



The body as a soft machine:

Part 2 of our interview with Thomas Myers

Case study special:

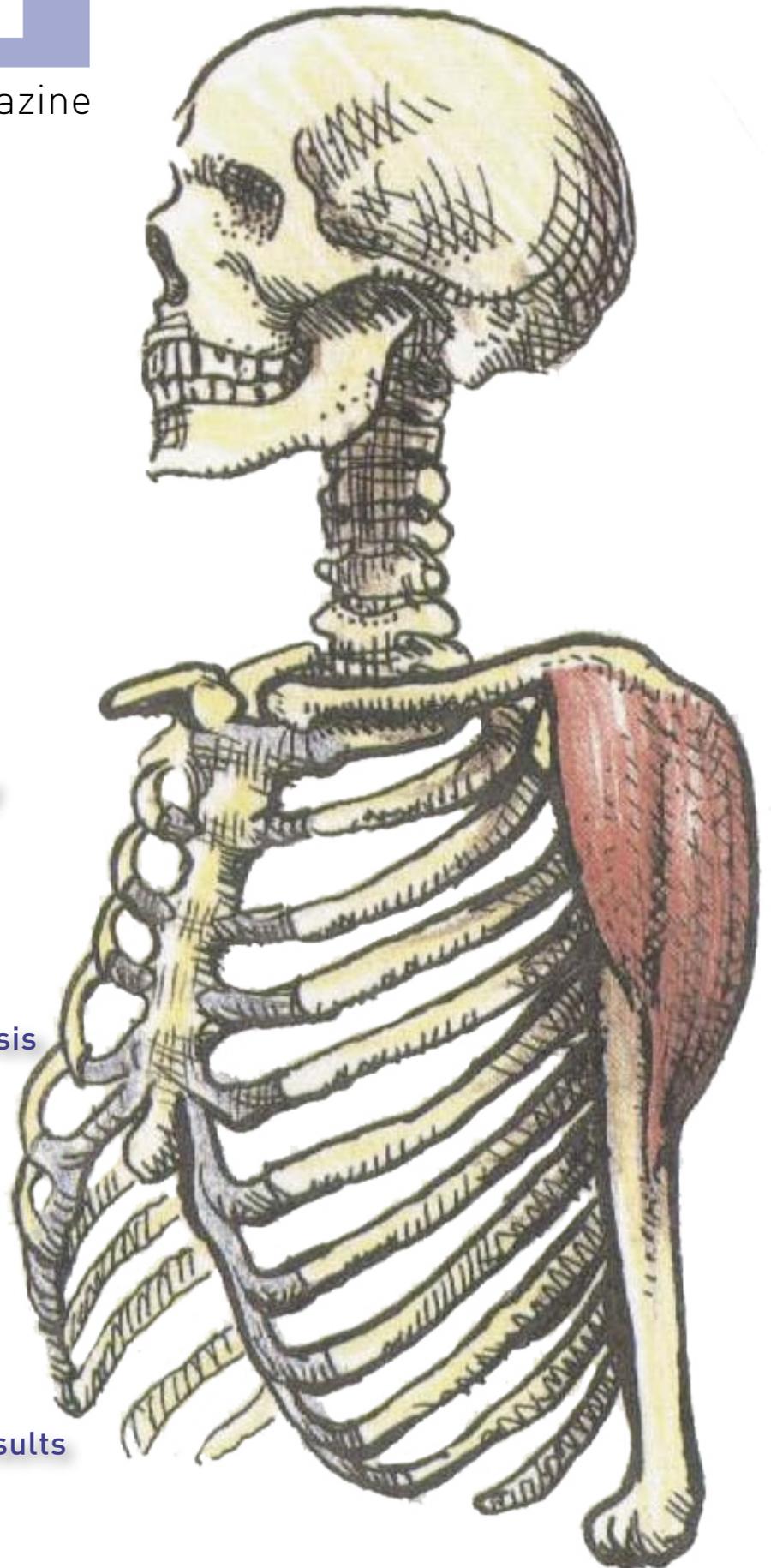
from stress fractures to scoliosis

Minimum education standards:

how much is enough?

