZE AWARD WINNER
- FOOT MOBILISATION THERAPIES
- FUNCTIONAL THERAPEUTIC MOVEMENT
- MOVEMENT WILL CHANGE LOW BACK PAIN
- THE FELDENKRAIS METHOD®
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# EDITORIAL ISSUE 1 2019

As a country in mourning we would like to acknowledge with our MNZ whanau, the 50 New Zealanders whose lives were ended so obscenely two weeks ago. It seems that how we assimilate their loss will determine the quality of life in Aotearoa for years to come. Many Massage Therapists have responded to the call to be part of the Emergency Response team in Christchurch – for that we thank you.

This year we are beginning with a focus on "Moving is Medicine". We seem to have more choice without effort at our fingertips, fewer reasons to leave our homes - including for work, fewer reasons to move. More than ever before, getting movement into the day is important and could be prescribed as medicine for some.

We kick this issue's articles off with a case report from Hayley Ward. Hayley is our first MNZ Case Report Contest prize recipient in 2018, winning the bronze prize. Her report looks at the effects of reducing sedentary behaviours in conjunction with massage therapy as a treatment approach to address low back pain.

We have a range of exciting articles from assisting movement with foot mobilisation therapies from Podiatrist Ted Jedynak, Jamie Johnston from The Massage Therapy Development Center looks at how movement can change low back pain and Walt Fritz explores MFR/Massage when working with the vocal athlete ahead of his Auckland course in August. Wellington Feldenkrais teacher and massage therapist Sue Field discusses exercising intelligently by using Feldenkrais and Odette Wood reviews Ben Cormack's Functional Therapeutic Movement course at the 2019 San Diego Pain

Summit. Clint Knox writes about working as a massage therapist as part of High Performance Sport New Zealand (HPSNZ) and two of our members share their profiles and stories for others interested in this area who may want to follow this path.

We have posters that you can print out for your clients aimed at giving them tips and encouraging them to move more in daily life. These range from Common Sense Exercise and Movement Guidelines, Lifestyle Medicine Tips on Exercise, and Physical Activity information.

We have all the usual regular columns – Executive Committee and staff reports, degree student Scott Barrett shares his profile in Student Corner, great book reviews, useful sites that you can visit to get information, our wonderful Massage Therapy Research Update and this time some fantastic prize giveaways in our product review column – you won't want to miss out on winning one of two awesome prizes from Whiteley Allcare and Shakti Mat NZ!

We hope you take some time to read, reflect and get involved. Remember, as the new membership cycle starts on 1 April 2019 it's important to renew your membership to help MNZ keep growing, and don't forget our 2019 national conference in Hamilton in September. We hope you have a prosperous yet thoughtful 2019.

*Carol and Odette*

## MNZ MAGAZINE ISSUE 1 2019

# CONTENTS

## REGULAR



## FEATURES

# ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

## SUBMISSION DEADLINES

The MNZ Magazine will be published:

Issue 1 2019 – 1st April (deadline 1st Feb)
Issue 2 2019 – 1st August (deadline 1st June)
Issue 3 2019 – 1st December (deadline 1st October)

Note: Dates may be changed changed or delayed as deemed necessary by editors.

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

## ADVERTISING RATES AND PAYMENT

**MNZ Magazine now ONLINE only.**

For current advertising opportunities and pricing please see:

https://www.massagenewzealand.org.nz/Site/about/advertise/advertising-opportunities.aspx

Advertisements must be booked via the online booking form and paid online.

https://www.massagenewzealand.org.nz/tools/email.aspx?SECT=advertise

## ADVERTISEMENT SPECIFICATIONS

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.

### Magazine Page Sizes

- Full page is 210mm wide x 297mm 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.

## ARTICLE SUBMISSION GUIDELINES

The following outlines requirements for submitting articles, original research and case reports. We also consider opinion pieces, reviews and other types of articles, providing that they do not contradict MNZ policies and processes.

Please contact the co-editors to discuss your submission prior to sending in.

- **Word count - Max 1800 words include references**
- **Font - Arial size 12**
- **Pictures - Maximum 4 photos per article, send photo originals separate from article (do not provide images embedded in Word document), each photo must be at least 500k**
- **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)**

**Co-editors – Carol Wilson, Odette Wood**

**magazine@massagenewzealand.org.nz**

**coeditor@massagenewzealand.org.nz**

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# PRESIDENT & EXECUTIVE REPORTS

## PRESIDENT

Welcome to yet another fantastic edition of our magazine, the first for 2019. Our editors do an amazing job coming up with fresh new content and up to date research for all of us to enjoy and learn from.

The Executive Committee have been busy streamlining certain processes and systems as new issues arise. Each new committee member brings their own 'flavour', areas of expertise and ideas, which make for a dynamic and constantly evolving organisation. I think this is brilliant! Presently, we have a great mix of those who have been around for a few years and some fresh faces. Now that we are a few months in, we are really consolidating as a team and have a wealth of combined experience on board, from a variety of backgrounds. I have been so thrilled with how we are supporting each other as a committee in order to support our members where needed and drive massage forward as a highly regarded profession.

We have been tidying up our agreement with Bizcover to ensure our members continue get a great deal on insurance and the coverage needed. We are also working on an agreement with more health insurance providers in addition to Southern Cross for our Level 6-7 RMTs. This is not only great for business for RMTs, but it also raises our profile and exposure. This is quite a process and won't happen overnight, but we will persevere and keep you updated.

By the time you read this our full membership with AHANZ (Allied Health Aotearoa New Zealand) should have been accepted. This will be significant for MNZ as it gives our organisation the platform to connect with other health professionals, ACC and the Ministry of Health.

Please feel free to email me with any feedback, ideas or concerns.

Teresa Karam

## VICE PRESIDENT

Happy First Edition of the New Year! I hope everyone had a safe and festive summer, enjoying the awesome NZ weather. Time is rolling by rather quickly, with much happening behind the scenes of MNZ in the Executive Committee. It's very difficult to appreciate exactly what a committee member does until we are actively involved. After having a few months in the role, it has become obvious that there is much to learn and record for future position holders so we can future proof these roles and the evolution that time brings.

The MNZ Vice President role brings with it the overseeing of any complaints regarding massage therapists. These complaints can be made by any person who has received massage and is not happy with the service provided. Due to the non-regulated status of MNZ and the massage environment in New Zealand, we are only able to explore further if it is one of our members that has had a complaint made against them. The great news is that most complaints received are not in relation to MNZ members.

Overseeing this complaints process has highlighted that many of the complaints have come about due to a lack of understanding of professional standards and behaviours, and sloppy delivery. I think it is very timely for us all to remember we are professionals dealing with a varied public population and with varied expectations. Some of us have been around for years and can get complacent with our practices, as we believe we have much experience and are experts. All credit to those that have been around before us and continue to guide us with experience and knowledge, remembering to deliver extremely high levels of professional service. To ensure we are practicing in a manner that is current and professional, check in with your colleagues, peers, business partners or MNZ. Ongoing awareness and discussion is often the best way to highlight any improvements or advancements in the profession. I believe the MNZ membership are operating at a high level of professionalism, reflected by minimal complaints, and hope that our awareness and support of each other continues to drive this. Let's keep our delivery levels high!

Finally, I would like to thank the Executive Committee and associated helpers for the assistance they have provided so far in bringing me up to speed. So much knowledge and support from busy and experienced members, very much appreciated!

Clint Knox

# EDUCATION OFFICER

Coming into my third year in this role it is good to reflect on how much knowledge I have gained over the past couple of years and yet as always with knowledge – the more you know the more you realise how much you don't know. There is always room for improvement.

The goals set in the very early stages of taking on the Education Officer role still ring true.

a. **GOAL**: Building a good relationship between MNZ and the providers who are growing our next generation of massage therapists.

   **REFLECTION**: There has been some great two-way communication and connection.

   **FOCUS**: Continue to build upon this foundation.

b. **GOAL**: Increasing student membership.

   **REFLECTION**: Several providers now have all their students enroll with MNZ as part of the orientation week.

   **FOCUS**: Student membership to be standard practice for all providers.

c. **GOAL**: Simplifying RPL process for overseas applicants.

   **REFLECTION**: We are using NZQA and practical tests to assess more complex applicants.

   **FOCUS**: Ensuring standards are maintained and improving timeframe for applications.

It is also good to have a new challenge and this year I would like to turn my attention to encouraging massage therapists to stretch their wings a little and undertake some good quality post-graduate learning. This rekindles the spark for your work and ensures that it is never mundane. We can never learn enough about the intricacies of the human body.

*Rosie Greene*

# REGIONAL LIAISON CO-ORDINATOR

Hello,

Over the last few months as I have travelled and holidayed around the North Island, I have had catch ups with lots of different massage professionals, students, education providers, old colleagues, new colleagues and suppliers. It has been very rewarding having these conversations and feeling the buzz and excitement from everyone. The main comments I have heard have been about the feeling of passion and commitment to the profession. Networks and friendships are being developed across the regions. We have seen an enhancement of public perception of massage in New Zealand. There has been a definite energy shift over the last 12 months or so. This is a direct reflection of all the hard work that you all put into your massage careers and the profession.

My absolute goal for 2019 as Regional Liaison Officer is to continue to build on all the hard work and input from 2018. Continue to support and encourage each other.

*Tania Kahika-Foote*

# RESEARCH OFFICER

Hello and welcome to first MNZ magazine of the year. My 2019 started with a hiss and a roar with only a little time over morning coffees to read Polit & Beck (2014) before racing off through Auckland traffic to Albany. I envisage an APP I can button-select massage research, while I sit in my car. Finding podcasts and hooking them up through Bluetooth takes ages! This is a reflection of a racing brain rather than antipathy towards technology. On that subtle reference, to a possible glitch in mid-lifers' generational capability for techno-agility, I recently heard an interview with author, John Leland, about his new book Happiness Lessons From the Oldest Old. It brought me up short. In becoming a massage therapist, I learnt how to slow down to the pace of other's needs. This is part of a 30-year practice. Racing, on the other hand, is a phenomenon of city life – and possibly technology. Slowing to listen to client's breathing and picking up the tenor of my breath in day-to-day life requires rebalancing – it's a continuum, therefore. Taking time to pore through the new edition of the MNZ Magazine may help us all balance the speedy vibe and connect back into our massage practice mode.

*Felicity Molloy*

# ADMINISTRATION REPORT

We hope the beginning of 2019 has been filled with refreshed feelings and rejuvenated plans for the year ahead.

The focus for this magazine involves movement. It is the role of the Administration team to keep things moving forward by giving support to the hard working and inspiring members of the Executive and Non-Executive Committees in this ever-growing organisation. There are several projects on the go. Some involve streamlining processes and systems to increase efficiency and professionalism. Others focus on increasing the professional image of the organisation and its' members and build on important business relationships and networks.

We continue to update and improve the information on offer to members and the public. Don't miss out on the "What to Expect at your Massage Appointment" monthly notices on the News feed of our website. These notices are also posted on Facebook and Instagram. Please share these posts! This continues to build exposure of MNZ and massage therapy on a national and international platform.

We encourage MNZ members to keep moving towards becoming a better therapist, student, colleague and member of the profession. Make the most of the benefits on offer to MNZ members. Attending regional and national meetings is a great way to connect with other therapists and health professionals. As a member you can publish listings yourself for free on our Marketplace board on the website. It's a great way to communicate and trade privately with other members. Also, keep an eye on the website News feed and Jobs Board for important notices and opportunities.

Finally, if you are able and willing to offer your valuable time to contribute to MNZ, even in the smallest of ways then please get in touch. We have an amazing team of people who can provide you with the support you need to keep things moving in the right direction. The smallest of change can lead to a most fundamental shift.

We hope you enjoy the Easter break!

Nici Stirrup & Melissa Orchard

**Executive Administrator / General Administrator**

# REGIONAL ROUNDUP

## UPPER NORTH ISLAND REPORT

As members of MNZ I feel that in order to maintain momentum and continue our successes in 2019 then we all need to take a turn at standing up and volunteering a little of our time, enthusiasm and support. It is with this in mind that I ask you all to consider helping out with your local networking meeting or indeed starting one up if there is not one in close proximity to you. It may seem daunting but in fact it is fairly simple and definitely rewarding.

The Auckland meeting in December was held at the Northcote Tavern with a small turnout of seven members and three non-members. Jeannie Douglas has kindly offered to organise three get togethers this year at NZCM Greenlane, the first being the end of April. We are still looking for a volunteer to be the Northshore Meeting Co-ordinator as we look to split the bi-monthly meetings between Greenlane and Northshore. The Meeting Co-ordinator has to choose discussion topics or arrange speakers, be there on the night as a point of contact and to facilitate, and brief me as to how the meeting went. I will do my best to support where I can with speaker ideas and advertising. We even have a tentative plan of speaker and venue for the Northshore for a meeting in March. If this is something you are interested in helping with please let me know.

The Northland MNZ group meeting in December had six members dining at the very yummy No.8 restaurant in Whangarei. Delicious food kept arriving, tasty wine was enjoyed and generous conversation kept flowing. A great way to end 2018. If anyone would like to put up their hand to take over organising the regular meetings please let me know as due to other MNZ commitments Tania is stepping down from this role as Meeting Co-ordinator.

December Hamilton meeting had nine attendees, a mix of members, non-members and student members. It was an informal occasion with a few nibbles and lots of conversation about what brought everyone into the massage profession, the benefits of being a member, the up-coming conference in 2019 and ideas for the 2019 meetings. The first meeting of 2019 was on the 11th of February and had a good group of MTs catching up, making plans for speakers for the year, discussing the upcoming conference and swapping favourite massage techniques.

After speaking with Tina Buckler and others at the MNZ Conference in Tauranga, the Whakatane region is all set to start meeting up. A date, time and place will follow soon. Please let me or Tina Buckler know if you are interested in meeting. You can contact Tina Buckler at debod@xtra.co.nz

Coromandel had their first meeting in over a year with 4 members catching up for a chat over coffee on the 6th December in Paeroa. It seems that there are a few MTs in this region who are keen to meet up. We'll be trying to arrange another date and perhaps vary the location throughout the Coromandel to make it easy for everyone to attend. Again, please email me if you would like to be the Meeting Co-ordinator for this region.

Don't forget that the conference is in the Upper North Island Region this year. Hamilton is where it IS happening and I am super excited about the line up of speakers and workshops. If you are in the Hamilton area and have room to billet or host a fellow MNZ member to make it more affordable for them to attend the conference then please let us know by emailing conference@massagenewzealand.org.nz

Annika Leadley

# MEMBERSHIP RENEWALS FOR 1 APRIL 2019 – 31 MARCH 2020

**Melissa Orchard**

All invoices did go out mid March, if you for some reason didn't receive your invoice, perhaps it went to your spam or junk mail box, please email me and I will email out another one.

It is a very busy time during the renewal period and if all members could follow the correct procedure, it will save a lot of time and money for MNZ.

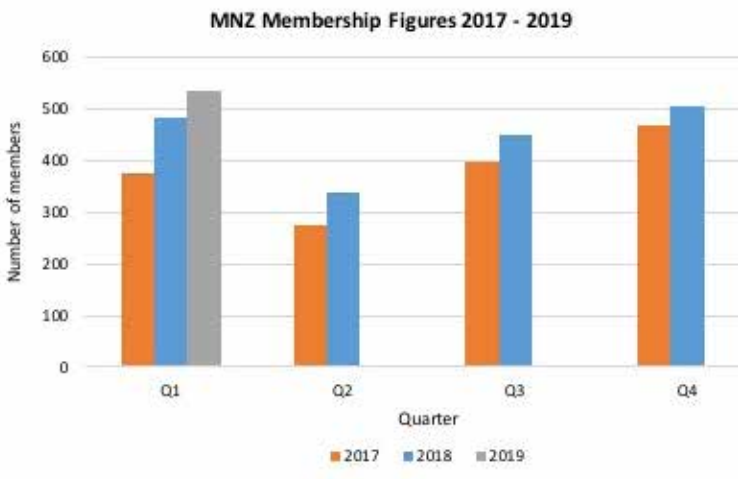
- Please make sure your CPD hours are up to date by logging them online at https://www.massagenewzealand.org.nz/Site/members/cpd/my-cpd.aspx
- Make sure your first aid certificate is current, if not please upload your new one on your CPD log at https://www.massagenewzealand.org.nz/Site/members/cpd/my-cpd.aspx
- Are your address details correct as this is where your paperwork will be sent to.
- You will have received an invoice from MNZ mid March. Once your CPD hours and first aid are complete please pay your invoice.
- As everyone will be renewing at once please be patient and your membership will be renewed in order. For those that haven't followed the procedure, please expect this to take longer.
- If you received the MMA magazine last year and don't wish to receive it anymore please email membership@massagenewzealand.org.nz when you get your invoice and I can adjust it accordingly. If you wish to receive the MMA magazine and didn't last year then let me know also so I can add it to your invoice.
- If you were a student member and want to upgrade to be a graduate RMT member for 2019, you will need to email me your massage qualification and a current first aid certificate to membership@massagenewzealand.org.nz.
- For those of you who are still studying, remember to renew your free student membership if you haven't already. You just need to email me a copy of a college letter stating what course you are studying this year. Perhaps you can encourage a few of your class mates to join too if they haven't already, direct them to our website.

If you have any questions regarding membership please email membership@massagenewzealand.org.nz

Thanks in advance for your patience, it's going to be a great year.

# MEMBERSHIP UPDATE

Figures for this quarter show a total of 536 members, made up of 407 RMTs, 108 students and 21 Affiliates. The membership numbers are increasing which is great to see, along with a lot of students upgrading to RMTs. These figures are higher than last year which was a record year. There are a lot of students joining at the moment and remember, if you were a student member last year you are entitled to the Graduate Membership fee this year. To upgrade to an RMT you will need to email a copy of your diploma and current first aid certificate to membership@massagenewzealand.org.nz. If you are a student please encourage your fellow students to become MNZ members too. It's a no brainer really, a free membership with many benefits. Keep getting the word out there to other non-member Massage Therapists, encourage them to come along to local MNZ Massage Group meetings and let's get them to sign up to Massage New Zealand too.



# MNZ CONFERENCE 2019

## WHEN

**20-22 September 2019**

## WHERE

**Wintec**

Rotokauri Campus, Hamilton

**FEATURING**

Ian O'Dwyer, Australia – Massage to Motion

Brian Utting, USA – Muscle Specific Deep Tissue Techniques & Bindegewebs Massage

Paula Jaspar, Canada – Massage for Pregnancy, Post Caesarean Section & Breast Health

and much more

**WWW.MASSAGENEWZEALAND.ORG.NZ**
**WWW.FACEBOOK.COM/MNZCONFERENCE/**

## MORE DETAILS TO COME

Save the date in your diary
Watch out for more info on the MNZ website or Facebook page

## REGISTRATIONS

Registrations will be open in May 2019
Pre-Conference Friday
Conference Saturday & Sunday
Non MNZ Members welcome

## COST

Early Bird Discounts
Discounts for MNZ Members and Students

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# WHAT'S ON...

| GROUP | WHAT/WHEN/WHERE/HOW TO REGISTER |
|---|---|
| Northland MNZ Networking | **Contact: Tania Kahika-Foote**<br>liaisoncoord@massagenewzealand.org.nz |
| Coromandel MNZ Networking | **Contact: Lisa Stent**<br>stentfamily@xtra.co.nz |
| Whakatane MNZ Networking | **Contact: Tina Buckler**<br>debod@xtra.co.nz |
| Auckland MNZ Networking | April - TBA<br>**Contact: Mark Fewtrell**<br>mark3massage@gmail.com |
| Hamilton and Surrounds MNZ Networking | Tuesday 9th April<br>**Venue**: The Cancer Society's Lions Lodge, Hamilton.<br>**Contact: Annika Leadley**<br>uppernirep@massagenewzealand.org.nz |
| MNZ Conference | 20th-22nd September<br>Venue: Rotokauri Campus, Hamilton<br>conference@massagenewzealand.org.nz |
| Tauranga MNZ Networking | **Contact: Melissa Orchard**<br>membership@massagenewzealand.org.nz |
| Wellington MNZ Networking | May: Breakfast Get together - TBA<br>July: Case Study Presentation – Scott Barrett<br>September: Small Business Workshop<br>November: End of Year breakfast.<br>**Contact: Iselde De Boam**<br>info@absolutetherapy.co.nz |
| Kapiti MNZ Networking | Thursday 4th April, 7pm: Chiropractic Care and Links with Massage<br>**Venue**: Functional Bodyworks, Paraparaumu<br>Presenter: Jack Madden, Thrive Chiropractic, Paraparaumu.<br>**Contact: Trevor Hamilton**<br>fbodyworks@gmail.com |
| Blenheim/Nelson environs MNZ Massage Group | **Contact**: Volunteer required |
| Christchurch MNZ Massage Group | **Contact**: Volunteer required |
| Dunedin MNZ Massage Group | **Contact**: Volunteer required |

*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*

# WHO'S WHERE

## WELLNESS AT WORK - MT EDEN, AUCKLAND

In case you missed it, Wellness at Work Ltd has moved to a brilliant new premises. 30 Sherbourne Rd Mt Eden, it's light and bright with loads more room and great atmosphere. Take a look and we look forward to seeing you soon.

*Chris Toal and Alla Kalinina*

## RACHEL DICKINSON - ISLAND BAY, WELLINGTON

After nearly 14 years at Freyberg Pool, Rachel Dickinson is moving her practice to the Bendy Buddha clinic. Owned by Kate Roberts - acupuncturist and yoga teacher extraordinaire - Bendy Buddha is a peaceful sanctuary in Wellington's seaside suburb of Island Bay.

Rachel will be there on Tuesdays and Fridays, and one Saturday a month:
107 Melbourne Rd, Island Bay, Wellington
www.bendybuddha.co.nz
racheldickinsonmassagetherapy@gmail.com

## NZ COLLEGE OF MASSAGE, WELLINGTON

We're proud to announce that we have moved to a vibrant, purpose built campus located at the historic Wellington Railway Station. This will make commuting so much easier and allow our students more time to study.

Level 1, Wellington Railway Station, 2 Bunny Street, Wellington 6011

**If you would like your new location advertised contact:**
**Carol Wilson, Co-editor, magazine@massagenewzealand.org.nz**

# STUDENT CORNER – DEGREE STUDENT

## SCOTT BARRETT – STUDYING AT NZ COLLEGE OF MASSAGE, WELLINGTON

### The City/Town you live/study in, where you work

I'm currently living in Miramar, Wellington, which is where I have also based my practice over the past couple of years. Harmonious Health - Soft Tissue and Neuromuscular Therapy, is currently unregistered and un-marketed as it is a part time job during study.

It is however in the process of becoming registered and will be moving to a separate premise in the CBD, to function as a fully set up clinic.

### Any interests

I am also trained in Reiki healing and can practise as a Reiki Master Practitioner. Harmonious Health aligns itself with similar values to the Te Whare Tapa Wha model, in that spiritual, social and mental health are just as important as physical health.

My main interests are exercise and running my dog or taking her to the beach, cooking, building and other DIY projects, singing, and helping people whenever I can (which is part of the reason I got into massage).

### Training

I enrolled in the first year Diploma in Wellness and Relaxation Massage at the New Zealand College of Massage... and loved it!

I have since completed that diploma and the second year Diploma in Clinical Therapeutic Massage, with the potential of having my most previous case study published.

I am currently enrolled in the third year part-time degree and really looking forward to

expanding my knowledge and the services I can offer.

I'm also looking at doing courses in acupuncture, visceral manipulation, and positive neuroplasty to further my knowledge and client base in the future.

### When did you join MNZ as a student member?

I originally joined MNZ as a student in 2017 because I liked the idea of getting involved in a profession, striving to be better regulated and monitored, so that massage therapists may be seen as a possible medical alternative.

### What motivated you to decide to train in Massage Therapy?

Growing up in Whanganui, my family members and friends would all ask me to give them a massage, and I used to love doing that for them. When I was still in high school though, I got into part time hospitality work, which eventually resulted in leaving high school and doing qualifications in front of house, as a chef, barista and bar worker. Over the 15 years I spent in hospitality, I was still interested in massage and had asked a few therapists what was involved in the training. After finding out the amount of physiology and anatomy that was involved, I was unsure and spent a few more years in hospitality. Finally at 28, I realised 30 was coming up fast, and if I didn't do something, I'd be working in hospitality for the rest of my life. I was freaking out about being a poor student again, but I had to take the risk.

### What are you enjoying most and what you are finding challenging in your massage studies?

As it turns out I loved Anatomy and Physiology, and although I strongly disliked research and writing reports, I'm starting to get my head around it now, and beginning to enjoy that as well... don't tell my tutors.

### Where do you see yourself working in the profession after you graduate?

I have just joined Absolute Therapy team in Wellington and look forward to learning lots from Iselde de Boam and the other therapists there, with the aim to continue there once I have my degree.

Also I hope to expand my own clinic into a multiple disciplinary clinic in the future.

### What do you feel that you get out of being a MNZ student member?

I also feel it's important that if you are going to providing massage, then you should know what you're doing, to provide a safe environment, and to be MNZ registered, even as a student, till I can upgrade once fully qualified. I really look forward to seeing where massage as a whole, leads to in the future.

# 2018 MNZ CASE REPORT CONTEST – TUI BALMS BRONZE AWARD WINNER

Massage New Zealand is delighted to announce that Hayley Ward has been awarded the **Tui Balms Bronze Award**, in the first **MNZ Case Report Contest**. Hayley entered the contest in November 2018 with her case report, "***The Effects of Massage Therapy and Movement Therapy on an Office Worker with Low Back Pain***". Hayley's case report was assessed and graded by our panel of independent judges and was deemed to have met the standard of the bronze award. Hayley provided a well written case report with good use of research to highlight the importance and benefits of utilising movement education in conjunction with massage therapy to address low back pain. It was evident that a great deal of work and thought had gone into the report and the judging panel commends Hayley on her work.

Hayley recently graduated from the Southern Institute of Technology with a Bachelor of Therapeutic and Sports Massage. This year Hayley begins the two-year Master of Science Communication, endorsed in Science in Society, at the University of Otago. Her research project will be based on environmental sustainability and will be similar to her Bachelor research project where she investigated the effects of an eco-friendly massage therapy workshop on the attitudes and behaviours of massage students. Hayley plans to contribute to the massage therapy profession mainly through academia. She is interested in continuing to mentor and peer-tutor students, contribute to research, and create learning resources.

**As the winner of the Tui Balms Bronze Award, Hayley:**

- Received a voucher to the value of $100, redeemable for Tui Balm products;
- Received a certificate as proof of the award;
- Had her achievement announced via MNZ social media, website and MNZ Magazine;
- Had her case report published in MNZ Magazine and on the MNZ website (you can read her case report on page 26);
- Was invited to present her case report at the 2019 MNZ National Conference (flights and accommodation covered by MNZ).


Hayley has also been encouraged to submit her case report to the International Journal of Therapeutic Massage & Bodywork (IJTMB) and has received some individual mentoring to assist her to bring her case report to the required standard for submission. This mentoring has been provided voluntarily, courtesy of international author, educator and MNZ Magazine Research Update columnist, Ruth Werner, BCTMB. We are very grateful to Ruth for offering her time pro bono.

The Case Report Contest is an opportunity for New Zealand massage therapists to showcase their clinical work, analytical thought processes and to actively participate in the profession, helping to increase awareness of the profession's value in modern, evidence-informed health care.

Case reports have the potential to have a positive influence in advancing the profession by helping to gain acceptance of massage therapy within the mainstream health sector, increasing awareness in the government sector and promoting the benefits of treatment and outcomes to the public.

Massage New Zealand would like to congratulate Hayley on her achievement, hopes she enjoys her prize and wishes her all the best for submission of her case report to the IJTMB for potential publication!

The 2019 MNZ Case Report Contest was announced in late February. Details are on the website and in this issue of MNZ Magazine. We would like to encourage more Massage Therapists and students of Massage Therapy to enter the contest.

For further information, contact:
admin@massagenewzealand.org.nz

# THE EFFECTS OF REDUCING SEDENTARY BEHAVIOURS IN CONJUNCTION WITH MASSAGE THERAPY ON AN OFFICE WORKER WITH LOW BACK PAIN: A CASE REPORT

By Hayley Ward (BTSM, SIT)


## ABSTRACT

**Background**: Sedentary behaviours have become ubiquitous in modern society, but they contribute to poor health at all ages, all-cause mortality, and prevalence of cardiovascular disease, cancer, Type II diabetes, mental health issues, obesity, and musculoskeletal complaints including low back pain (LBP). Targeted efforts are required to reduce the frequency of sedentary behaviours and address the resulting symptoms. There are no case reports that address sedentary behaviours in conjunction with massage therapy to treat LBP.

**Method**: A 38-year-old male with chronic LBP received six remedial massages over seven weeks with education on reducing his sedentary behaviours. His goals were to reduce his pain-related disability and lumbar pain with progress recorded using the toe-touch test, Roland-Morris Disability Questionnaire; the Defense and Veterans Pain Rating Scale; and International Classification of Functioning, Disability, and Health (ICF) model.

**Results**: All assessment measures showed improvement and the client's pain-related disability significantly decreased. He no longer met the criteria for chronic LBP and reported that his LBP did not interfere with activities of daily living. His workday sedentary behaviours decreased by 38.9% (from 18 to 11 hours). The most dramatic differences were improvements in his toe-touch test results and ICF model and he reported meaningful improvements in his general vitality and productivity at work. Six-months post-treatment, most of the benefits have been sustained.

**Conclusion**: Reducing sedentary behaviours alongside massage therapy is a novel treatment approach for individuals with chronic LBP and may be especially helpful for clients that live sedentary lifestyles. In tandem, reducing the client's sedentary behaviours targeted the underlying cause and massage therapy treated the symptoms. Further study is needed to determine if this readily accessible, lower-cost alternative to more invasive treatments is effective and the results are generalisable to a wider audience.


**Keywords**: low back pain; chronic pain; pain-related disability; sedentary behaviour; massage therapy

## INTRODUCTION

Low back pain (LBP) is now surpassing papercuts as the principal occupational hazard of office workers, and it is one of the leading causes of health loss and disablement worldwide.[1] It is estimated that 80% of the population will have a significant episode of LBP during their lifetime and the number of episodes is higher among office workers.[2] Noxious stimulation of spinal muscles, ligaments, dura mater, facet, sacroiliac joints, and intervertebral discs can lead to back pain.[3-5] However, 90% of low back pain cases are idiopathic and referred to as non-specific back pain (NSBP).[6] Treatment of NSBP presents a challenge without any structures or sources ostensibly responsible[7], and treatment outcomes could improve with the use of the biopsychosocial (BPS) model.[8] The BPS model states "environmental (e.g., social, political, physical environment) and individual (e.g., cognitive and affective processes) factors influence the experience of disability" as opposed to the medical model that "views disability as a direct result of disease processes that require treatment."[9, p. 25] An environmental factor significant to this case report is the prevalence of sedentary behaviour in contemporary culture.

Current literature indicates that sedentary behaviours (SB) are a key risk factor for LBP.[10-13] SB are "any waking behaviour characterised by an energy expenditure ≤1.5 metabolic equivalents, while in a sitting, reclining or lying posture"[14, p. 9] and differs from a lack of exercise. People can achieve the recommended levels of physical activity for their age and still spend a high portion of their time engaging in sedentary behaviour.[15] Eighty percent of Americans are insufficiently active[16] and spend over 60% of their time engaged in SB.[17]

However, there is mounting evidence that shows the total volume and accrual of prolonged bouts of SB contribute to poor health at all ages; all-cause, cardiovascular, and cancer mortality; and prevalence of cardiovascular disease, cancer, Type II diabetes, mental health issues, obesity, and musculoskeletal complaints.[18-21] The risk factors for cardiometabolic morbidity and all-cause mortality are independent of physical activity and remain "even when controlling for overall levels of moderate to vigorous physical activity."[22, p. 258] In sum, we are unable to erase the adverse effects from a lifetime of sitting with regular gym visits.

Excessive sitting can cause tightness in the lower body musculature, decreased circulation, deconditioning, and poor posture that leads to increased pain and stiffness in the lower back and contribute to chronic LBP (CLBP).[10] LBP is activity-limiting by definition,[23] and many individuals with chronic pain tend to engage in avoidance behaviours such as muscle guarding and restricting movement for fear of pain or reinjury. Consequently, they spend more time being sedentary and the reduction in activity can be a contributing factor in sub-acute pain becoming chronic pain.[9] Individuals with LBP have been observed to adopt a more static sitting posture than their healthy counterparts, thereby missing the opportunity to engage in frequent low-intensity muscle contractions that are associated with preserving spinal health.[24] At risk are desk workers who commonly suffer from LBP. Their vocation dictates long, uninterrupted periods of sitting and other SB that contribute to a 1-year prevalence of 30-50% for LBP.[25]

Conversely, recent literature reviews[26-27] have not found a causal relationship between sitting and LBP, instead concluding that SB alone do not contribute to incidences of LBP. This is in alignment with the BPS model as numerous factors contribute to the insidious development of LBP and its progression into a chronic condition.[28] Although the literature is inconclusive on the association between sitting and LBP, Vink and Hallbeck[29, p. 272] maintain it is plausible for "discomfort . . . caused by unfavourable or un-ergonomic sitting positions, sitting behaviour or working conditions . . . to lead to musculoskeletal complaints such as LBP."

Non-surgical, non-pharmacological treatment approaches are suggested for treatment of CLBP and typically involve painkillers and muscle relaxants; ice and heat; reduced activity but generally not bed rest; stretching and strengthening exercises; and manual therapies such as physiotherapy and massage therapy.[30,31] Surgery is reserved as a last resort in cases where it is responsible however most cases of NSBP spontaneously resolve themselves within days or weeks of onset.[32] Relaxation and outcome-intended massage therapy is indicated for LBP and NSBP by current literature[32-36] and has been suggested as a non-invasive, cost-effective treatment for CLBP.[30] Pierson[37, p. 38] notes that massage therapy has the unique ability to "concurrently address the mechanical, neurological, and emotional symptoms in a personalised, holistic manner." Hence, remedial massage therapy could be employed to target implicated physiological structures (if known) as well as provide psychological benefits (e.g., stress relief, improved mood).[38] This would offer a BPS perspective to treatment of the multi-faceted nature of LBP and CLBP.

As we are unable to 'out-exercise' our sedentary lifestyles,[22] van der Ploeg and Hillsdon[39] advise light intensity movements (e.g., ambulatory) as well as moderate and vigorous physical activity when reducing sedentary behaviour. Recent studies have demonstrated that workplace interventions to decrease prolonged sedentary behaviour have led to reductions in LBP and CLBP with no loss of productivity, indicating they are suitable for the work environment.[40-43] Therefore, "targeting a reduction in sedentary behaviour (primarily prolonged seating) may be an additional, non-invasive treatment strategy" to treat LBP.[10, p. 321] This could be achieved through dynamic workstations where workers can alternate between sitting and standing, and move more often in general.[44-46]

This manuscript is a retrospective case report detailing the effects of addressing SB and the use of remedial massage therapy on a 38-year-old male office worker with CLBP. His primary goal was to reduce his pain-related disability and thereby improve his ability to participate in life activities, and his secondary goal was to reduce his lumbar pain. There is no published evidence that couples reducing SB with massage therapy to treat LBP. This is a novel approach to treatment of CLBP, and the therapist hypothesised that this treatment approach would lead to a clinically meaningful improvement in the client's pain-related disability and moderate reduction in his pain levels.

## METHOD

### Case Presentation

The 38-year-old male is a self-referred office worker who presented with idiopathic LBP. The pain began nine months before treatment commenced and was localised to his right posterior iliac crest. His goal was to reduce his pain-related disability and lumbar pain but was cognisant that massage therapy might have limited effects. His job is desk-based, and duties entail computer work and interacting with clients with a daily car commute of 30 minutes. He had not sought previous treatment for the LBP nor received a medical diagnosis. He disliked taking medication and did not take any throughout treatment.

The client did not attribute the pain to a single event of high magnitude load, and his health history suggested the cause was cumulative stress and trauma. An active individual, he substituted running with gym work when the pain began. However, despite his running and gym work, the rest of his lifestyle is rather sedentary, and his average workday featured over 10 hours of sedentary behaviour (1-hour commute; 6+ hours work; 1.5 hours eating; and 2+ hours watching television).

Several activities of daily living (ADL) aggravated the LBP such as putting on socks, emptying the dishwasher, "sitting for extended periods [including driving], standing from a sitting position, and bending over in the morning." The client described the LBP as a "subtle stabbing," experiencing near-constant pain that worsened throughout the day. The worst pain (8/10) is experienced when he stood up and was aggravated by prolonged stillness. The 8/10 intensity lasted only minutes, and the client reported that the LBP appeared to be related to a secondary pain in his right anterior hip area, noticeable when bending forward.

## CLINICAL FINDINGS

The client presented with moderate hypertonicity in the bilateral thoracic and lumbar erector spinae and quadratus lumborum (QL), right iliopsoas, and right gluteus minimus and medius. Range of motion was restricted at the trunk; the client could only reach his knees during active trunk flexion (the toe-touch test) that caused pain in his right lumbar area, and active trunk extension and lateral flexion to the right caused pain in his right anterior hip. Passive right hip extension also provoked right anterior hip pain. The trunk range of motion (ROM) tests indicated tension in the erector spinae group, QL, and psoas muscles, and the hip ROMs indicated tension in iliopsoas, tensor fasciae latae (TFL), rectus femoris, and sartorius. The hip findings were supported by positive results bilaterally from the Thomas test (special test that indicates iliopsoas contracture).[47]

Several clinical findings led to an assessment of NSBP: no neurological symptoms, negative sacroiliac joint special tests, daily pain pattern, exceeded expected healing times, and no red flags present.[47] This assessment was supported by the subjective data, palpation and ROM findings. While NSBP is idiopathic, contributing factors in this case were hypertonic erector spinae, QL, and psoas, and it is suspected that the lumbar and anterior hip pain were likely exacerbated by SB. The mechanism of injury for the hip pain was identified as chronic hypertonicity in the hip flexors from prolonged seated postures related to the client's SB.[48] An average workday consisted of 8 hours sleeping in the recovery position with knee bent on affected side; 1-hour

commute; 6+ hours work; 1.5 hours eating; and 2+ hours watching television. This equates to over 18 hours per weekday and 77% of his workweek engaged in SB with a flexed-hip position.