The evolution of the Sports Medicine team:

working together for better results





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Editor's note

In a time when business is dominated by aggressive marketing, well-planned promotion and proactive go getters, is the Remedial Massage industry passively fading? And when the industry does promote itself, does it adequately promote the difference between Massage Therapy and Remedial Massage Therapy? The recent STT poll shows 94 per cent of voters said no. And whose role is it to promote the industry anyway?

There are more questions than answers when debating this topic. One would expect that the associations should market and promote the industry, but when the associations have differences of opinions, some are not financial enough to advertise, and some only have RMT as a side venture membership, then the chances of a nationally consistent promotional campaign are extremely unlikely. So do we have to do it ourselves? And if we all decide that we will, can you imagine the array of messages we will deliver to insurance companies, GPs, other physical therapists and consumers? Would this be beneficial for our future? One would suggest not as the perception would be division and disarray. One strong lobby group promoting and marketing an agreed message to all relevant parties would show strength in unity. The groups lobbied would be more likely to listen, more likely to respond and communicate and eventually more likely to integrate. Problem is, who will form this group and how will the industry decide what the message should be?

This edition of the STT eMag explores two areas of the industry that are arguably in need of policy changes. We explore the current haziness of the 'Sports Massage' world, its lack of definition, its lack of competency and point of difference. Plus we ask questions on the minimum entry requirements into educational institutions. Geoff Walker delivers the second instalment of his interview with Thomas Myers and we have pages of case studies for you to read through in our case study special. Enjoy this edition of the STT eMag and don't hesitate to contact us with your thoughts and opinions.



*Yours in Soft Tissue Therapy,
Brad Hiskins*

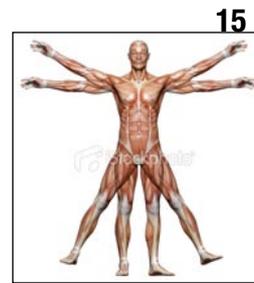
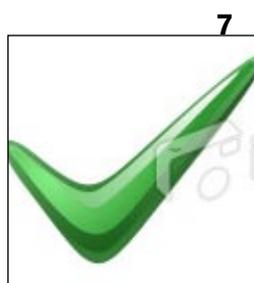
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Soft Tissue Therapy eMag

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Where is our industry going?

In this edition, we talk to Penny Neuendorf, who was until recently the course coordinator of the Advanced Diploma of Soft Tissue Therapies at the Canberra Institute of Technology.

Where do you see our education in 10 years' time?

TAFE-based for at least the practical component and maybe to an Associate Degree level, with the final theory being taken on by the universities.

Where do you see our research in 10 years' time?

I see the research component as the only way I can see us getting the appropriate funding is through universities, if you look at a lot of the current research it is massage therapists doing PhDs. The associations are keen and looking into it but I am still to be convinced on how this will pan out. It would be ideal as it would mean that the involvement could be widespread though the massage community and I would love to see it happen.

What areas do we need to collect data on within the next 10 years to objectively form our future?

All areas – the more data there is, the more we can manipulate it to suit our purposes, to give soft tissue therapies the professionalism that it deserves.

Where do you see our job growth in 10 years' time?

It has taken at least 17 years while I have been in the profession to get the 'prostitute' component out of the public's mind when you mention massage. I think in the next 10 years, we will change the view of the other health professionals (physios, doctors etc) on soft tissue therapies and there will be positions in public and private hospitals. We will be sought after by all health orientated professionals to work alongside them.

What association format would you like to see in 10 years' time?

I would like to see an umbrella organisation to represent all therapists as there are way too many personalities in the profession for one organisation to work well. I think this is important to get representation on a professional level.

What are our greatest hurdles to achieve these goals?