## ASSESSMENT MEASURES

Assessment measures were selected to record changes to the client's pain-related disability and lumbar pain, his primary and secondary goals respectively. Zale and Ditre[9] note that pain-related disability includes physical, occupational, recreational, and social functioning domains. The toe-touch test, Roland-Morris disability questionnaire (RMQ), and ADLs impaired by his LBP provided functional outcomes; the Defense Veterans Pain Rating Scale (DVPRS) measured pain and biopsychosocial changes; and the International Classification of Functioning, Disability, and Health (ICF) Model recorded changes that may not be captured in the other measurement tools.

The toe-touch test was used before and after each treatment with the assumption that improved results reflected a reduction in the client's pain-related disability (i.e., trunk flexion required to put on socks). The RMQ is a self-reported measure of disability for LBP that describes current restrictions in activities. A higher score on the 24-point scale indicates a greater level of disability and is sensitive to change over time in individuals with LBP. The most validated used outcome measure for back pain,[49] it was used at the first and last session as well as at reassessment. In addition to the RMQ, the client was asked what ADLs were affected by his LBP (e.g., ability to bend over to empty dishwasher) each session. The RMQ is a highly respected outcome measure but is standardised and did not include many of the client's ADL restrictions. The DVPRS is a self-reported numeric pain rating scale that uses functional language to better depicts clients' experiences of pain. Supplementary questions measure how the pain interferes with usual activity and the biopsychosocial dimensions[50] and was utilised at each session. The ICF model goes beyond clinical outcomes and considers what is meaningful to the client, thereby identifying what constitutes a positive outcome for the client.[8] For this client, it was decreasing his pain-related disability in order to resume running and enjoy a better quality of life.

## THERAPIST PROFILE

This case report was completed as part of the therapist's third-year coursework for the Bachelor of Therapeutic and Sports Massage degree at the Southern Institute of Technology, Invercargill, New Zealand. All sessions were conducted at the Southern Institute of Technology's massage clinic, and all interventions were within the therapist's scope of practice.

## INTERVENTION

Treatment consisted of six 30-60 minute weekly massages (with one exception) from March to May 2018. At each session, the client received a remedial massage and strategies to incorporate more movement into his day. An overview of treatment sessions is provided in Table 1. Sessions were 60-90 minutes in duration depending on the client's availability. Discussing SB was used in conjunction with remedial massage therapy to create long-term change. Massage therapy can create tissue change and lengthen hypertonic tissue, but effects would be temporary if SB (contributing factors to the lumbar and hip issues) were not improved. The client gave written informed consent to participate in this case report and publication.

Neuromuscular therapy (NMT) treatments formed the foundation of each massage intervention, and the protocols used were based on the Southern Institute of Technology's[51] NMT protocols that are similar to Chaitow and DeLany's.[33] Myofascial release (MFR), soft tissue release, compressions, and a scraping technique with a ceramic spoon were included in treatment with the intent of improving the quality of tissue.[3,7,32-36,38,52] Although the mechanisms are unknown, anecdotal evidence and the therapist's experience support their efficacy at creating tissue change.

Addressing the client's SB centred on practical solutions that he could implement into his daily life such as exercises from the Daily Movement Multivitamin (DMV) poster purchased from Nutritious Movement[53] and discussions on how to create opportunities for movement in the client's workday. This included creating a dynamic workstation and encouraging the client to walk into the adjoining office to talk to his co-worker instead of yelling or telephoning him and going to reception to pick up the mail instead of having it delivered. Ergonomics were not included as part of treatment as the therapist did not wish the client to think that prolonged sitting was healthier if done in an 'optimised' position.[44] Foam rolling was advised as a form of self-care that the client found enjoyable and necessitates more movement than static stretching. Evidence for the physiological benefits of foam rolling are limited by methodological heterogeneity. However, on balance, Cheatham et al.'s[54] systematic review indicates foam rolling may temporarily increase range of motion.

Treatment began by lengthening hypertonic muscles suspected to be contributing to the client's symptoms, detailed in Table 1. The client's pain-related disability and lumbar pain decreased after the first two


*Figure 1. Daily Movement Vitamin excerpt from Nutritious Movement.*(53)

| | |
|---|---|
| **Session 1**<br>**Day 1** | *Treatment* 30 minutes, MFR to bilateral lumbar region, and spoon technique and NMT applied to right QL.<br>*Rationale* QL was indicated by the subjective data, palpation findings, and reduced trunk flexion.<br>*Outcome* Significant tissue change, pain decreased from $^{4}/_{10}$ to $^{0}/_{10}$, and increased trunk flexion.<br>*Client education* Client given DMV sheet to complete activities daily and brainstormed ideas on how to incorporate movement into his day and reduce pain when driving (e.g., altering steering wheel height and trial the heated car seat function). |
| **Session 2**<br>**Day 8** | *Treatment* 30 minutes, MFR to back and NMT to right QL, spoon and hot towel used on right QL.<br>*Rationale* QL was indicated by the subjective data, ROM findings, and its hypertonicity.<br>*Outcome* Adequate tissue change, no pain and increased range of motion on all ROM tests.<br>*Client education* Use foam roller and meet with his workplace health and safety liaison to improve his workspace and potentially get a standing desk. |
| **Session 3**<br>**Day 22** | *Treatment* 30 minutes, MFR and NMT to right iliopsoas.<br>*Rationale* Iliopsoas indicated by trunk and hip ROM tests; psoas attaches to TP L1-L5 and can mimic QL pain (attaches to TP L1-L4).<br>*Outcome* No pain on ROMs; increased trunk flexion – interesting that treating the hip flexors enabled greater trunk flexion.<br>*Client education* Discussion on reducing sedentary behaviours at home. Start "walking meetings" with colleagues. |
| **Session 4**<br>**Day 29** | *Treatment* 40 minutes, MFR and NMT to bilateral erector spinae and right QL.<br>*Rationale* Muscles indicated by subjective, ROM findings, and reduced trunk flexion. Worst session for client as he had just moved house.<br>*Outcome* Pain reduced on ROMs and range of motion increased. Client noted "the nagging in my back when I stand is gone."<br>*Client education* Reflected on progress and discussed long-term change to his sedentary behaviours (i.e., how to maintain new habits). |
| **Session 5**<br>**Day 35** | *Treatment* 50 minutes, NMT to right TFL, iliotibial band (ITB), gluteus medius and minimus.<br>*Rationale* Muscles indicated by subjective (no LBP – *only* hip pain), hip pain present on ROMs – possibly exacerbated by his recent return to running.<br>*Outcome* Substantial tissue change, all ROM pain gone, and the client said he "can't believe how good it feels, bloody spectacular!"<br>*Client education* Analysis of sleeping position (8 hours in recovery position with flexed right hip) and trialling sleeping on other side, sleeping without a pillow, and with a pillow between his knees. |
| **Session 6**<br>**Day 42** | *Treatment* 60 minutes, NMT to right quadriceps, TFL, ITB, gluteus medius and minimus.<br>*Rationale* Again no LBP, only hip pain. Therapist misread ROM findings and should have treated iliopsoas.<br>*Outcome* Significant tissue change and increased trunk flexion despite treating muscles not indicated by the ROM findings.<br>*Client education* Recapped self-care to date and completed some DMV activities together to ensure he was completing them correctly. |

*Table 1. Massage Intervention: Overview of each session's treatment, rationale, post-massage results, and client education.*

massages. However, as the LBP subsided, the client's anterior hip pain became more prominent. The LBP possibly masked the hip pain. After consultation with the client, the treatment focus moved to the hip pain which was more acute than the LBP had been. Furthermore, a hypertonic psoas muscle could be contributing to the LBP and hip pain because of its origins on the vertebrae L1-L5.

## RESULTS

At the end of treatment, the client reported significant reductions in his pain-related disability and lumbar pain as well as increased vigour. Most improvements were sustained five weeks post-treatment during reassessment and six-months post-treatment during a follow-up phone call despite not receiving any massage therapy since treatment ended. His sedentary behaviour on workdays had decreased 38.9% (from 18 to 11 hours), largely due to a new standing work desk. The client reported being able to move more freely in his ADLs (e.g., put on socks, empty dishwasher, and walk dog) and had resumed running. His work rate improved as he was better able to concentrate. His LBP had not returned six-months post-treatment, and he only experienced occasional hip pain with certain movements (e.g., in the last 5° of standing up after prolonged sitting). Overall, the client's adherence to self-care (reducing his SB) was high during and after treatment and is to be commended.

The client's toe-touch test results improved at each session as shown in Figure 2, with positive results maintaining five weeks after treatment and his trunk and hip ROM tests were pain-free and within normal limits at the end of treatment and during reassessment. The modified Thomas test that was initially positive was negative at the final session and remained negative five weeks later.

The client's RMQ score decreased from four to three items on the 24-point scale at the end of treatment (Table 2). This is a 25% improvement but infers minimal change as both scores indicate a lower level of disability. The DVPRS (Figure 3) showed improvements to pain, activity, sleep, mood, and stress, however, five-weeks post-treatment scores reversed slightly or returned to their initial values. The ICF Model, shown in Figure 4, lists biopsychosocial changes in the client pre-treatment and five-weeks post-treatment. Notable changes include improvements in his activities (able to empty dishwasher and put on his socks pain-free), participation (can run 6km and attend his running group), environment (standing work desk has reduced his sedentary behaviour by one-third), and personal (the client now feels empowered to take ownership of his health).

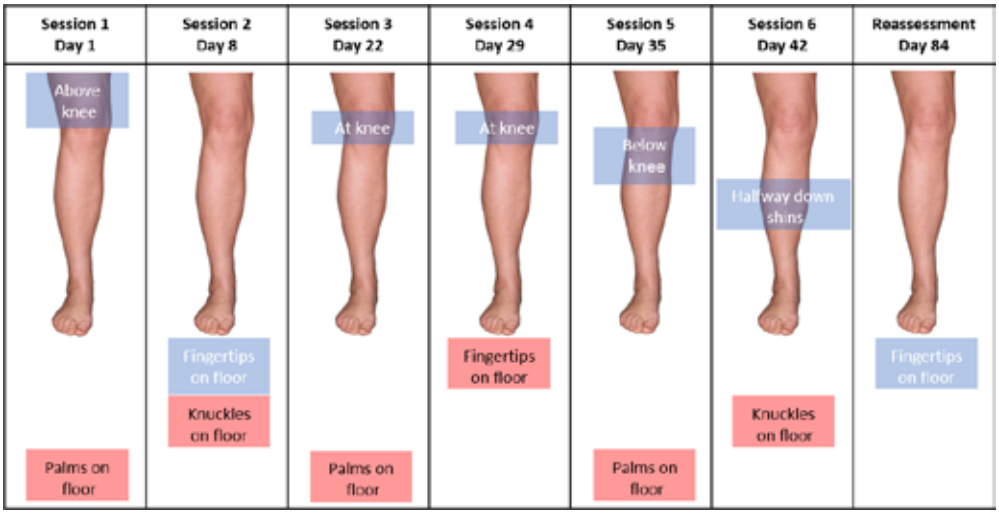


*Figure 2. Toe-touch test Results from Pre-Massage (blue boxes with white font) and Post-Massage (red boxes with black font).*

| Item | Statement | Session 1 Day 1 | Session 6 Day 42 | Reassessment Day 84 |
|---|---|---|---|---|
| 1 | Stay home | | | |
| 2 | Change position frequently | ✔ | ✔ | ✔ |
| 3 | Walk more slowly | | | |
| 4 | Not doing jobs around the house | | | |
| 5 | Use a handrail up stairs | | | |
| 6 | Lie down to rest more often | ✔ | ✔ | ✔ |
| 7 | Hold on to something to get out of easy chair | | | |
| 8 | Try to get other people to do things for me | | | |
| 9 | Dress more slowly | | | |
| 10 | Stand for short periods | ✔ | | |
| 11 | Try not to bend or kneel down | | | |
| 12 | Difficult to get out of a chair | | | |
| 13 | Back painful most of time | ✔ | ✔ | ✔ |
| 14 | Difficult to turn over in bed | | | |
| 15 | Appetite is reduced | | | |
| 16 | Difficulty putting on my socks | | | |
| 17 | Only walk short distances | | | |
| 18 | Sleep less well | | | |
| 19 | Get dressed with help of someone else | | | |
| 20 | Sit down for most of day | | | |
| 21 | Avoid heavy jobs around the house | | | |
| 22 | Am more irritable and bad-tempered with people | | | |
| 23 | Go upstairs more slowly | | | |
| 24 | Stay in bed most of time | | | |
| | **SCORE** | 4/24 | 3/24 | 3/24 |
| | **IMPROVEMENT** | - | 12.5% | 0% |

*Table 2. Roland-Morris Disability Questionnaire results (attenuated version for publication).(55) Clients are instructed to select each statement that describes their current activity restriction.*

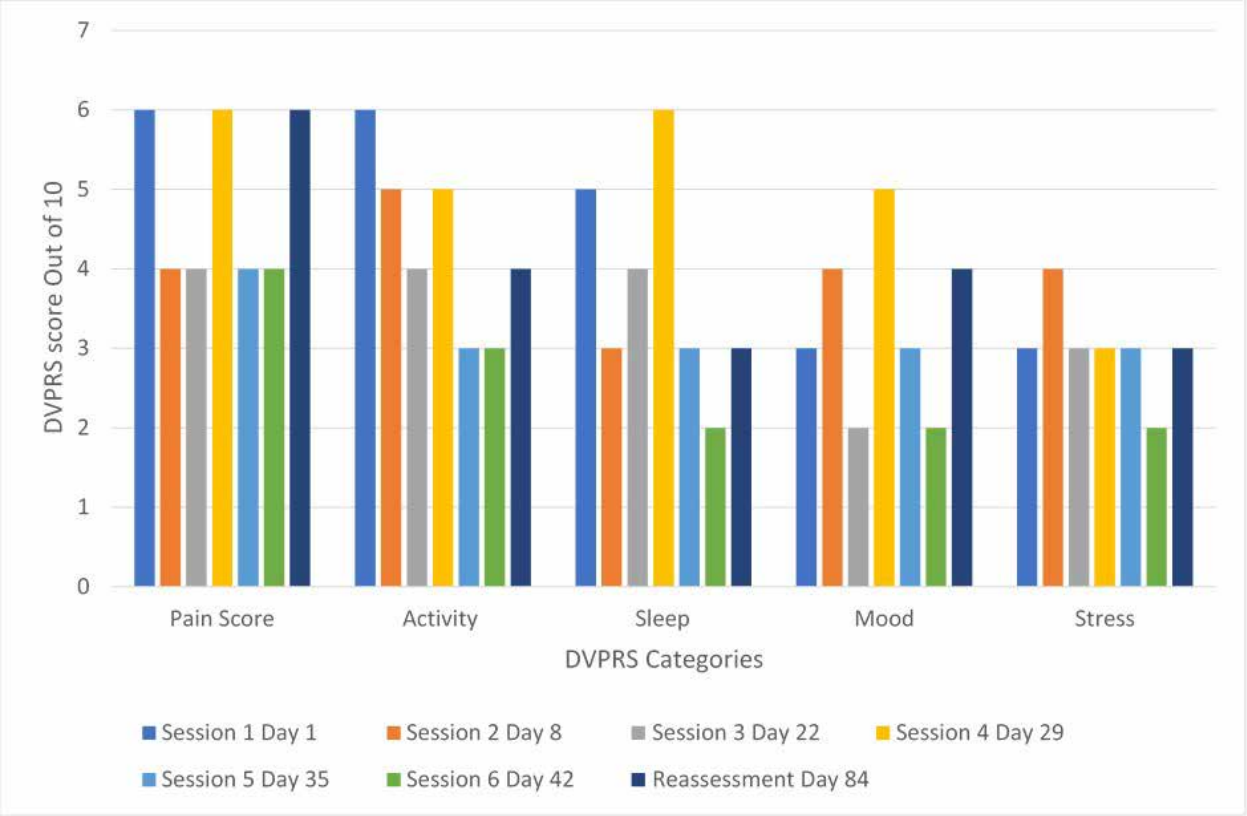


*Figure 3. The client's DVPRS results from each session.*

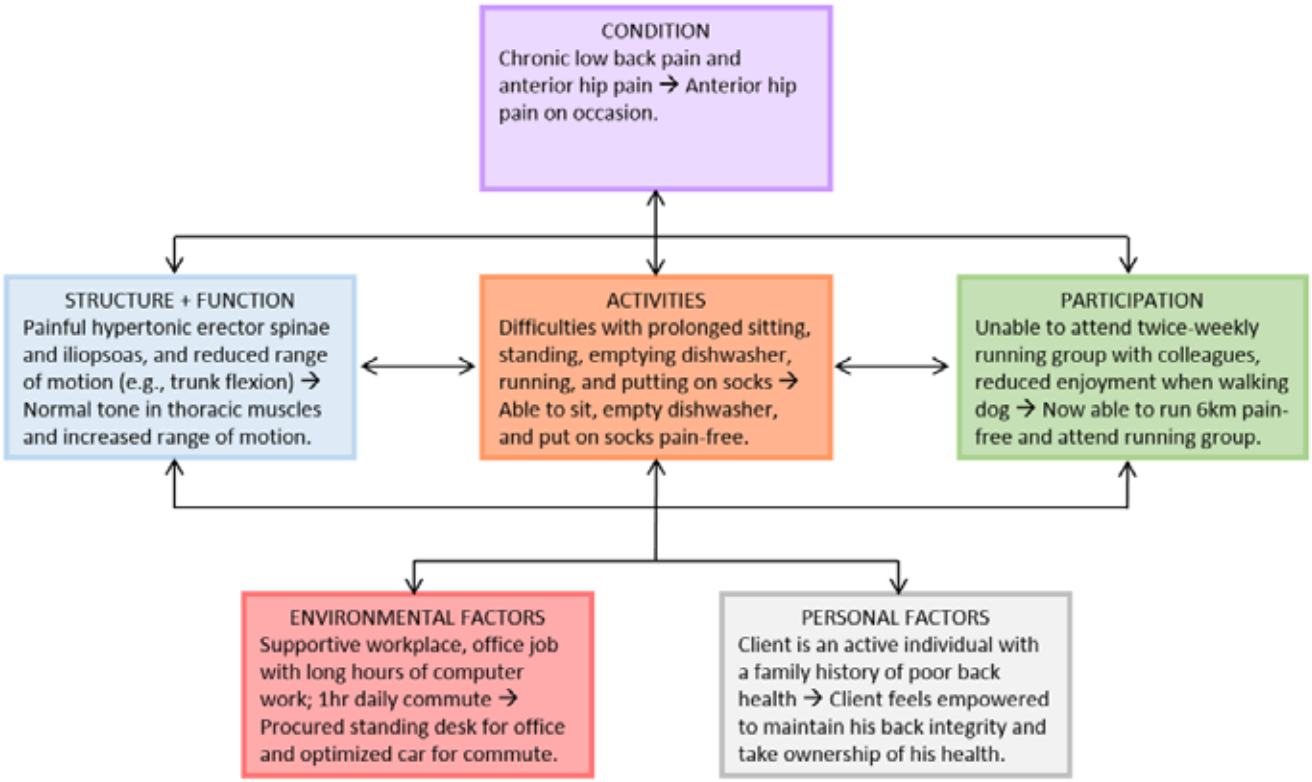


*Figure 4. The ICF Model demonstrating pre-and post-intervention biopsychosocial changes.*

## DISCUSSION

The goal for this case report was to determine if reducing sedentary behaviour in conjunction with remedial massage therapy could be beneficial to a client with CLBP. The results suggest that the treatment plan had a positive effect on the pain-related disability and lumbar pain of the participant. Most notably, substantial improvement was experienced by the client in his ability to complete ADLs such as put on socks, empty the dishwasher, drive and walk his dog pain-free, and has returned to his social activity, running. Alongside this achievement in functional outcomes, the client's toe-touch test results improved during each treatment session and throughout treatment. After each treatment, results showed a pronounced difference regardless of whether the trunk extensors, hip flexors or extensors were treated, indicating tension in all muscle groups. Initially, the client was able to reach above his knees, by the end of the treatment plan he could place his knuckles on the floor. Five weeks post-treatment, the benefit was sustained, suggesting his LBP-related stiffness had significantly reduced. The participant's sitting time decreased by 38.9% on workdays, from 18 hours to 11 hours and as he implemented more movement into his workday, he reported a boost in productivity due to increased mental alertness. The client reported that the standing desk reduced a barrier to more frequent ambulation. The client's lumbar pain has ceased and had not returned at reassessment, suggesting that the client no longer met the criteria for CLBP. The anterior hip pain remained at a lesser extent. However, given its suspected cause (years of 18 hours of daily hip flexion), it is understandable that six massage sessions were unable to resolve it.

The client's positive subjective experience appears to contradict the outcome measures. The RMQ showed marginal improvement (from 4 items to 3 items, a 25% improvement) that is not enough to be considered a minimal clinically meaningful difference[56] and there was considerable variability in the DVPRS results. The client did not distinguish between the LBP and hip pain (therapist's error) that may have distorted the DVPRS results. Fogel[57] notes pain-levels can be inconsistent in individuals with chronic pain, in part due to the multifactorial nature of chronic pain. However, the client now only experiences moments of hip pain when completing certain movements and no longer meets the eligibility criteria for CLBP, and in balance, the treatment appears to be successful at reducing his LBP. Although not an outcome measurement tool, the ICF model was effective at presenting the client's improvement in function and quality of life. The domains allowed important factors to be documented that may have otherwise been overlooked. Examples include the client's meaningful activities and relationships (participation domain) and the client's personal and professional spaces (environment domain).

This case report did not follow a set protocol but designed treatments in accordance with the session's assessment findings, the client's input, and clinical reasoning. It is an example of evidence-informed practice that can contribute to the evidence base for the efficacy of massage therapy. Other strengths of this case report include the long-term run-out period, the assessment measures used, and the combined treatment approach. The study could have benefited from using a fitness tracker (e.g., Fitbit) to measure change in physical activity levels through the intervention. Lotzke et al.[58] used daily steps as a measure of total physical activity in their study of the physical activity levels of LBP patients awaiting lumbar fusion surgery. The use of a fitness tracker or hip-based accelerometer[18] could provide an objective metric of SB as well as physical activity if data was analysed in hourly and daily intervals. This could identify total and temporal movement patterns (e.g., did the individual meet their daily step total but engage in prolonged sedentary behaviour?,[15] how often did the client engage in ambulatory movements?). Depending on the therapist's qualifications, advising clients on physical activity may be outside their scope of practice, and they may have to work with another healthcare practitioner (e.g., physical therapist).

## CONCLUSION

Millions of people worldwide suffer from LBP and CLBP. Addressing SB in conjunction with massage therapy is an exciting and promising approach to treatment that may lead to improved health outcomes. Treatment was successful in helping the client to reduce his pain-related disability, and CLBP and the benefits of this treatment approach went beyond the initial sphere of influence to the client's immediate family and colleague (e.g., colleague also got standing desk). As a case report, causality cannot be shown. Robust research is warranted to determine if the results are generalisable to the wider population. LBP clinical trials could investigate the efficacy of the combined treatment approach with control; massage-only; addressing sedentary behaviours-only; and combined-approach groups. The study of SB is a rapidly expanding field, and with SB a ubiquitous part of modern society, health care practitioners could benefit from expanding their knowledge and application of the topic.

## ACKNOWLEDGMENTS

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# STEPPING AHEAD WITH FOOT MOBILISATION THERAPIES

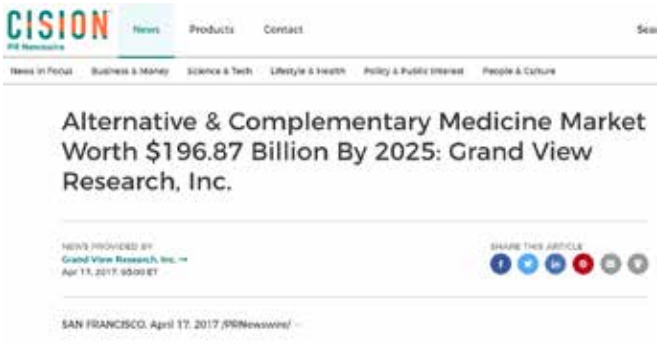
**By Ted Jedynak**
**Podiatrist + International Educator in Manual Therapies**

How confident are you in addressing your clients with foot problems?

The biomechanics of foot functions, normal and compensatory, are highly complex. Manual therapy professionals like remedial massage therapists, chiropractors and physiotherapists generally only have a basic level of knowledge of foot biomechanics.

While podiatrists typically have a higher level of training in the biomechanical principles of the foot and leg, their manual therapy skills are low, if at all present. This is because few training institutions include manual therapy in their curriculum.

Yes, 'hands-on' skills are subjective and can take time to develop but this also happens to be something our consumers, our clients are demanding. The alternative and natural health industry is on its way to being worth 196 billion dollars! This is despite the greatest technological evolution in history.


CISION

Alternative & Complementary Medicine Market Worth $196.87 Billion By 2025: Grand View Research, Inc.

Upon graduating as a podiatrist in 1982, the primary treatment option for musculoskeletal conditions I and my peers were taught was orthotic therapy. In my clinic, I would often hear my clients ask (or complain!), '**...isn't there something else you can do for me apart from orthotics?**'

In particular, business women, gymnasts and ballet dancers had difficulty accommodating orthoses due to the nature of their footwear and activities. This clinical demand sent me on a quest to find alternative treatment options.

In 1994, a reflexologist told me about a Doctor of Podiatric Medicine from the US (equivalent of our orthopaedic surgeons) who was coming to Australia to teach Foot Mobilisation Techniques (whatever that was! I had no idea). All I knew was that this doctor claimed that 80% of the cases he previously operated on, he would now treat using Foot Mobilisation Techniques (FMT).

So off I went to undertake a three day workshop in Melbourne.

This workshop proved to be a watershed moment in my professional career. I now had a glimmer of what could be possible when using FMT in my own clinic. The 'lights came on'!

Unfortunately, about six months after the workshop, my mentor passed on. This meant I didn't have anyone to guide me or help me with my FMT evolution. (This was 1994 so still no Google to help me out).

I did have a couple of physio and chiro mates who were willing to take me under their wing and help me develop my manual therapy skills. These professionals, however, did not understand foot mechanics and physiology like a podiatrist and I did not really understand the physiological and neurological effects of manual therapies.

In the ensuing years, I endeavoured to marry my understanding of podiatric biomechanics with the physiological principles of manual therapy professions. The key factor that needed to be considered was the function of the foot (weight bearing adaptor and propeller of the whole body) combined with the ratio of muscle:collagenous structures. (This is the opposite of an upper body area such as the spine or shoulder).

While I trialled and tested FMT on my own clientele, I was consistently surprised by the clinical results. It almost seemed like magic because I couldn't fully understand or explain the results my patients reported back to me.

Recently, I received this message from an FMT student, Adrian Mendez, in Boston, USA:

Ted, I am a massage therapist who actually works doing stretch therapy (using something similar to AIS, Active Isolated Stretching).

The other day when I was working with one of my clients I did a test hamstring stretch, then I did the first three movements of the FMT 1 (the talar glide, the fibular glide and the talar mobilization), then I retested the hamstring and the range of motion increased by 20 or 30 degrees.

Crazy! And so far I am getting the same result every time! My question is: why is that? It is like magic to me!

And once more, thank you for sharing all these, I really appreciate you sharing your knowledge.

While FMT can appear to be 'magic', there is a clear scientific evidence base to the modes of actions of FMT.

In 2002, I set up the Foot & Leg Centre (below), a clinic that specialised exclusively in FMT and Manual Therapies. The first practitioner we employed in 2003, was a remedial massage therapist. (He remains a senior practitioner in that clinic to this very day).


We found that training a remedial massage therapist in FMT was much easier than training a podiatrist due to well-developed hands on skills.

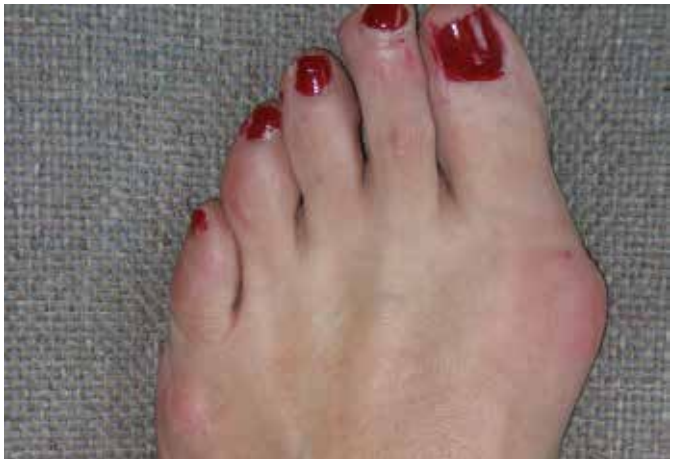
## FMT PRINCIPLE #1 – STRUCTURE GOVERNS FUNCTION

Dr Andrew Taylor Still, pioneer of Osteopathy, is credited with the term 'Structure Governs Function'.

There are 28 bones in each foot. Leonardo da Vinci described the foot as '**...a masterpiece of engineering and a work of art'.**

The foot's role as an adaptor to the earth while weight bearing and propelling the whole body, means it is subjected to tremendous forces. These forces can cause the structure to change and vary widely.

Just think of the common Hallux Abducto Valgus (HAV) presentation (below). The change in the Hallux structure position significantly affects the function of the 1st Metatarso-Phalangeal Joint's (MtPJ) ability to 'push off' effectively.



## FMT PRINCIPLE #2 – CONNECTIVE TISSUE ALWAYS ADAPT TO ITS SHORTEST FUNCTIONAL LENGTH

This is paraphrasing Dr H G Davis who pioneered the law known as Davis' Law on Soft Tissues in 1867.

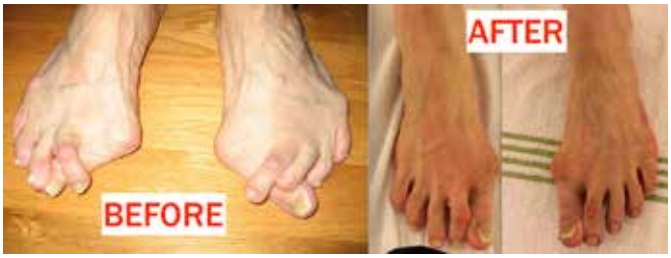
Woo et al (1975) demonstrated that joint hypomobility results from collagen cross-linkages, which occur in response to immobilisation or disuse. The biomechanical and biochemical physiological effects of connective tissue to immobilisation are described.

Factors such as intra-articular adhesions, contracture of the joint capsule, or muscle shortening are also responsible for gross joint stiffness (Binkley & Peat, Woo et al.). Akeson (1980) documented that a sequel to joint immobilisation is joint stiffness.

So (1986) argues that mobilisation procedures play a major part in regaining the range of movement or function of the joint. Exercises help to maintain the range of movement gained from mobilisation. 'The importance of passive mobilisation lies in the restoration of gross movements and accessory movements, which cannot be gained by patients through exercises alone, and certainly not by rest.'

Implementing FMT to break down the cross-linkages described by Woo et al to restore joint mobility is the biomechanical basis for joint mobilisation used in chiropractic (Lantz 1988) and physiotherapy (Maitland 1991). This basis can also be used for restoring joint mobility in the foot and leg.

Go back to the HAV example above. The connective tissues on the lateral side of the 1st MtPJ will adapt by shortening and thereby maintain the joint deviation. While surgeons may release this shortening surgically, we as manual therapists can also achieve this result conservatively (and without the risks of surgical side effects).

> “FMT IS NOT A SILVER BULLET OR AN OVERNIGHT CURE, RATHER, IT’S A THERAPY THAT CAN HAVE LOCAL AND LIFE-CHANGING RESULTS BOTH FOR CLIENTS AND THERAPISTS.”

To achieve these kinds of results conservatively does require time and effort. Therapists (and clients!) who aren’t willing to be disciplined with the time, effort and work required to change collagenous structures are assured to be disappointed with FMT.

FMT has been shown to be helpful for the treatment and management of heel spurs, achilles tendonitis, plantar fasciitis, arch strain, sesamoiditis, bunions, hammer and claw toes, sinus tarsi pain, neuromas, cuboid syndrome, capsulitis, high arched feet, ankle sprains, flat feet, tarsal tunnel syndrome, shin splints and metatarsalgia.

FMT is not a silver bullet or an overnight cure, rather, it’s a therapy that can have local and life-changing results both for clients and therapists.

FMT works most effectively when combined with specific corrective exercises so that consistent corrective forces can be applied to the joints’:

- collagenous structures (ligaments, capsules and tendons)
- related muscles (so that new movement patterns can replace previous patterns)
- neurological structures (so that new efferent messages can be sent to the related muscles)

**Readers of this introductory article are invited to join a free online mini-course in FMT for ankles to personally assess the suitability of FMT for them and their clinical services.**

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## AUTHOR BIO

Ted gained his degree in podiatry in 1982 and consulted exclusively in private practice through his clinical career and has specialised exclusively in MSK Therapies for the lower limb since 1996. Ted created 3 Manual Therapies (MT) specialist clinics in Australia, 2002, 2005 and 2012. He has been a Clinical Consultant in QUT’s Musculoskeletal Specialist Clinic (2012).

Ted has been training practitioners in MT since 1996 and is now a full time international educator since selling his MT clinics in Australia in 2016. He facilitates both live workshops and online e-courses.


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# COURSE REVIEW: FUNCTIONAL THERAPEUTIC MOVEMENT – LOWER BACK AND LOWER LIMB: BEN CORMACK, COR-KINETIC

**Reviewed by Odette Wood, MNZ RMT**

In February 2019 I attended Ben Cormack's Functional Therapeutic Movement course which was being run as a workshop as part of the San Diego Pain Summit. Ben is a UK-based musculoskeletal therapist with a clinical background in sports therapy, rehabilitation, pain science and exercise, stretching back 15 years. He specialises in a movement and exercise-based approach with a strong education component and patient-centred focus. We featured one of Ben's articles, "The Science Behind Why Assessing and Blaming Posture for Pain is BS" in issue Q2, 2018 of MNZ Magazine.

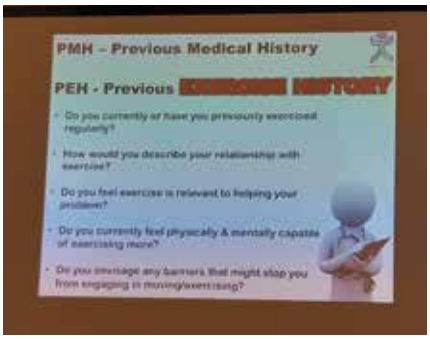
I've been following Ben on Facebook and via his Cor-kinetic blog for 18 months or so now and his approach resonates with me. Over that time I have integrated some of his approaches and resources into my practice with clients living with persisting pain and I have found them valuable tools to use. When the opportunity came to attend one of his workshops while I was attending the 2019 San Diego Pain Summit, I jumped at the chance (if you want to know more about the San Diego Pain Summit, check out the excellent review written in MNZ Magazine Q2 issue 2018, by Rachel Ah Kit).

This two day workshop focused on working with clients with lower back and lower limb conditions. While the majority of participants were Physiotherapists/Physical Therapists, there were a number of other health professionals represented, including a number of Massage Therapists.

On day one Ben took participants through an overview of current pain science, looked at how pain affects movement and explored lower back pain (LBP) in terms of current best practice, evidence of current exercise treatments for LBP and movement habits of those with LBP. The day then


finished with some practical work in groups designing an effective movement rehab programme for LBP.

On day two we looked at LBP case studies, how beliefs and expectations affect treatment, effective goal setting, barriers to adherence and did some group work coming up with an effective rehab program.




Some key concepts that I took from the workshop were:

- Any exercise can be relevant if it is framed in the right way for the client, the best exercise is the one that gets done, making it fun can make a big difference;
- It's important to get an understanding of a client's exercise history and their previous experiences – if someone has not done a great deal of exercise in the past, or they have had bad experiences with it, it is important to know this when starting working with a client, as it will influence how you can frame exercise (movement) for them;
- Self-efficacy is key and (the appropriately matched) movement can help build this and confidence in clients;
- Finding out the client's goals, history, beliefs, expectations, their readiness for change and motivation are important elements when working with clients in a rehab program;
- Work to create a positive narrative with clients by reinforcing optimistic messages. For example, when working with clients with LBP, helping them to understand that most LBP has a short (2-6 weeks) timeframe, that the majority (90%) of LBP falls into the non-specific category, and that back pain is common and normal;
- A great way to frame exercise to clients is with the analogy of "movement snacks". Snacking is something that we do almost unconsciously, in small "bites". Movement doesn't have to be done in long or intense sessions, breaking it down into "snack" portions, "sneaking" it in through the day/week can be a more effective way for

people to incorporate it into their routine.

- Exercise gives us a variation of adaptations, e.g. strength, flexibility, ROM, endurance, mindful movement, confidence and self esteem, variability and load;
- Exercise is low cost, self-administerable, low risk and often as effective as surgery;
- Focus on how the client's rehab is, not how their pain is – this focuses on the positive, not the negative;
- Pelvic tilt is normal (and as MTs, let's not pathologise it!);
- Stiffness is perceptual and protective;
- Avoidance is a predictive process "I think if I move I will be in pain, so I won't move" – this is making a prediction about pain, which can be inaccurate;
- Pain is an experience NOT a sensation – find out what the client's pain means to them;
- To help clients engage in their movement rehab, get them to plan the when, where and how with you before they leave at the end of their appointment. This can help them to become more invested in participating and adherence because they own it more.