The personalities in the profession. The attitude of the other health professionals, mainly physiotherapists. And finally, the good old guys that did their qualification 20 years ago have only updated with short course on techniques they know and are not interested in upskilling the general massage population. I believe we can go places in the next 10 years where we haven't been accepted before. People like Eleanor Oyston who are promoting to hospitals and the sports/



rehab component where we are at all the big sporting events will also increase our profile. If with upskilling and some form of registration we can get a minimum wage setting in the next 10 years, we will have achieved these goals.

Penny Neuendorf, BHSc, Adv Dip Remedial Massage, Grad Dip. Tertiary Teaching and Training, Dip Aromatherapy, Cert Complex Lymphoedema was Therapy Teacher and Course Co-Ordinator – Advanced Diploma of Soft Tissues Therapies, Department of Health Science, Canberra Institute of Technology until 2008.



Our industry's education system

– the good, the bad, and the ugly on minimum academic levels.

Would positive clinical outcomes in Massage Therapy (MT) and Remedial Massage Therapy (RMT) be considerably improved if our industry introduced a minimum-level entry educational standard?

Brad Hiskins ponders these questions.



The Massage (MT) and Remedial Massage Therapy (RMT) industry is one of very few, if any, in the area of healthcare that does not have an entry score from high school to allow entry into its educational institutions. This most significant point has, and will continue to have, a profound impact on the culture, the philosophies and future of the MT and RMT industry. Whether this hinders or enhances our industry is the focus of this article.

When students graduate from high school, the score they attain will define the courses and the universities to which they can apply. For some high school graduates, their academic dreams are realised and they go to the university of their choice, while the bulk of graduates are forced to compromise their dreams and aspirations. They are relegated to second, third, and fourth choices of study and future career options. Hence, those that perform better academically have vastly more options in tertiary studies. This pecking order, conceived by educational institutions eons ago, is the very root of entry into all of the greatest learning institutes around the world. In essence, these institutions seek to attract the most academically gifted students, which in turn assures the best graduates for any given profession. Right?

Traditionally, students who graduate from high school with the highest grades opt into the medical industry. The medical degree institutions openly seek the brightest, smartest, most academically gifted students into their courses in order to produce the best possible General Practitioners (GPs). But, is that what actually happens? Do the brightest, smartest, most academically gifted students produce the best possible GPs? Furthermore, do they produce the best osteopaths, chiropractors, physiotherapists and so forth?

Do you have personality plus?

In recent years, questions have been raised surrounding the 'personalities' of practitioners in healthcare professions, including those mentioned above. In particular, many healthcare industries, including the powerful Australian Medical Association (AMA), have pondered the question of what is classically termed 'bedside manner' – that is, do their members connect with their patients? Do they possess the ability to be empathetic and caring? This matter has been considered by the AMA over the last decade or so and

aired in a variety of formats in the media. Questions as to whether 'personality' is necessary in achieving a positive clinical outcome will remain debatable, but, whatever the case, it is clear that healthcare is driven by discerning consumers who will switch industries or allegiances, where practical, for better service.

Although there is limited evidence demonstrating that academically gifted students or graduates are without any character or personality, there does seem to be a socially stigmatised suggestion that this may be, in some circumstances, a tendency in academically top-heavy healthcare industries. This has prompted at least one healthcare industry to take positive action.

Is the osteopathic industry changing the rules?

The osteopathic industry has reviewed its entry requirements into its degree. In recent years, a lesser academic level, coupled with a 'personality interview', has provided an avenue for some applicants into the osteopathic degree. Rather than requiring all applicants to have outstanding grades, the osteopathic industry has become proactive in seeking graduates that may not be academically gifted, but nonetheless, can become wonderful assets to the osteopathic profession.

In essence, the osteopathic industry sought academically competent people, rather than the academically gifted. Moreover, they desperately sought young, attentive, and energetic people that were vibrant and had a caring disposition. They see the future of their osteopathic practitioners, and their industry on the whole, as more than a set of clinical tests and treatment skills. They are seeking to fortify their industry's standing with a new breed of practitioners who possess the ability to achieve positive clinical outcomes, as well as communicate and connect with their clients. Sounds like a good idea.

This contrary approach to recruiting students of osteopathy is extremely perceptive. Redirecting focus away from an academically top-heavy student body acknowledges, for one thing, different learning styles. However, this approach has not resulted in a substantial shift away from the 'old school' way of rewarding the most academically gifted high school graduates. They will continue

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to be presented with the most lucrative career opportunities – they will remain the majority of students occupying university placements in the osteopathic industry for the time being.

Massage and Remedial Massage – it's a 'no rules' zone!

Now we turn our attention to our industry, MT and RMT. Our educational entry requirements are non-existent. In contrast to the issues that the AMA are facing, we may be facing the opposite, that is - do we need to set some minimum level of education for our industry? We have no academic entry requirements to enter our industry in Australia.

There may be isolated educational institutions that set a minimum level but it is not a requirement set by any of our massage associations or any government regulator. Entry into our industry is based solely on your ability to pay for your education – it is simply a user pays system for massage and remedial massage. This means that literally anyone can pay, then study, and then practice MT or RMT. Most State-run Technical and Further Education (TAFE) institutes will provide support and counselling for students with a variety of physical and psychological learning difficulties in order to assist them in graduating. In some circumstances, some of these learning difficulties would be insurmountable in terms of satisfying the minimum requirements of any of the other healthcare industries. So why is it OK in our industry?

Based on this, and in line with the questions that other healthcare industries are asking themselves – does our industry need to review the circumstances under which people enter our industry? Does our industry suffer through not having a minimum educational level for admission? Would you have surgery performed on you by someone who hadn't passed high school?

The world is full of colourful lunatics

We have a wealth of colourful characters in our industry, both educated and uneducated. This is good and bad for our industry. Some of these characters elevate our industry in the eyes of others while others cause disdain. Isn't it a fact that everyone knows an MT or RMT that probably shouldn't be practising? They may be great with their hands-on skills, but is that good enough? Is their knowledge of the human body adequate enough for them to be attempting to make changes in another person's physiology?

Our standing in the healthcare industry has provided many of these characters, that is, MTs and RMTs, the opportunity to progress through the healthcare industry ranks to lead esteemed and fulfilling careers. On the flipside, we must acknowledge the fact that with any upside, there is a downside. We know that we must be harbouring MTs and RMTs who should not be providing treatments or health information to the general public. At present, our industry of MT and RMT provides a default safety net for those who didn't, or couldn't, secure a career in medicine, law, accounting, engineering, physiotherapy, chiropractic, osteopathy, nursing, or occupational therapy, for example. While there are no doubt loose canons in all industries, our industry makes no effort at all, even at the barest of minimum levels, to protect the general public from

these people. Other healthcare industries force their ranks to prove that they are capable and proficient in gathering information, retaining information, collating information, organising information, and problem solving. They do this using a ready-built, no-brainer system called high school graduation.

With no entry-level academic minimum in our industry, it would be difficult to imagine that our entire industry is academically competent. Our MT and RMT schools and colleges all have different levels of 'competence'. Even though the most recently released Training Package is supposed to standardise all future MT and RMT graduates, it won't. Oftentimes, students have and will continue to fluff, bluff, and stumble their way through tough subjects like anatomy, pathophysiology, and pathology, never truly comprehending the content of the topic. Believe this or not, though it is a fact, some massage and remedial massage educational entities believe that competence in anatomy is achieved by providing their students with a workbook to fill out at home. These workbooks are then handed into to their teacher/s to be marked. With that, and pending them copying words properly from a textbook into their workbooks, these students are considered as being competent in anatomy. How can this be?

MT and RMT does have a tendency to attract people who are changing vocations too. This is simple for them because there is no academic entry level, anyone can apply, no matter what their academic background. This is not always a negative. However, not too many of these career shifters will opt into medicine or physio. Why not? Because it's too long and too hard to complete. That's why they opt for the 'easy' option, MT and RMT.