Ben is a dynamic presenter, his workshop was packed full of information delivered in an easy to understand way. I particularly like the way he includes evidence in the form of research papers to back up what he is trying to get across. He interacts with course participants and gets people involved in the learning process. You come away having learnt a lot but with concepts and tools that can easily be implemented into your practice.

You can find out more about Ben and Cor-Kinetic at https://cor-kinetic.com/

*Odette Wood and Ben Cormack, San Diego Pain Summit.*

A great free resource that Ben has made available on his website is his Common Sense Exercise & Movement Guidelines. As a downloadable sheet, it can be printed off and shared with clients. You can download it from here https://cor-kinetic.com/common-sense-exercise-movement-guidelines-now-downloadable/


*Ben Cormack's Checklist for Self Management.*

# COMMON SENSE EXERCISE & MOVEMENT GUIDELINES

1. Do something you enjoy – Don't always expect to enjoy it.
2. See it as an investment in YOU, your health & pain levels – Do it for YOU not because you are told too.
3. Exercise is NOT just the gym, try to be active in lots of ways. Sport, hobbies or walk rather than take the escalator for example.
4. See it as quality YOU time away from the phone/work/family.
5. The aim is not always to be fitter but to build confidence in your body and functionality. Fitness measures are a by-product.
6. People who exercise regularly prioritise it. It does not need to be your main priority though.
7. Try to enjoy using your body – remember how good it can be or how it has made you feel previously.
8. It is a journey and NOT a destination. The aim is to keep going not to achieve some level of fitness.
9. Fitness comes in many formats – Don't let anyone tell you what you are doing is worthless or the RIGHT way.
10. Learn what makes you feel good & bad (type, duration, intensity) and adjust accordingly – Builds confidence (self efficacy) in your ability to adjust.
11. Not every workout has to be the best ever. In fact not many are great.
12. Don't be afraid to ask for help if required.
13. Aim for 3 times per week. Sometimes 2 & sometimes 4. But over 4 weeks an average of 3.
14. Get those around you to support and motivate you not hinder you. This is important.
15. There is no minimal dose but look to build up intensity, frequency and duration.
16. Don't measure yourself against others fitness or health, they don't matter.
17. If you feel bad then do less, feel good do more.
18. Allow yourself adequate recovery and its ok to miss a session if you are busy or life is stressful.
19. Try to use your strength once a week and also try to get out of breath for a few minutes once a week. You need to at the very least maintain these.
20. Be a positive influence on others and their journey.

COR-KINETIC
EVOLVING MOVEMENT

# LEARN HOW MOVEMENT WILL CHANGE LOW BACK PAIN

By Jamie Johnston, RMT

*Article reprinted with permission of the author from* https://themtdc.com/learn-how-movement-will-change-low-back-pain/


There are several modalities commonly used for low back pain that aren't recommended, like TENS, laser therapy, imaging, and corticosteroids, but when we look at what is recommended we have an opportunity to make a real difference for those suffering from back pain.

One of the big things recommended is a biopsychosocial approach along with education. In order to start this kind of approach, patient reassurance is critical in order to help the patient feel safe.

**In addition to reassurance, supervised exercise is also a crucial part of helping patients deal with their back pain. However, these two go hand in hand as it will quite often take a considerable amount of reassurance to convince a patient that it is okay to move.**

**One way to help is by looking at what the research says for exercise and low back pain, which you can use as a tool to convince (and reassure) patients this is the best course of action.**

## Exercise for Low Back Pain

Remember the old days when bed rest was the main prescription for low back pain?

Well, now bed rest is actually discouraged unless the pain is too severe, then only two days of bed rest are chosen. In contrast to this, we now understand that staying active has far better outcomes than the way we used to manage this.

**And I know many of you might be saying "exercise is out of my scope of practice" and while this may be true, active and passive range of motion probably is within your scope, so there is no reason you can't incorporate some of this into your treatments.**

I know there is probably some concern over being able to recommend "specific" exercises (or movements) but don't worry it doesn't have to be all that complicated…in fact, it shouldn't be! Supervised movement without the use of expensive equipment is one of the specific recommendations, so you can do this right in your treatment room.

This is especially true in the acute stage, where strengthening, extension, and specific exercises are not recommended. Rather, in this case, we want to use graded exposure to physical activity. Graded exposure is essentially getting a patient to move (gradually) into a feared or painful movement (we've had articles about this before which you can read HERE for a more detailed description).

For example, when it comes to acute low back pain, if your patient is scared, or experiencing pain with a certain movement like standing forward flexion, have them change the plane of movement and try flexion again. Try having them sit comfortably in a chair, then lean forward. This is still spinal flexion, it's just in a more supportive position. When they can move in this position comfortably, point out how capable they are of the movement and reassure them that flexion is safe. You can then gradually work up to standing flexion until this feels safe again.

There are many ways to do this, it just takes a little experimentation on your part.

**When it comes to chronic low back pain there is no evidence that one exercise is superior to another.**

However, recommendations show that remaining as physically active as possible along with an early return to work is well supported by evidence (probably why some workplaces have a gradual return to work programme). **While there are no specific exercises highlighted as more effective than others, the exercises that work are simply the ones your patient will do**. Find out what's important to them and encourage them to do it. Whether it is strength training, going for a walk, playing with their kids, or playing hockey, the intent is to build confidence in their bodies as opposed to fixing a problem.

Inevitably the question of dosage comes up and the research shows that too much, or too little exercise with some patients can run

the risk of developing persistent pain. This is where it's important to experiment a little to see what works best for the patient, we don't want them to overdo it, but also want to avoid not doing enough (one of the reasons bed rest has been eliminated).

**Overall since we know a biopsychosocial approach is most effective, encourage things like movement in general, getting back to work, staying connected with the things and the people they enjoy. Just make sure these things are done gradually.** If we can address peoples' fear of movement by using graded exposure early on, we have a better chance of avoiding prolonged pain and disability. So, don't stress about 'specific' exercises, the overall goal is to get our patients moving and keep them moving. Movement along with some education and reassurance can go a long way in not only improving low back pain but also the patient's quality of life.

## AUTHOR BIO

Jamie Johnston is the creator of the website The Massage Therapy Development Center (TheMTDC) an excellent resource for Massage Therapists around the world. Jamie is a Registered Massage Therapist in Victoria BC, Canada. He is also a former Massage College Clinical Supervisor, First Responder instructor, hockey fan and firefighter. Currently, he works with Hockey Canada in the women's development program. As a continuing education instructor, Jamie teaches other Massage Therapists how to incorporate therapeutic movement and pain science into their treatments and still can't believe he gets to be part of other RMT's learning process. He gets excited to meet new colleagues and still learn something from them every time he teaches a class.

When not at work you can find him at the gym, at the ice rink, on the golf course or at the firehall.

You can connect with Jamie via TheMTDC facebook page here, where Massage Therapists can share ideas about how to improve the perception of the Massage Therapy industry.

# THE FELDENKRAIS METHOD® - EXERCISE INTELLIGENCE

**By Sue Field**

The Feldenkrais Method is named after its founder, Israeli scientist Dr. Moshe Feldenkrais. He developed it in response to his own knee injuries.

As an exercise system it is more akin to a mindbody system such as yoga, rather than gym or physiotherapy type exercises. Watching a group Feldenkrais class, it appears to be a rather strange, slow sequence of movements, with lots of rests in between. However, actually doing a lesson can produce surprising results such as improved posture, and a sense of more freedom and lightness of movement.

Dr. Feldenkrais (1904-1984) was an engineer, physicist and judo master. His engineering background gave him a good intellectual understanding of biomechanics. Judo gave him the practical understanding. He was also inspired by observing babies, and realised that their exploratory, self-directed learning process could be used at any stage in life. Dr. Feldenkrais based the method on physics, martial arts and learning. He was an early exponent of the theory of neuroplasticity, believing that the brain's motor cortex can adapt new neuromuscular pathways.

After developing the method for his own use (to cope with a soccer-related knee injury) he went on to working with individual adults. He then developed group lessons so that more people could benefit. He trained others to become Feldenkrais teachers – initially in Israel, and later to large groups in the USA.

A key element to the lessons is paying close attention to the movements, and the quality of movement. A lighter, more fluid movement quality indicates efficiency of muscle use, where muscular work is more evenly and effectively distributed. Each muscle needs to contribute to action according to its size and function, with no muscle underworking or overworking. Another key element is exploration of many different variations of movement combinations. This enables discovery of variations on ingrained movement habits.

Group classes are called Awareness through Movement lessons. The slowness gives the opportunity for the student to pay attention to the process of movement, rather than simply moving according to habit. This allows time to notice habits, and to experiment mindfully and discover better options. A lesson is taught through verbal instructions, rather than by demonstration. The teacher describes each movement, and what aspects to pay attention to. Learning is achieved not by copying the teacher, but through each individual's personal exploration of movement. Given the opportunity, the system's body intelligence assures it chooses more efficient options. Each person improves in their own way.

Repetition to embed new habits is, of course, important. Much like practicing a golf swing or tennis serve, it's not simply repetition. You use the mind to improve on technique. In this case, "technique" relates to the movement patterns which form the basis of all action. Most people experience a noticeable difference by the end of a Feldenkrais lesson. With regular lessons they find that daily movement habits and body awareness improve.

Feldenkrais lessons vary from very quiet to quite dynamic. Many lessons are based on developmental movements, such as rolling or crawling. This harks back to a baby's learning process, which laid the foundations for all movement patterns through life. Other lessons are based on activities such as yoga poses, martial arts moves, or everyday movements such as standing up from a chair. There are lessons around exploration of themes such as breathing, tongue/jaw function, voice, or pelvic floor. Some lessons are fairly abstract movement explorations, which nevertheless link together in a way that is meaningful to the sensorimotor system.

A toddler develops basic functional skills well, with head and spine beautifully aligned, and the ability to move easily e.g. from upright to floor. Over a lifetime people develop their own very personal movement and postural habits, which may include patterns which create stress on muscles and joints.

The Feldenkrais Method is commonly used to alleviate pain or tension. Feldenkrais is a very helpful adjunct to therapies such

as massage, osteopathy or physiotherapy, as it prevents the body from returning to inefficient habits. It is also used to improve sports or performing arts activities, recover from injuries or surgery, and for neurological issues such as stroke or cerebral palsy. Because it deals with the basics of musculoskeletal function, its applications are wide. Many people also appreciate the meditative nature of a lesson, and find over time that they become more relaxed mentally and physically.

Of interest to therapists is that they may use the method to reduce work-related stress while doing such a strong physical activity as massage.

Feldenkrais is not a substitute for exercise activity such as yoga, pilates, running, or gym work, however, the body awareness and improved functional basics it provides may mean it enhances all other activities.

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www.feldenkrais.org.nz - the website of the NZ Feldenkrais Guild.

## AUTHOR BIO

Sue Field, Feldenkrais Teacher and Massage Therapist, Wellington

Sue came to the Feldenkrais Method from a background of massage therapy and yoga. She was motivated by her own chronic neck pain and tension, and a desire to help her massage clients.

She did the professional Feldenkrais training in Sydney (1993 – 1997), setting up her practice in Nelson. In 2003 she moved to Wellington, where she runs regular group classes and workshops, for anyone who wants to improve function and body awareness.

She has a clinic on The Terrace, where she does massage and individual Feldenkrais sessions. She credits the Method with helping her to continue doing massage, with no injury over a 30 year period as her neck is no longer a problem.

There are Feldenkrais teachers in all main centres (and some smaller ones) in New Zealand. See www.feldenkrais.org.nz, the website of the NZ Feldenkrais Guild.

# MYOFASCIAL RELEASE/MASSAGE WITH THE VOCAL ATHLETE

**By Walt Fritz, PT**

Massage/manual therapy in sports and movement is typically thought of with regards to performance in traditional sports or athletics, but what about the vocal athlete? Have you ever thought that massage/manual therapy could help these athletes? While not meeting the typical athlete stereotype, singers, and others who use their voice professionally, experience issues of overuse and injury, much like the amateur or professional athlete. They benefit from massage/manual therapy for these issues, as well also benefitting from intervention to improve upon already high-level performance capabilities. Through focused manual therapy intervention, these vocal athletes can significantly benefit from your services, and you may find a unique niche for your services.

I borrow the term, "Vocal Athlete" from a colleague, Marci Daniels Rosenberg, who along with Wendy LeBorgne, wrote the book, "The Vocal Athlete. Application and Technique for the Hybrid Singer"[1]. While the scope of their book reaches well beyond our work, they speak in depth of using manual therapy, myofascial release (MFR) included, with the vocal performer, both for remediation of dysfunction as well as enhancement of existing strengths.

If you haven't heard of a massage therapist working with voice and the vocal athlete, an online search query of "massage voice" or "'myofascial release' voice" provides you with enough hits to keep you busy reading website articles for weeks. Google Scholar reveals evidence speaking to the positive results of using massage therapy for the improvement in voice[3] and you can read about therapists utilising various forms of vocal massage in their practices at links[4-7].

**What are the expected outcomes that I seek when applying MFR with the voice patient, and how might that sort of intervention look?**

While I teach a seminar that attracts speech-language pathologists/therapists (SLPs/SLTs), as well as MTs, OTs, and PTs who specialise in disorders of the neck, mouth, and upper chest, the percentage of voice patients that I see in my physical therapy practice is small. However, I do see patients referred with dysphonia, which is defined as "difficulty in speaking due to a physical disorder of the mouth, tongue, throat, or vocal cords"[11]. It can be simple hoarseness, acute or chronic, but can be more complex and nuanced and is broken down into many different types. After being correctly diagnosed by a medical specialist, ruling out cancer, etc., it is often treated with Botox injections or therapy by an SLP/SLT. Patients come to me through referral networks that know of my expertise to determine if MFR/manual therapy can help a patient to overcome the disorder or learn management strategies. I have also been fortunate to work with a few performers (vocal athletes) who find the slow, graded, MFR-style stretching helps them reduce vocal strain and fatigue. I frequently see them when they are in town for bursts of sessions, as well as less occasional tune-ups to both improve performance and teach them strategies for dealing with their issues on their own. I know of therapists who travel with big-name performers, providing manual therapy while the artist is touring.

Keeping with the nature of my approach to myofascial release, I work from a patient-directed model which is heavily reliant on finding agreed upon areas of the body that, with palpation, pressure, or stretch, replicates familiar aspects of the patient's issues. Such a patient-directed model contrasts markedly with many models of MFR, manual therapy, and massage that rely more strongly on the therapist's experience and opinions as to what is at fault and what needs intervention. While this often serves the patient and results in positive gains, it can all too easily gloss over patient preferences and experiences, which

makes up a full one-third of the evidence-based model of care that most professions work[8,9]. While my specific MFR treatment which relies on static, lighter holds, massage and manual therapy in general populates the medical literature as being helpful for various issues of not only voice but also swallowing, breathing, jaw dysfunction, and many more conditions.

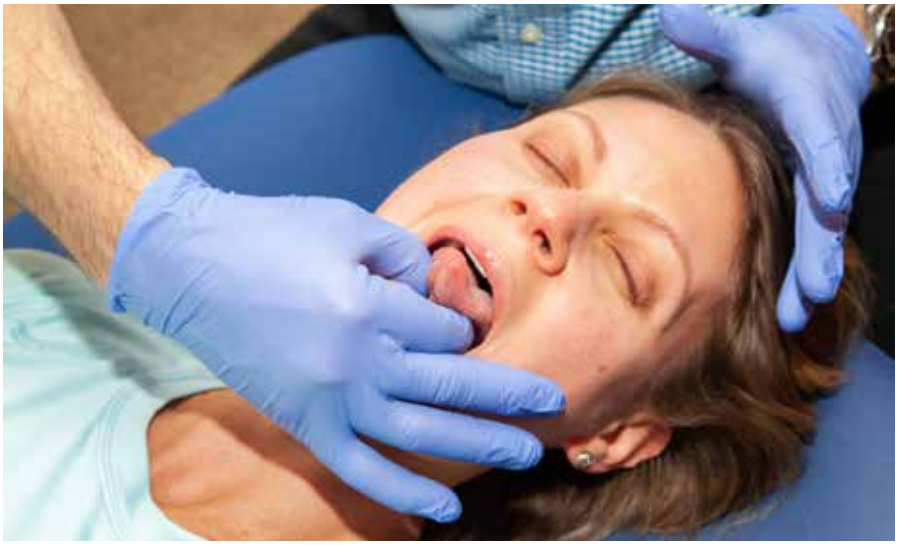
In my work with the vocal athlete, we start with the collection of a full history, which includes a discussion of what the patient hopes to achieve from my services. I look at their medical history, including surgeries, medications, tests, and more, as well as what they have done in the past to help remediate their current situation. Like most of you, I have a large pool of objective testing to pick from that may include a range of motion, functional strength assessment, neurological tests, as well as more specific assessment of the condition. These issues may present as pain, movement difficulty, the perception of weakness, or in the case of the vocal athlete, patterns of strain and fatigue that seem to limit performance.

Next comes the hands-on assessment, which in the case of the MFR-style work that I use and teach involves lightly placing hands on the area of patient concern, which is one point where my approach diverges from others. While many have been taught more far-reaching narratives of causation, with the belief that nothing can be sustained unless, for instance, the feet are leveled, the pelvis is balanced, the core is strengthened, the posture is improved, or C1 is in proper placement, I try to see all of those beliefs as recipes vs. fact. This statement might be seen as insulting, given the typical reports of outstanding outcomes utilising such disparate causation narratives, but if each one was true, then no other narrative would come close to having successful outcomes. The "facts' that many of us were taught are most probably recipes and stories that we tell ourselves and in turn, our patients. My original MFR training taught that we were to "find the pain, look elsewhere for the cause" as if we can ever really know what the cause is. In my MFR family of origin, the cause was invariably identified as a fascial restriction; one that no one else had found, which gets slippery when the concept of fascial restrictions has never been shown to

be true, much less all of the other aspects of so-called fascial evaluation and treatment. I make many enemies in the MFR, massage, and manual therapy circles by questioning what we have been taught, but I am quite comfortable in this role. I speak to this concept at length both in my seminars as well as on my blog.

While all of the above may matter and can be used successfully, the primary aspect of evaluation I rely on is palpation to connect/replicate an aspect of familiarity to the patient's condition. Throwing more cold water on our beliefs and training, palpation itself has quite poor inter and intra-rater reliability, when it comes to locating what we think we are locating. For instance, my palpatory training in myofascial release consisted of me feeling tightness and claiming it to be a fascial restriction. However, the next therapist might palpate the same area and claim it to be a trigger point (or spasm, knot, etc.). I have a few appropriate references in the extensive bibliography I make available to support my seminar that speak to such palpation reliability issues[13]. While I acknowledge the limitations of palpation, I still use it extensively, but hopefully in a less rigid context. My goal with palpation is not to locate and define the problem, but to begin a conversation about relevance with my patient.