The question of our industry's academic credentials, or lack thereof, will continue to linger as a thorn in our side whether we like it or not. In fact, isn't it prudent of the other healthcare professions to be wary of us? It is a fact that they will never be fully confident in our abilities without the absolute assurance of a minimum educational requirement.

Show me the money or show me the door

Recently, nine healthcare professions were included in Medicare Australia's (an Australian government agency concerned with improving health outcomes) Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Program. This program provides a General Practitioner (GP) guided healthcare program for people with chronic diseases. The GP is charged with the responsibility of assembling a team of healthcare professionals (those included on the schedule) to assist and aid the patient in the management of their disease.

MTs and RMTs were not among the healthcare professions that were included as part of this program.

If we look seriously at why we were not included in this system, we should start at the beginning. We need to ask whether or not our lack of baseline education is, or was, a factor that led to our exclusion in this very important initiative. If so, do we need to revisit our minimum educational standards? Should these people with chronic diseases be deprived of our skill set because we don't have a minimum educational standard?

Further to this, does our lack of educational standing mean that we should be: the lowest paid WorkCover (NSW) Providers;

the least paid by insurance companies; unrecognised by the Department of Veterans' Affairs, and ranked lowest for health fund remunerations? One of the main problems with this is that as long as the government, the insurance companies, WorkCovers, the health funds, and the rest of the healthcare industry view us with caution and scepticism, that is how the majority will see us.

Each time we are disqualified or excluded from providing our services – people suffer. Each time the rebates offered for our services are lessened, our standing in the community becomes lessened. Each time an insurer ceases paying for treatment, each time a Veteran is refused treatment – people suffer. We rank low in the delivery of healthcare in Australia. If our low education standards are contributing to this, shouldn't we change it?

Now we all know that people vote with their feet, right? If a client gets a good result from any healthcare practitioner, they will go back to that practitioner. This method of 'changing the world' is long and slow, and it doesn't change the fact that we still have no minimum educational standard. We may do great work, our clients may rave about us, we may be booked out for weeks ahead, we may get referrals from the odd doctor here and there, but our industry still has no minimum educational standards. This affects us all.

But physios still do massage at university, right?

It wasn't all that long ago that physiotherapists actually included massage in their treatments – yes, they were trained in it and they did it. Today, throughout their four-year degree, they cover a 90-page manual on soft tissue and massage techniques in all of about three hours.

With the introduction of electrotherapeutic devices, Pilates exercises, traction machines, hot and cold therapy, therabands, posture devices and son on, the need to have any physical contact with their clients has become old-fashioned. In their university degrees, more emphasis is placed on physics, biochemistry, cardiorespiratory physiology, neurodynamics, biomechanics and academia, rather than with the basic, most effective hands-on techniques. With this, massage, the labour-intensive form of treatment, fell out of favour with many physiotherapists. So, who was the hard, physical work going to be left to? After all, we can't have university graduates doing manual labour, can we – that is a tradesperson's vocation. This is when our vocation was carefully placed into our state-based Technical and Further Education (TAFE) institutes.

So who's teaching massage and remedial massage if the universities aren't?

Our TAFEs are traditionally trade-based education facilities. Traditionally, they are there to educate tradespeople, rather than professionals. They cater more to the working class. They cater to those who weren't so academically gifted.

While it is recognised that MT and RMT require a sound knowledge base, we have been inserted into the TAFE system of education, because MT and RMT is more about brawn than brains. You don't need to

go to university to rub oil on a body. Right? This is, in part, is how we've been neatly placed, and hence, categorised in the healthcare industry.

The MT and RMT industry have another unique, glaring difference to every other healthcare industry. Not only can you get educated at a state TAFE, you can learn MT and RMT at any one of literally hundreds of private colleges around the country. Some are a credit to our industry, some are absolute disgraces to us and to the entire healthcare industry.

It would be no great stretch of the imagination to ponder that there is just as much money generated from the education and training MTs and RMTs, as there is from those practising it. The privately run organisations survive on people entering their courses. It was spouted many years ago that the single city of Bendigo in Australia produced more RMTs each year than Australia produced physiotherapists.