I continue to trust much of what I was taught and from the years of experience, as I am seeking areas of apparent tightness, density, or overall grumpiness through my palpation, but once I feel like I may be on to something, I turn the dialogue away from what I have found and toward my patient and what they are feeling. I try not to sell them that the tightness, density, or grumpiness is the problem; instead, I ask them what they are feeling. Ideally my palpation, whether mild pressure, stretch, or other stimulation, begins to replicate familiar aspects of the condition they are seeking my help with, whether a mild exacerbation or even a lessening of the symptom. "What do you feel" is one of my favorite open-ended questions, as it gives them a chance to respond with no sense of being guided. Once they tell me what they feel, I'll ask, "Is that a familiar feeling? If so, in what way? When do you feel that?" If my findings do not connect with a familiar sensation, I'll move on. If I can replicate aspects of their experience, I ask a series of additional questions, starting with two 0-10 questions. First, I ask the very familiar, "0-10, how much (fill in the blank with the sensation that they reported) are you feeling right now?" After they respond, I'll ask, "0-10, what number will you stop me? What number would be too much?" These two questions hopefully determine if I am near provocation, regarding symptoms intensity. If my pressures/stretching is replicating familiar feelings that are well within the range of acceptable, I'll ask what is often a difficult question, "Does my stretch feel like it might be helpful?" Many might be unable to answer that questions with certainty. If so, I'll turn the question around and ask, "Is there anything about my stretch that



feels like it might be harmful?" If so, I'll stop immediately. Once we establish that my stretch feels safe and potentially helpful, in traditional MFR fashion, I'll simply hold a light stretch or pressure until symptoms shift, change or dissipate. My hands-on technique is much like the traditional/historical type of MFR treatment, but my interview style is far-removed from what is usually used.

Working with the vocal athlete often involves having them "perform" during treatment. I'll ask them to move (perform) when working with dysfunction, as I am hoping that my touch introduces a sense of greater ease of vocalisation or movement, as well as with attempts at performance enhancement. One joy of teaching this work to speech and voice professionals is the excitement when the therapist who is acting as my demonstration model, who may be a performer themselves, notes changes in their vocal tone, range, or pitch from my touch during and after the course of a short intervention. In much the same manner that I work with actual patients, I'll immediately have them put their hands in the areas we just worked and ask them to try to replicate the felt-sense of the sustained stretching to give them tools to help themselves. My goal is to give them a locus of control over their situation. No matter the disorder, I'll always follow with functional movement, which can include what might be seen as traditional exercises or, more commonly, functional movement as well as self-stretch using principles found in evaluation and treatment. In the two videos linked below [10,12], you can see a bit of how my intervention progresses, from evaluation through to treatment.

If working with the vocal athlete interests you, I hope you'll consider joining me in Auckland 17-18 August 2019, where I'll be teaching my Foundations in Myofascial Release Seminar for Neck, Voice, and Swallowing Disorders. You can find more information at www.FoundationsinMFR.com.

## AUTHOR BIO

Walt Fritz, PT owns the Pain Relief Center in Rochester, NY, USA and travels worldwide to teach his science-informed version of MFR, Foundations in Myofascial Release Seminars. His audiences include massage therapists, speech-language pathologists, voice professionals, physical therapists, and occupational therapists. You can learn more at **www.FoundationsinMFR.com** and his accompanying blog, **http://www.waltfritzseminars.com/blog/**

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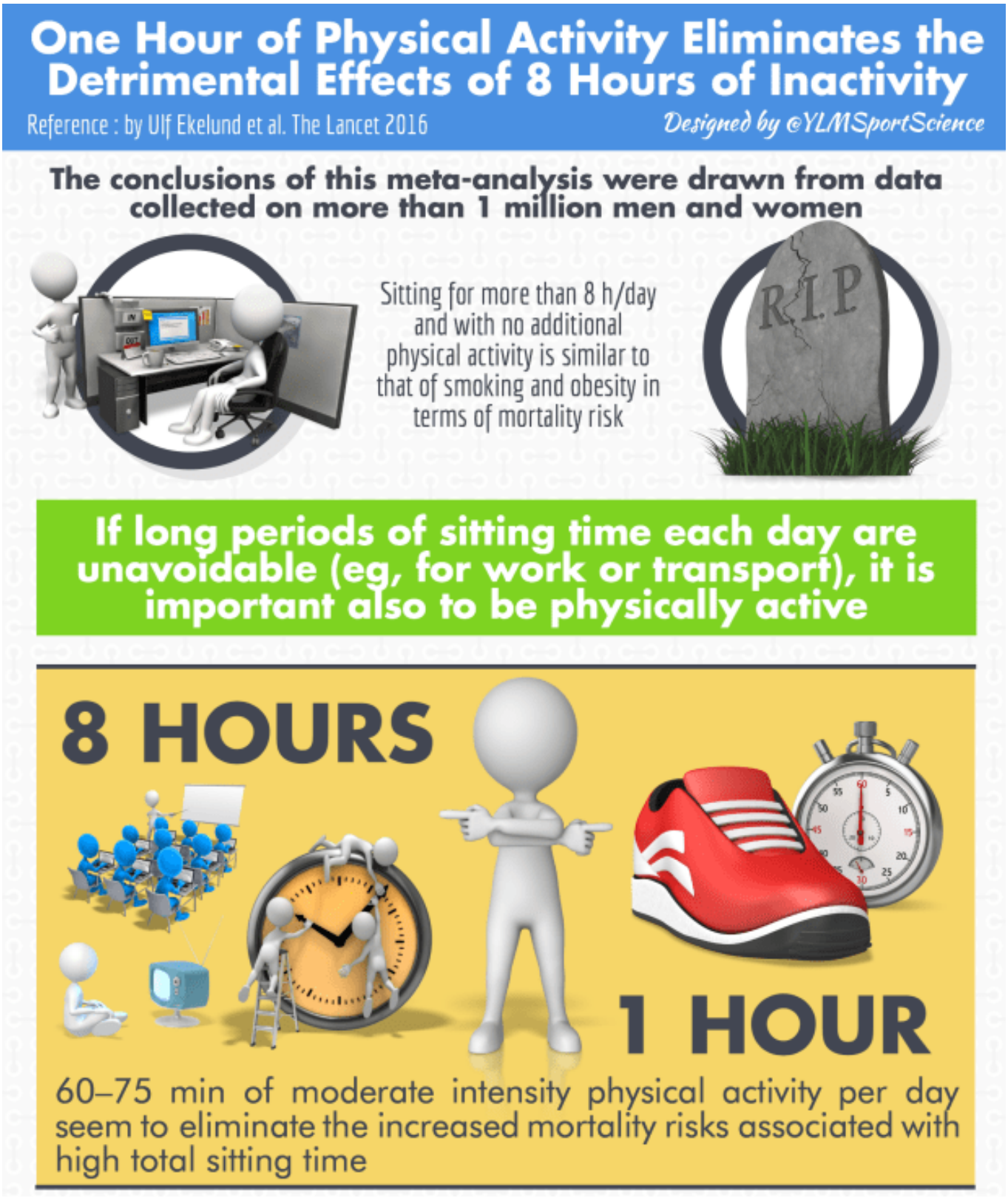


## PERMISSION TO PUBLISH FROM

**Professor Jill Cook, Sports Medicine Research Ctr, LASEM Research Centre**

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# MASSAGE IN HIGH PERFORMANCE SPORT NEW ZEALAND (HPSNZ)

**By Clint Knox, HPSNZ Performance Massage Therapist**

High Performance Sport New Zealand (HPSNZ) provides sports science and medicine services to athletes from Commonwealth and Olympic Games sports, with performance massage therapy being one of those services.

Previously, performance massage therapy was delivered by individual identified providers under the New Zealand Academy of Sport (NZAS) model. Providers operated from their own clinic environment and were reimbursed by NZAS. The massage therapist was described as a "fee for service provider" which in limited numbers still exists regionally where there is an identified need. There were many providers in each location where athletes lived and trained.

HPSNZ has moved away from this model to create a more efficient system for delivery, integrating multidisciplinary support teams to provide performance solutions for athletes. This has been achieved by applying a centralised approach, whereby athletes are based within the HPSNZ regional training centres, enabling providers, athletes and coaches to operate from a single base. Auckland, Cambridge/Karapiro, Christchurch, Dunedin, Wellington and Wanaka are the nominated regional hubs with massage providers and there remain a very few non-centralised. The expectation is that athletes access providers in the centres, only on exception and through system driven approval do they get access to the non-centralised providers. The HPSNZ Massage Therapy Providers are only contracted to deliver services to athletes from Olympic and Commonwealth Games level sports that have government financial support and have had prior approval through the HPSNZ system. Rugby is typically not covered through this system, except for rugby sevens.

The total number of Performance Massage Therapy Providers nationally is low, with very little turnover, resulting in a high level of consistency and delivery within the program but very minimal opportunity for exposure and growth/development of additional providers, due to no new roles becoming available. Typically, there has been uncertainty as to how aspiring providers can enter the High-Performance system, as there has been no recognised professional pathway into this unique environment.

HPSNZ is currently developing a pathway that is transparent and will provide exposure to the centralised environment. This is expected to take the form of an internship, with more detail to be released soon after this publication (if not already). The aim is to provide opportunities not only for future proofing HPSNZ's provider system but developing the massage profession by sharing the expertise in the elite sports environment.

HPSNZ will initially be presenting a profile piece on some of the Performance Massage Therapy Providers engaged in the centralised system, to create awareness of the current providers amongst Massage New Zealand members, and continued in successive magazines.

Please be patient and be aware there are currently no positions available for massage therapists in HPSNZ.

Any correspondence regarding anything HPSNZ massage related should be directed to Fiona Mather, Head of Performance Therapies, Fiona.Mather@hpsnz.org.nz

# HPSNZ PROFILE – ANNETTE O'CONNOR


**Annette O'Connor – HPSNZ Massage Therapist**

I am currently a Registered Massage Therapist Level 6 (Diploma in Therapeutic Massage and Certificate in Massage Teaching) and a High Performance New Zealand (HPSNZ) Massage Provider. I am a graduate of Otago University (Diploma in Physical Education), Illinois State University (Master of Science, concentration in Sports Medicine/Athletic Training) and the National Athletic Trainers Association USA (Certified Athletic Trainer).

My pathway into HPSNZ began in 2008 when I became a Massage Provider for the NZ Academy of Sport North Island (NZASNI), attained through an application process. My provider status for HPSNZ continued in 2013 after the New Zealand Academy of Sport North Island (NZASNI), the New Zealand Academy of Sport South Island (NZASSI) and the Sport and Recreation (SPARC) high performance unit restructured to form HPSNZ.

Born in Christchurch, I moved up to Mt Maunganui with my family at the age of 6. Other than temporarily relocating for study purposes my love of the area always brought me back where I have raised two children Cole and Kaydi.

I have 28 years of massage experience initially setting up a clinic in central city Tauranga in 1990, offering massage alongside fitness testing and fitness programming for individuals and sports teams. Today I run a home based massage therapy clinic - Kiwi Sports Care, located at 33 Fantail Drive in Maungatapu, Tauranga offering remedial, relaxation and sports massage. My clientele varies from elite and recreational athletes to clients with injury, posture and stress-related muscular conditions including those with specific conditions such as Multiple Sclerosis as well those wanting ongoing maintenance massage.

I also have an extensive background in strapping from Illinois State University which I offer to clients and I have run many strapping workshops. Outside my profession I have been involved in teaching gymnastics for the past 25 years. I was a national ranked gymnast and the injuries I faced as an athlete were the catalysts that lead me into the sport and health sector eventually steering me into a career as a massage therapist.

I have been involved with many sports teams. This is an area of work I enjoy immensely and continues to excite me. Every event is always about the people I meet and work with. A highlight is the lasting relationships I have made over the years. My journey into this area of work began in 1990 as a massage volunteer at the 1990 Auckland Commonwealth Games and continued on a voluntary basis for some time offering massage and strapping alongside front line injury management for club, provincial and national invitational rugby teams, as well as massage recovery at triathlon and other endurance events. My more recent community work has extended to junior slalom kayak paddlers in the areas of injury prevention, conditioning and injury management, and also to surf life saving athletes.

I have been very privileged to have worked with a number of NZ teams including the Silver Ferns Netball Team, Tall Ferns Basketball Team, White Ferns Cricket Team, Bay of Plenty NPC Steamers Rugby Team (6 years) and the NZ All Black Sevens Team (17 years). I have been a member of New Zealand Health Teams at two World University Games, (Bangkok 2007 and Shenzhen 2011), three Commonwealth Games (Melbourne 2006, Glasgow 2014 and Gold Coast 2018) and two Olympics Games (Beijing 2008 and Rio 2016).

My work philosophy centres on keeping things simple whether it is my massage approach or advice I give to clients. I believe most importantly in focusing on what I think I do well and listening to my clients to meet their needs and expectations.

# HPSNZ PROFILE – HANS LUTTERS

Hans Lutters – HPSNZ Massage Therapist

Having grown up in Whangarei as a child, Hans Lutters immigrated for a second time to New Zealand from the Netherlands with his young family in 2006. After graduating for diplomas in massage therapy, lymphoedema therapy and advanced sports massage in the Netherlands, it was Hans' dream and goal to establish a clinic in New Zealand that specializes in these modalities.

Starting off in Auckland, the family soon moved to Christchurch in 2007, where Hans founded his private clinic, the Hands On Clinic. Hans and his team are also associated with SportsMed Canterbury, well known for its outstanding multi-disciplinary team and service in the area of sports healthcare. Hans is a member of Massage New Zealand (MNZ) and the Australian Lymphoedema Association (ALA). And since 2009 he has been an accredited provider for High Performance Sport New Zealand (HPSNZ). He was a member of the NZOC health team for the Commonwealth Games in Glasgow in 2014, the Rio Olympic Games in 2016 and the Gold Coast Commonwealth Games in 2018.

Having qualified as a teacher in the Netherlands (ROC), Hans teaches Manual Lymphatic Drainage (MLD) based on a combination the principles of the Casley Smith method and Vodder. His courses are being attended by a wide variety of health practitioners throughout New Zealand. He also gives presentations to other medical practitioners and health groups to promote awareness for this modality, especially combined with sports massage. MLD is an effective modality which is not only beneficial for treating primary and secondary lymphoedema. It also enhances recovery from sports injuries, which benefits Hans' treatments for athletes.

As an accredited HPSNZ massage therapy provider, Hans looks after all the national and international carded athletes, either permanently or temporarily based in Christchurch. He is working at the local HPSNZ Apollo Centre twice a week. Besides that, he attends monthly meetings with other national HPSNZ providers via Skype and a couple of annual national HPSNZ gatherings when required.

In order to obtain the best results for these athletes, Hans collaborates with other colleagues from the HPSNZ team, such as physiotherapists, (strengthening) coaches and doctors. Hans really values this multidisciplinary cooperation, not only to achieve the best results treatment wise for the athletes, but also from an educational perspective for himself. There is always so much to learn from others! That's also the reason why Hans enjoys his regular meetings with other HPSNZ accredited massage providers. During these meetings the team cover a variety of topics such as setting guidelines for sports massage within HPSNZ, looking at improvement of standards of massage in general and sharing of event experiences. For Hans it is a true privilege and honour to be part of the HPSNZ and NZOC community!

HIGH PERFORMANCE SPORT NEW ZEALAND

# VOLUNTEERING FOR MNZ WAS THE BEST DECISION I EVER MADE!

Volunteering for MNZ was the best decision I ever made!

My skill set has grown, my profile has grown and ultimately my business has grown. I put a lot of this down to putting my hand up in 2016 to be more involved with MNZ.

I'd been a member of MNZ since about 2009 and I never really did anything with it other than read through the magazine, struggle to keep up with my CPD points and renew my membership every 2 years. I had wanted to attend the networking meetings but the closest were 1.5 to 2 hours' drive from me.

That all changed in 2016 when I met another Massage Therapist and MNZ member who happened to be the mother of a friend of a friend. Completely coincidental meeting, however it was her that introduced me to a further MT and MNZ member who had recently moved to Hamilton.

The three of us met for coffee marking the start of a new branch of 'MNZ Networking Meetings'. We decided to carpool to the conference that year in Auckland and that was when I was nudged, pushed, tripped or fell (I'm not sure which) into the role of Upper North Island Regional Co-ordinator.

Since then I have come to know dozens of MTs both in my immediate locale and throughout NZ. By helping arrange and attending local meetings I have:

- Made solid friendships with other like-minded individuals.
- Built a base of professionals to which I can refer my clients to including Chiropractors, Skin Specialists, Acupuncturists, Physiotherapists, Clinical Exercise Physiologists, Breathing Experts, Kinesiologists, Podiatrists, Counsellors, Mindfulness Experts, Yoga and Pilates Instructors, Supervisors and more.
- My professional profile has grown both with other MTs and other professionals to refer and be referred to.
- My skillset has grown as I now have colleagues and mentors I can question and check in with. Also, I have been exposed to more techniques and modalities some of which I have chosen to study further.
- My business has grown through the contacts I have made, my increased profile and my continuing developing skillset. I currently only work part-time but I am at my maximum capacity which is perfect.

There are two sayings that come to mind 'No man is an island' and 'The more you give the more you get'. We are stronger when we work together, take the time to meet other MNZ members in your region and encourage those who aren't a member to stand with us. I have certainly found that with the small amount of effort I have put in to being a member of MNZ I have received it back tenfold. Get in touch today to find out how you can be involved!

Annika Leadley

**Upper North Island Regional Coordinator**

# CALL FOR REMITS 2019

Massage New Zealand is now calling for remits to be tabled at the Annual General Meeting (AGM) to be held in **Hamilton at Wintec on Saturday 21st September 2019.**

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 1st July 2019.

**Sending Remits:** Remits must be emailed to the Executive Administrator.

Also, if you have any queries regarding AGM please contact the Executive Administrator at admin@massagenewzealand.org.nz

# LIFESTYLE MEDICINE
# TIPS ON EXERCISE

**Think movement not exercise.** Introduce small amounts of movement into your whole day. Walking, stretching…even cooking instead of getting take away. Our bodies are designed to move gently and frequently. They are not designed to be thrashed for one hour then remain inactive for the remainder of the day. Think of all the small incidental ways you can move all day.

**Feel replenished, not depleted.** If you choose a sport or exercise program, it should leave you feeling replenished, not depleted. If you run for an hour and feel exhausted all day, then only run for half hour instead and feel good all day. Feeling exhausted after exercise could mean you are depleting your energy resources and putting too much strain on your hormonal systems.

**Enjoy it.** There are many proven mental health benefits from movement and many people have treated anxiety and depression through running, yoga or other physical activities. Loads of feel good hormones are released with exercise and sports can be a great way to socialise and enjoy friendships.

**Stand don't sit.** Research shows that people who are sedentary, eg. those who sit at work all day, are at a higher risk of obesity, cardiovascular disease, postural issues and Type 2 diabetes. Sitting is so bad for us that those who work in sedentary roles actually die younger on average compared to those who have active jobs. Our basic cellular metabolism is reliant upon movement. And, it's as simple as standing up instead of sitting.

EDSER health

www.edserhealth.com.au

# MANUAL LYMPH DRAINAGE - WHAT'S ALL THE 'BUZZ' ABOUT?

by Michelle Vassallo

Manual Lymphatic Drainage (MLD) is a highly specialised technique that may be used to treat many injuries and pathologies. Massage therapists may be unaware of the full depth MLD may achieve for both themselves and their clients. Added to this, quite often, initial training may not give them the confidence to successfully apply the technique. The reality is that MLD is a multi dimensional discipline.

## WHAT MAY MLD DO FOR YOUR CLIENTS?

- It could be used as part of a post sporting and post injury RICE protocol when clients are unable to receive deep tissue or other massage techniques that would otherwise be contraindicated.
- It could be included as a valuable 'add in' to the massage treatment plan and used as a prequel to other techniques such a myofascial tension technique and deep tissue. "With the use of MLD we gently and specifically engage the fascia and the fluid, simultaneously releasing the tissues of the lymphatic-extracellular fluid and fascial planes. In one movement we may negate many of the negative side effects of fascial work, that may lead to bruising and inflammation." [1]
- It could be used pre and post-surgery to prepare tissues for incision and also to promote healing and tissue health post surgery preventing infection and other post-surgical complications. [2]
- MLD not only stimulates the vital functions of the skin, tissues and internal organs, but also serves to assist with elimination of possible cellular waste and stimulate the parasympathetic relaxation response, inhibiting muscle tonus and pain.[3]

A common list of massage room pathologies that may benefit from MLD includes:

- Fluid retention, lymphoedema, sinusitis, hay fever, pain relief, Irritable Bowel Syndrome (IBS), fibromyalgia, post sporting, carpal tunnel syndrome, golfers and tennis elbow, bruising and oedema.

## WHAT COULD MLD DO FOR THE THERAPIST?

When delivered in a relaxed, confident and precise manner MLD as a modality allows the practitioner to work at a much lighter and slower pace.

The pressure used to perform MLD has been compared to the pressure used to roll an uncooked egg across a bench, slowly. In other words it does not require much pressure at all. This in itself is a bonus to the massage therapist who can often spend a full day delivering treatments that require more pressure intensive techniques.

MLD is all about moving fluid, and moving fluid requires deft touch, gentle manipulations of the surface of the skin and super slow movements.The reality is that the lymphatic system moves SLOWLY. As a result, the therapist's body moves in a more relaxed and easy manner, allowing rhythm in your work and softness for your wrists, hands and arms.

If you are reading this and you don't know anything about this amazing modality get curious. Do some research and find out exactly how the lymphatic system works, and why it is such an important add in to your massage modality list. There are many clients who could benefit from this type of therapy and many MT's who could benefit as well.


## AUTHOR BIO

Michelle Vassallo, director of Rhythm Massage Development and Education. She is a therapist who has passionately designed various massage workshops with a focus on making them comprehensive and relevant to therapists. Her teaching specialities are Manual Lymphatic Drainage, Research Literacy, Self Care for Massage Therapists and Palliative Care.

A dedicated educator with 17 years of experience in the field of bodywork, she guarantees a fun and dynamic learning journey for her students. (see advertisements). Her blog can be found at: https://blog.rhythmmassage.com.au/


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2. Chikly, B. (2001) Silent Waves – Theory and Practice of Lymph Drainage Therapy, IHH Publishing, Scottsdale, USA
3. Foldi, M., & Strobenreuther, R. (2003) Foundations of Manual Lymph Drainage (3rd ed.). Elsevier, USA

Background Reading that may interest the Therapist

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https://chiklyinstitute.com/LDT/Articles

rhythm
massage
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and education

# MANUAL LYMPHATIC DRAINAGE FOR YOUR EVERYDAY CLINICAL PRACTICE: LEVEL 1

## TWO DAYS WITH MICHELLE VASSALLO

AUCKLAND, NEW ZEALAND

## Introduction

Manual Lymphatic Drainage (MLD) is a specialised technique that can be used to treat many injuries and pathologies.

MLD provides many benefits for your clients, particularly with assisting the body to detoxify, speed up healing times and provide well-being through excellent cellular and tissue health.

MLD not only stimulates the vital functions of the skin, tissues and internal organs, but also serves to eliminate cellular waste and stimulate the parasympathetic relaxation response inhibiting muscle tonus and pain.

MLD provides an excellent alternative when regular massage is contraindicated and can also be used as part of an overall treatment in conjunction with any other modality.

**It is a fabulous addition to the toolbox of Massage and Myotherapists.**

## Presenter & Founder

Michelle Vassallo, Director of Rhythm Massage Development and Education, and a fellow therapist, has specially designed this workshop to specifically focus on making it comprehensive and accessible for Massage and Myotherapists.

**Her career highlights include working with Australian professional football clubs instructing in the benefits and correct usage of MLD as a highly effective pre and post game treatment protocol, especially good for post injury management.**

Michelle has also taught extensively at many of the massage training facilities in Australia and Canada but most notably both Victoria University and RMIT University both of Melbourne.

**A dedicated educator with many years of experience in the field of bodywork, she guarantees a fun and dynamic learning journey for her students.**

# How does it work?

The application of MLD works in a number of ways. Firstly the manual 'traction' on the skins surface allows the underlying anchoring filaments to be 'lifted' thus allowing more room for fluid movement.

Secondly the manual activation of each node group allows the nodes themselves to work at a faster rate thus clearing fluid more effectively and efficiently.

MLD increases both node and tissue health by allowing swifter removal of waste products and also increasing the production of more immunocompetent cells.

# What will you get from attending this workshop?

This unique training course covers the many dimensions of Manual Lymphatic Drainage with a focus on area specific delivery and integration with other treatment modalities:

- All areas of the body will be reviewed and students will be provided with an understanding of the lymphatic system.
- Illustration for students from a hands on perspective on how to achieve complete evacuation of lymph nodes and complete drainage of specific areas.
- Review of current research in the area and the efficacy of MLD within this research.
- Demonstration and practice of exact area specific.
- Development of specific treatment 'prescription' for effective results using MLD with other treatment modalities.

**By the end of this two-day certification course, you'll possess the ability to understand and perform lymphatic drainage with confidence and skill. You will also learn how to use it as part of your other favourite treatment modalities to produce excellent and immediate results for your clients every treatment, every time.**

# Continuing education credits

**Massage & Myotherapy Australia Members:** 20 CPE points

**ANTA Members:** 16 CPE points

CPE points also available with NZ associations upon enquiry.

# Workshop questions

Please head to rhythmmassage.com.au to drop us a line or jump onto the Rhythm Massage facebook page facebook.com/rhythmmassage for updates and interesting articles!

# Workshop times & locations

**Auckland:**

When: 22nd and 23rd June 2019

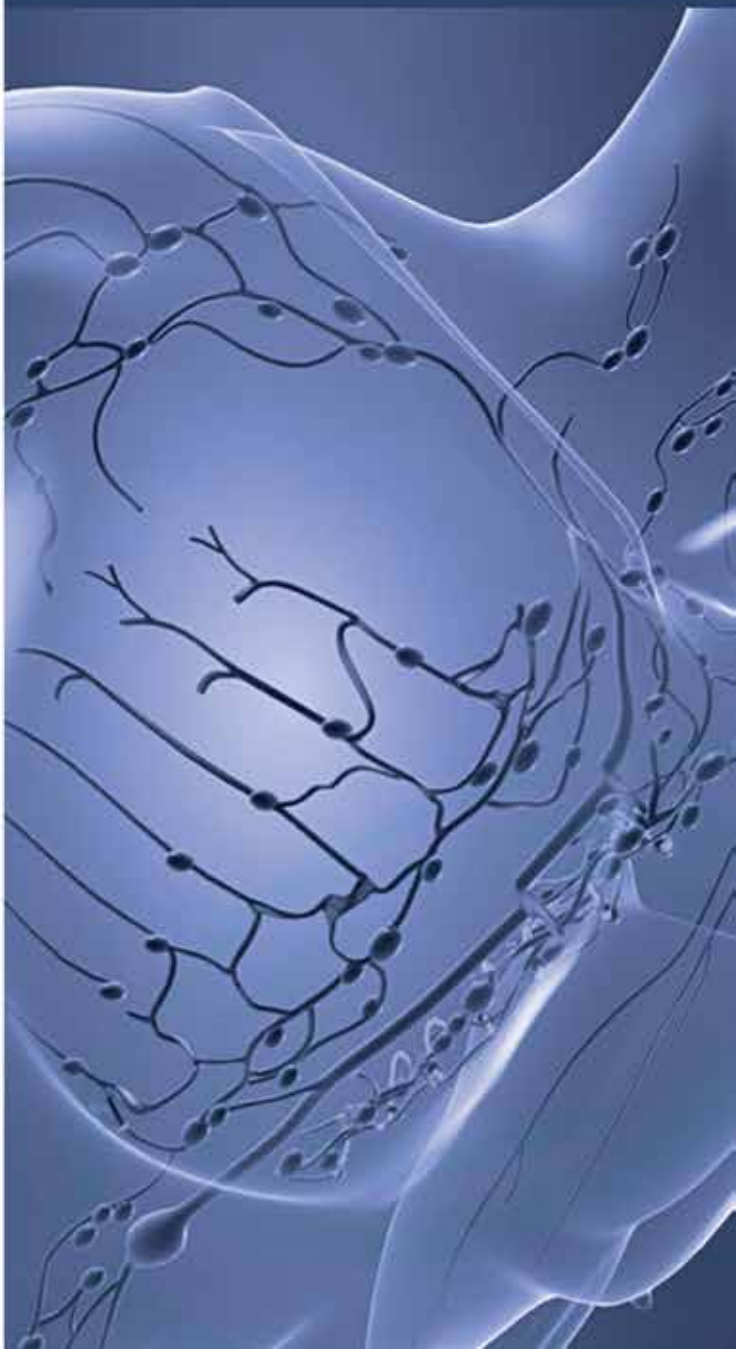
Venue: Wellpark College
14 Mills Lane, Albany
Auckland, New Zealand

Time: 9.30am – 4.30pm each day

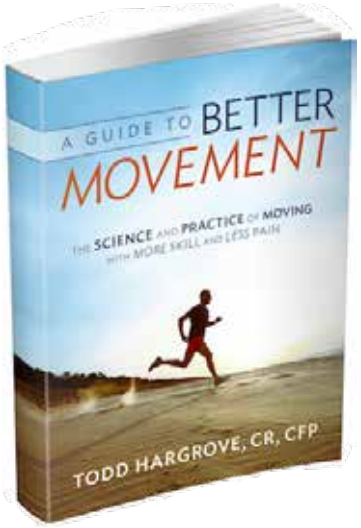
**Cost to attend this workshop is $495 per person. Please check our website for further details.**

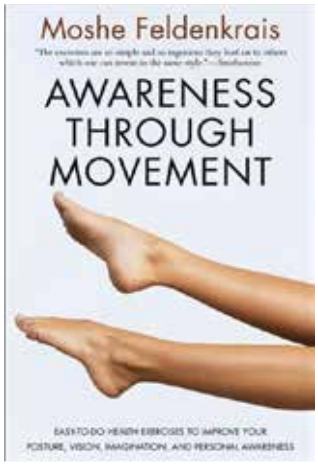
# Registration

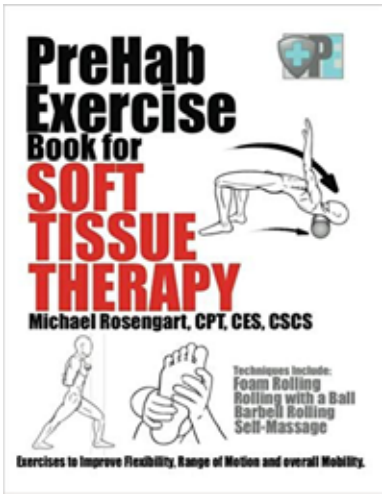
Places are limited so to avoid disappointment book early. To register visit **rhythmmassage.com.au.**



# BOOK REVIEWS




## A GUIDE TO BETTER MOVEMENT

**Todd Hargrove**

**Better Movement, 2014**
**RRP $32 NZ**

A Guide to Better Movement offers a clear and practical look at emerging science related to the brain's role in movement and pain. It is written for movement professionals, athletes, chronic pain sufferers, and anyone else interested in moving better and feeling better. In it, you will learn: the essential qualities of movements that are healthy and efficient; why good movement requires healthy "maps" in the brain; why pain is sometimes more about self-perception than tissue damage or injury; the science behind mind-body practices; general principles that can be used to improve any movement practice; and 25 illustrated and simple movement lessons to help you move better and feel better.

Retrieved from Book Depository https://www.bookdepository.com/A-Guide-to-Better-Movement-Todd-Hargrove

Also follow Todd Hargrove on his BLOG https://www.bettermovement.org/

Of interest may be:

- Three reasons it matters why a treatment works.
- Why do muscles feel tight.

## AWARENESS THROUGH MOVEMENT

**Moshe Feldenkrais**

**Harper Collins Publishers 2011**
**RRP $22 NZ**

Thousands of people have found renewed health and increased sensory awareness through the Feldenkrais method.

This book offers a method for people of every age to integrate physical and mental development into an invigorating wholeness via a programme for the perennial ideal of a healthy mind in a healthy body.

Exercises for posture, eyes, imagination and more attempt to simultaneously build better body habits and focus new dimensions of awareness, self-image and human potential.

Retrieved from https://www.bookdepository.com/Awareness-Through-Movement-Moshe-Feldenkrais

## PREHAB EXERCISE BOOK FOR SOFT TISSUE THERAPY

**Michael Rosengart**

**CreateSpace Independent Publishing Platform, 2016**
**RRP $20 USD (paperback)**

An illustrated guide to foam rolling and other soft tissue therapy techniques that are designed to improve joint Range of Motion, tissue length and responsiveness as well as overall mobility. Has over a hundred different exercise illustrations with detailed instructions for individuals to use as part of their training program to improve overall mobility. Develop an understanding of why mobility exercises are an important part of a training program and then proceed to learn how to apply several different types of Soft Tissue Therapy techniques with the aim to prevent a host of Movement Dysfunctions and Compensations Patterns. Also includes a descriptive list of Compensations Patterns and Movement Dysfunctions that may impede an individual's performance and eventually lead to injury.

Retrieved from: https://www.amazon.com/PreHab-Exercise-Book-Tissue-Therapy/dp/1523239360

# WHAT'S NEW - PRODUCT REVIEW

## PEDIROLLER

The pediroller is a small latex-free ridged foot roller that can be a very useful self-massage tool for clients (and for massage therapists on their feet all day!). It's slightly contoured shape means that it fits nicely into the curve of the foot, making foot rolling simple. Unlike wooden or hard plastic rollers, it doesn't feel too rigid, which can be uncomfortable for some people. It comes in one size but it is wide enough for all foot sizes. It comes with an instruction sheet with clear instructions for how to best use it, including some plantar fascia exercises and stretches for the Achilles. It is really easy to use and clients enjoy the sensation and effects of using the pediroller.

Features the product is promoted for include:

- Helps relieve heel and arch pain and plantar fasciitis
- Refreshes tired feet
- Aids circulation
- Can be used as cold therapy by chilling or freezing
- Easy to clean
- Latex-free

The pediroller is available from Whiteley Allcare. They are a New Zealand owned and managed business, based in Kumeu Auckland. Whiteley Allcare supply a complete range of products to healthcare professionals across New Zealand. They specialise in allied healthcare products for Physiotherapy, Hand Therapy and Podiatry and also have a great range of Massage Therapy related products. Whiteley Allcare are a small team who pride themselves on their ability to provide a high level of personalised service.

I've been a customer of Whiteley Allcare for a while now and always find them excellent to deal with. They have some fantastic deals – like free freight Fridays which happens once a month. Their deliveries are very quick and they respond to any problems very quickly.

You can find out more about Whiteley Allcare, including how to register as a customer, by visiting their website https://www.allcare.co.nz


Whiteley Allcare have very kindly provided us with a pediroller to give away in this issue of MNZ Magazine!

Answer this question:

**WHAT DOES FMT WORK MOST EFFECTIVELY WHEN COMBINED WITH?**

*(Refer to the article in this issue of MNZ Magazine: Stepping Ahead with Foot Mobilisation Therapies, by Ted Jedynak).*

Send your answer to: co-editor@massagenewzealand.org.nz by April 15th.

Contest only open to current paid members of Massage New Zealand.

## SHAKTI MAT

If you haven't heard about Shakti Mats then you've not heard about one of the most popular relaxation and self-care tools around. Launched in 2014 by young entrepreneurs, George Lill and Jon Heslop, after a chance encounter with the inventor of The Shakti Mat, Swedish Yogi Om Mokshananda. The two fell in love with the product and its alignment with ethical, effective self-care. They quit their graduate jobs and committed full time to the new endeavour, living out of a tent in Auckland to save money and build up the business.

An acupressure mat based on the Indian bed of nails, Shakti Mats have thousands of small spikes which apply pressure to the area in contact with the mat. The theory is that lying on a mat supports circulation, relaxation, mental clarity, and overall well-being. Unlike the original bed of nails, the spikes on Shakti Mats are small plastic ones, much less intense than nails!

Given our understanding of anatomy and physiology, from a nervous system perspective it is feasible that the relaxation response that can be experienced from lying on a Shakti Mat is a result of the contact of the plastic spikes with the skin organ, with the spikes stimulating mechanoreceptors in the skin such as the pacinian corpuscles and ruffini endings, which respond to pressure. If you consider the Gate Control Theory, then perhaps the initial spikey sensation may be interfered with by the nerve signalling occurring as a result of the pressure from lying on the mat. I'm not aware of any scientific studies done on the mats but many people find them very beneficial for relaxation and self-treatment of pain and muscle tension. My first experience of lying on one had me in a deep state of relaxation for 40 minutes and clients who have them also report a sense of deep relaxation and have found that it helps to manage conditions such as low back pain, neck and shoulder tension. Having a tool for self-treatment in addition to massage therapy sessions can be a great way for clients to self-manage and feel a sense of control and self efficacy.

The Shakti brand strongly values its ethical approach. The word 'Shakti' in Sanskrit is a feminine principle, and symbolises empowerment, abundance and change. The mats are manufactured in a workshop in the holy city of Varanasi, India. The women who work there are supported with good pay, good hours, daily meals, free medical care, sick pay, time off for weddings and other events, and a safe and happy work environment.

You can find out more about Shakti Mats, including how to become a retailer by visiting their website

https://www.shaktimat.co.nz

Team Shakti have very kindly provided us with a green Shakti Mat to give away in this issue of MNZ Magazine!

Answer this question:

WHAT INTERVENTION WAS USED WITH THE CASE REPORT PARTICIPANT?

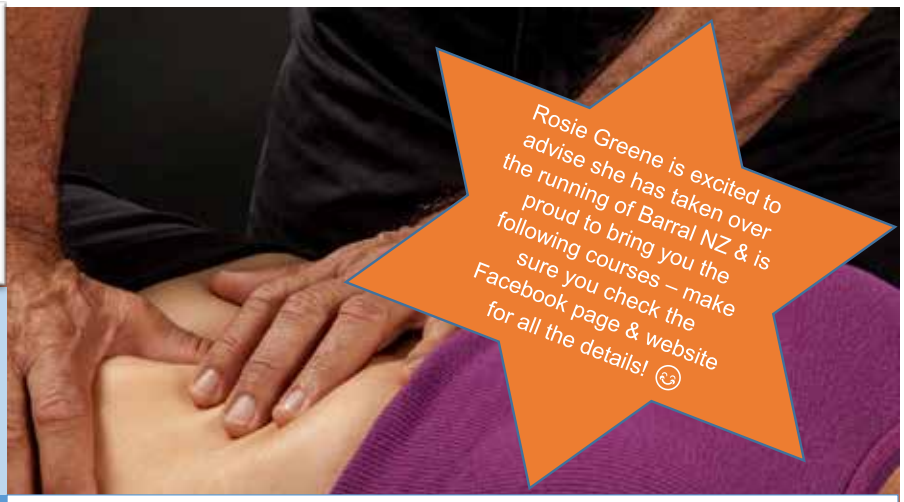
*(Refer to the article in this issue of MNZ Magazine: The Effects of Reducing Sedentary Behaviours in conjunction with Massage Therapy on an Office Worker with Low Back Pain: A Case Report, by Hayley Ward)*

Send your answer to: co-editor@massagenewzealand.org.nz by April 15th.

Contest only open to current paid members of Massage New Zealand.

SHAKTI

THE BARRAL INSTITUTE New Zealand




**Discover Visceral Manipulation or "organ specific fascial mobilisation", the work of renowned French osteopath JP Barral, who has suggested that "over 90% of musculoskeletal issues have a visceral component".**

## Instructor Information

Instructor for VM1 and VM2
- Rosie Greene

Following on from the workshops at the MNZ conference as reviewed in the MNZ magazine 4th Quarter 2017, join Rosie in Auckland or Christchurch for these 4-day intensive workshops where you will learn skills you can use in the clinic immediately.

---

Instructor for VM3 & VM5
- Annabel Mackenzie

Join Annabel, a highly skilled, Canadian instructor, who teaches the breadth of the Barral Curriculum worldwide in 3 languages.

**BOOK NOW!**

**www.barral.co.nz**

## Upcoming 2019 Courses – Christchurch

**Visceral Manipulation 1: Abdomen 1 (VM1) – Prerequisite - open to health professionals**
**8th – 11th June 2019, Christchurch**
In this four-day course, participants will learn an integrative approach to evaluation and treatment of the structural relationships between the viscera, and their fascial or ligamentous attachments to the musculoskeletal system.

**Visceral Manipulation 2: Abdomen 2 (VM2) – Prerequisite – VM1**
**13th – 16th June 2019, Christchurch**
In this four-day course, Visceral Manipulation: Abdomen 2, participants will expand on the functional anatomy, hand placements and techniques learned in VM1. You will explore the deeper structures within the abdominal cavity, focusing on the kidneys, pancreas, spleen, greater omentum, peritoneum, and their connective or suspensory tissues.

**Visceral Manipulation 3: The Pelvis (VM3) – Prerequisite – VM2**
**2nd – 5th November 2019, Christchurch**
This studies the relationship between the structural and functional mechanics of the pelvis and the integration of the pelvic organs with the complex ligament systems of this region. You will learn techniques for differentiating between somatic and visceral causes for pelvic and low back pain

**Visceral Manipulation 5: Manual Thermal Evaluation & introduction to VisceroEmotional (VM5) – Prerequisite – VM1-4**
**7th – 10th November 2019, Christchurch**
This four-day course, VM5 is divided into 2 parts, Manual Thermal Evaluation and Visceral Emotional Listening. The techniques learned in VM5 are essential to the whole person evaluation and treatment. Each organ holds emotions; it is our "stop gap system" for the mind, and when discharged, the body/mind communication can be restored.

# USEFUL SITES AND LINKS

## WEBSITES

### The Sports Physio

https://thesports.physio/

Adam Meakins is a physiotherapist, strength and conditioning specialist, and an extended scope practitioner with an interest in the management of the shoulder and upper limb working in the NHS and private practice in Hertfordshire, England.

He has been a lecturer for Brunel University's physio program but now teaches his own highly acclaimed and renowned shoulder workshops across the world. He is also actively involved in a number of clinical research projects and has published papers in peer-reviewed journals, and written a chapter for the latest edition of the best-selling sports medicine book, Brukner & Khan's Clinical Sports Medicine. This makes him a clever clogs.

Adam is a popular speaker at conferences and professional events on subjects in and around sports injury and musculoskeletal medicine and is a strong advocate in the use of social media to help share ideas and disseminate information. His honest, at times blunt, irreverent (he swears a lot!) and controversial views and opinions mean he is not afraid to call it as he sees it. He's not a fan of manual therapies because of their passive approach, but if you follow him via his website, N.A.F podcast and social media, you will get exposed to some different views around movement that will challenge your thinking for the better. In person he is a nice guy and very funny!

### JoePro

https://www.joetherapy.com/membership-features

**$5.99 USD /month online**

Joe Yoon is a certified personal trainer, licensed massage therapist, and founder of Joetherapy, a fitness training business. He also became a licensed massage therapist in 2013.

Having joined his JoePRO programme, advertised as 9 minutes per day, the programme has given new ideas for stretching and mobility. Plus it uses all these modalities—stretching, mobility, strengthening—without a lengthy time commitment.

Also he has an Instagram that is great to send to clients as links to watch useful homecare stretches.

https://www.instagram.com/joetherapy/?hl=en check out some of the neck stretches and hamstring releases.

## FACEBOOK PAGE

### Hannah Moves

https://www.facebook.com/hannahmoves/

Nick Hannah is a physiotherapist in Ontario. He describes himself as a sarcastic skeptic helping people make moves. He's taken social media by storm with his funny, poignant and scientifically sound memes advocating a biopsychosocial/whole-person (remember that phrase "whole-person, talked about by Brian Broom at the 2016 MNZ AGM) approach to rehabilitation. He's worth checking out.

## VIDEOS

### Tendinitis, Tendinosis, Tendinopathy? Exercise is the best medicine for tendon pain.

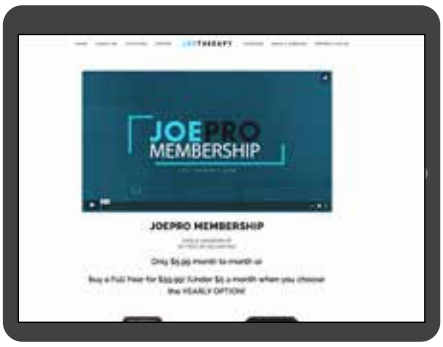
https://www.youtube.com/watch?v=GKkSp-TlofI

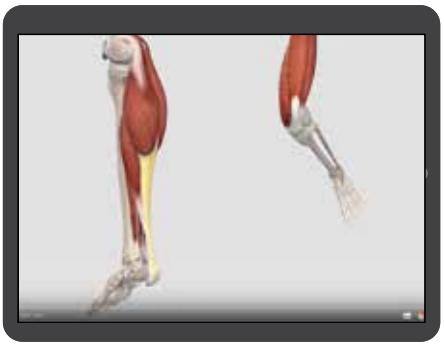
Short video with well-regarded Physiotherapist and tendon clinician-scientist Jill Cook talking about tendon pathologies and rehab.

### The Mysterious World Under the skin

https://www.youtube.com/watch?v=bWU_DnC9t4I

The 42 minute youtube link is a good review to relook at the structures involved with fascia, but overall the information presented is about 10 years old in focus.


# CAN MASSAGE THERAPY MAKE A DIFFERENCE IN RECOVERY FOR RECREATIONAL ATHLETES?

Greetings, MNZ readers

This installment of Massage Therapy Research Update, in keeping with the theme of the whole edition MNZ Magazine, is dedicated to new information on the topic of massage and sport.

A little background about the process of putting this article together:

This is a rich topic. I was overwhelmed with the volume of clinical trials, systematic reviews, and meta-analyses on the topic of massage therapy for athletes. There's a LOT of material to choose from. At the same time, I was underwhelmed with the clarity of any findings. As I dug into the piles of studies to select what to share with you, I decided to hone in on one topic: massage therapy and recovery from athletic performance, which could include factors like delayed onset muscle soreness (DOMS), pain, perceived recovery, fatigue, blood markers for muscle damage or fatigue, and many other ways to describe what athletes go through in the first 24-48 hours after they complete a demanding event.

Even limiting myself to that one topic didn't yield consistent results—some studies find good responses to massage therapy in some measures, and poor ones in others. Other studies find the opposite. And reviews—those "studies of studies" that compile data from clinical trials that fit certain criteria—typically pronounce that the role of massage therapy for athletes is unclear at best.

## WHY SUCH DISPARITY?

It turns out that athletes are probably a much more diverse population than many researchers give them credit for. Recreational athletes' and elite or professional athletes' recovery processes are not necessarily the same; metabolisms are different between these groups. What happens for men is not necessarily analogous to what happens for women. The type of sport makes a difference too—a swimmer's recovery looks different from that of runner or a cyclist. The type of massage therapy being offered is another a substantive variable. So it appears that trying to test the role of massage therapy for athletic recovery requires that high-level studies be quite limited in scope, and that means they may not be generalisable to larger populations of athletes.

So with all this in mind, I present to you here just two studies that address the question of massage therapy and recovery from athletic performance. I chose them because they are quite different: one is a clinical trial, and one is a systematic review with meta-analysis. Their findings are likewise variable.

I will include abstracts (edited for length), links to the original open-source articles, and some of my own thoughts from diving into these pieces.

## EFFECTS OF DIFFERENT RECOVERY STRATEGIES FOLLOWING HALF-MARATHON ON FATIGUE MARKERS IN RECREATIONAL RUNNERS.

**Thimo Wiewelhove, Christoph Schneider, Alexander Do¨ weling, Florian Hanakam, Christian Rasche , Tim Meyer, Michael Kellmann, Mark Pfeiffer, Alexander Ferrauti**

**Public Library of Science 2018 Nov 9.**

Link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6226207/

## ABSTRACT

**Purpose**

To investigate the effects of different recovery strategies on fatigue markers following a prolonged running exercise.

**Methods**

46 recreational male runners completed a half-marathon, followed by active recovery (ACT), cold water immersion (CWI), massage (MAS) or passive recovery (PAS). Counter-movement jump height, muscle soreness and perceived recovery and stress were measured 24h before the half-marathon (pre), immediately after the recovery intervention (postrec) and 24h after the race (post24). In addition, muscle contractile properties and blood markers of fatigue were determined at pre and post24.

**Results**

Magnitude-based inferences revealed substantial differences in the changes between the groups. At postrec, ACT was harmful to perceived recovery and serum concentration of creatine kinase, with CWI being harmful to jump performance. CWI was beneficial for reducing muscle soreness and improving perceived stress, with MAS being beneficial for reducing muscle soreness and improving perceived recovery. At post24, both CWI and MAS were still beneficial for reducing muscle soreness, with ACT being harmful to perceived recovery, serum concentration of creatine kinase and free-testosterone.

**Conclusions**

In recreational runners, a half-marathon results in fatigue symptoms lasting at least 24h. To restore subjective fatigue measures, the authors recommend CWI and MAS, as these recovery strategies are more effective than PAS, with ACT being even disadvantageous. However, runners must be aware that neither the use of ACT nor CWI or MAS had any beneficial effect on objective fatigue markers.

***My thoughts on reading the whole article:***

This study, from a German and Australian team of researchers, looked at 46 recreational runners competing in a half-marathon. The authors separated participants into four groups so they could compare passive recovery (that is, rest), active recovery (that is, a "warm down" running protocol), cold water immersion, and a 20 minute massage intervention only for the legs. The massage protocol is described with enough detail to replicate, which makes a nice change from many studies of this kind.

The measures included objective blood chemistry scans, a test for jump strength, and participants' reports of pain, stress, and perceived levels of recovery. The scientists took measurements before the race, immediately after, and 24 hours later.

I am not enough of a physiology expert to know if the measures they chose for objective markers of fatigue and muscle damage are the best possible, but they are well defended, and certainly scientists track creatine kinase and c-reactive proteins in many studies looking for signs of muscle damage.

My sense is that the authors may have been surprised at the findings. In general, massage and cold water immersion had the best effect on pain and perceived recovery - that is, whether the athlete feels ready to resume training. The passive intervention didn't appear to make any major differences except in the blood markers over time. And - perhaps most surprisingly - the post event exercise "warm down" program appeared to have substantial negative impact on several measures, including objective blood markers and perceived recovery. This may lead trainers to rethink what they advise recreational athletes to do after a challenging event.

There are a couple of takeaway messages from this article that I thought were especially important. The first is relevant to previous Massage Research Update articles and our general awareness that the perception of pain and the presence of damage are not always congruent. Here is a quote from the "Practical Application" section about massage and cold water immersion:

> This feel-better phenomenon may be critical for the restoration of exercise performance because **performance has been shown to be impaired in the presence of muscle pain regardless of the extent of exercise-induced muscle damage.** *[Emphasis mine]*

In other words, the perception of pain doesn't necessarily correlate with levels of tissue damage, and if we can decrease the perception of pain, then an athlete may be able to perform better.

The other point, which the authors make themselves, is that although massage may make athletes feel better faster, it was not shown to be more effective than rest to clear up markers of fatigue or muscle damage. The caution inherent in this is that an athlete who receives massage may be inclined to return to activity prematurely, which carries the risk of injury.

Bear in mind that these findings were with "recreational athletes", that is, not professional or elite athletes. In general, the findings in favour of massage therapy appear to be greatest among this group, so it is not a given that similar results would be seen with frequent marathon runners, for instance.

## AN EVIDENCE-BASED APPROACH FOR CHOOSING POST-EXERCISE RECOVERY TECHNIQUES TO REDUCE MARKERS OF MUSCLE DAMAGE, SORENESS, FATIGUE, AND INFLAMMATION: A SYSTEMATIC REVIEW WITH META-ANALYSIS

**Olivier Dupuy, Wafa Douzi, Dimitri Theurot, Laurent Bosquet and Benoit Dugué**

**Frontiers in Physiology, April 2018, Volume 9, Article 403.**

Link: https://doi.org/10.3389/fphys.2018.00403

### ABSTRACT

**Introduction**

The aim of the present work was to perform a meta-analysis evaluating the impact of recovery techniques on delayed onset muscle soreness (DOMS), perceived fatigue, muscle damage, and inflammatory markers after physical exercise.

**Method**

Three databases including PubMed, Embase, and Web-of-Science were searched using the following terms: ("recovery" or "active recovery" or "cooling" or "massage" or "compression garment" or "electrostimulation" or "stretching" or "immersion" or "cryotherapy") and ("DOMS" or "perceived fatigue" or "CK" or "CRP" or "IL-6") and ("after exercise" or "post-exercise") for randomized controlled trials, crossover trials, and repeated -measure studies. Overall, 99 studies were included.

**Results**

Active recovery, massage, compression garments, immersion, contrast water therapy, and cryotherapy induced a small to large decrease in the magnitude of DOMS, while there was no change for the other methods. Massage was found to be the most powerful technique for recovering from DOMS and fatigue. In terms of muscle damage and inflammatory markers, we observed an overall moderate decrease in creatine kinase

and overall small decreases in interleukin-6 and C-reactive protein. The most powerful techniques for reducing inflammation were massage and cold exposure.

**Conclusion**

Massage seems to be the most effective method for reducing DOMS and perceived fatigue. Perceived fatigue can be effectively managed using compression techniques, such as compression garments, massage, or water immersion.

*My thoughts on reading the whole article:*

This team of researchers from Canada and France set out to see if a large body of evidence yields any clear-cut data about post-exercise recovery interventions to reduce a variety of problems. To do this they conducted a systematic review (a narrative comparison of studies with a set inclusion criteria) and a meta-analysis (a statistical comparison of similar studies).

They analysed a total of 99 studies that met their inclusion criteria, and compared what happened for measures in three main domains: DOMS (80 studies), perceived fatigue (17 studies), and muscle damage/ inflammatory markers (43 studies) under a number of different types of post-exercise protocols.

To be included in this review, studies had to have an exercise intervention and a recovery intervention, with detail about those procedures; details on the modalities and timing of the interventions; and validated measures for DOMS, perceived fatigue, and muscle damage or inflammation markers among healthy adults age 18-65.

They had two independent reviewers go through all 99 studies to code the data and submit it to what looks to me (not a statistician) like a rigorous statistical analysis. Because statistics are not my strong suit, I will have to rely on the rigor of the publication (Frontiers of Physiology) for assurance that the numbers are correct.

The interventions they compared included active recovery, stretching, massage, massage + stretching, electrostimulation, compression garment, immersion, contrast water therapy, cryotherapy, and hyperbaric therapy.

*Here are the findings related to massage:*

Massage compared well to most other interventions. In the domain of muscle damage and inflammatory markers, massage had a clearly positive effect on creatine kinase and interleukin-6. (No data were available about C-reactive protein.) Massage was also clearly more effective than other interventions for perceived fatigue. For DOMS it was ahead of the other options at 24 and 48 hours after the event, but compression garments scored better at 72 and 96 hours.

So we might have a bit of consistency here: Wiewelhove (who studied the recreational athletes doing half-marathons) concluded that massage is helpful for "perceived recovery," and Dupuy (combining data from 90 studies) finds that massage is good for "perceived fatigue." Are perceived recovery and perceived fatigue the same thing? Hard to say, but maybe they're close enough to lump them together.

However, the studies are also contradictory. Wiewelhove did not report benefit from massage related to chemical markers for muscle damage or inflammation, but Dupuy did.

I have a theory about this, which, if I were ever to have a chance to ask Dr. Dupuy about, I would. A specific inclusion criterion for the Dupuy meta-analysis was that each article must include (and describe in detail) a post-exercise intervention. The Dupuy study does not address post-exercise rest (e.g., a non-intervention control). Since the Wiewelhove study found that passive rest was the best option for chemical markers of muscle damage—and even included a warning that massage might prompt athletes to return to training too soon because it doesn't address markers of muscle damage and inflammation, this seems like a serious discrepancy. I would like to ask Dr. Dupuy why passive recovery appears to be left out of this very large-scale systematic review and meta-analysis, when it could be an important comparator for chemical markers of damage.

The Dupuy study has many strengths and a few significant weaknesses. I appreciate how the authors have tried to categorize some of the variables that influence outcomes of clinical trials. But the lack of any control group comparisons is a problem for me. I also take issue with some of the massage studies they cite, simply because I know that not all of them are of equal value. That said, we can't move forward through this question without trying to identify where we're getting stuck—and the Dupuy study is helpful for that.

I hope this very brief foray into the world of research about massage therapy for athletes isn't too discouraging. Yes, we have a lot of contradictory information, but those unanswered questions create opportunities for us to learn more deeply about our craft. That said, I hope the next edition of MNZ Magazine gives me something a little less challenging to explore!


## AUTHOR BIO

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 a Massage Therapy Foundation Trustee from 2007-2018, and she was the President of the Massage Therapy Foundation from 2010-2014,

Ruth can be reached at www.ruthwerner.com or rthwrnr@gmail.com

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