What would happen if academic entry levels were introduced to Massage Therapy? Or Remedial Massage Therapy?

Who would suffer if minimum educational levels were ever to be introduced?

Who would benefit if minimum educational levels were ever to be introduced?

How would Australia's academic institutions react?

How would Australia's massage associations react? (Note: we do not currently have an independent Remedial Massage association.)

Would it change the way MT's and RMT's long-term professional image was perceived?

Would it smooth the progress of our assimilation into government sanctioned healthcare systems such as the Medicare and chronic healthcare system?

Would educational standards eliminate the characters and personalities in the MT and RMT profession?

Would educational standards lift the MT and RMT industry to thrive and to produce industry specific, academic research?

Australia may not have minimum academic entry levels for MT or RMT for many years to come. We will remain the only major healthcare industry to have an education and training system that does not screen its applicants for basic literacy and numeracy skills.

Do the negatives outweigh the positives for keeping this system or does the MT and RMT industry need a wake-up call.

What do you think? Email info@softtissuetherapy.com.au.



Taking massage therapy **seriously**

By Geoff Walker

It is no secret that we have a vast array of therapists, from all walks of life, who include themselves in the ‘massage industry’. Naturopaths, herbalists, personal trainers, acupuncturists, beauticians, strappers, physiotherapists, chiropractors, osteopaths, and sports trainers all entice clients to their practice by using the word ‘massage’. Plus, we are all too familiar with the fact that sex workers (aka adult services) use the term ‘massage’ as a suggestive term for all manner of services that they are willing to provide in their businesses. Whatever happened to truth in advertising? Whatever the speciality, all lay claim to the fact that they ‘do’ massage – that is, they are in some form, part of our industry and they may even belong to the same association as you. One wonders however, how many of these people who advertise massage and ‘do’ massage, list massage therapy (MT) or remedial massage therapy (RMT) as their occupation on their tax returns at the end of each financial year.

How much is enough to call yourself a massage therapist?

A serious therapists cranks out at least 1000 treatments per year. There is a blurring of the lines in our industry. Who is and who isn’t an MT or RMT causes considerable angst amongst career therapists who work tirelessly to lift the profile and perception of our industry. It seems that we will continue this struggle for years to come. Those of us who are career practitioners of MT or RMT (ie. those who complete more than 1,000 treatments per year) have been able to educate many in the general populous about the virtues of practitioners who practice often, rather than those who practice occasionally. More specifically, we have been able to see that many clients can now, and do, differentiate between good MT/RMTs and poor ones.

All industries have different skill-sets and distinct sub-interests. Likewise, therapists within our own industry have different skill-sets and sub-interests. Now, we can define these through qualifications or competencies, or by other methods, but the fact remains that we need to be able to distinguish between skill-sets and interests within our industry.

There is a growing number of therapists in our industry who have very limited opportunity to gain quality educational experiences because their skill-set has surpassed what the industry, in general terms, has to offer. While this may sound pompous or bombastic, it is factual. It is now more the norm to hear of RMTs wanting good quality, clinical, evidence-based workshops to attend. Generally, these experiences are difficult to come by. These therapists are educated enough to know that ‘Hot Rock’ or ‘Big Kahuna’ massage, among a plethora of others, is a fad or fashion, rather than an evidence-based clinical soft tissue technique. These RMTs want to attend workshops on neural tension testing, neural tension treatment, assessment,

myofascial dry needling (MDN), active and passive tissue tension techniques, practice building... they’re looking to become better educated – to be the best they can be.

With that said, how often do we see new graduates, as well as seasoned therapists who are not satisfied with existing merely as an RMT because they know that the word ‘remedial’ doesn’t carry much clout with anyone; it is a benign term – crikey, everyone’s using it! So what do therapists do to attract more people to their practice? The proclaim that they do ‘sports massage’ as well!

What does it take to be a sports massage therapist?

What is sports massage and who does it? Let us break it down into simpler terms. If we look at a definition of ‘massage’ firstly, is that really all we do as Diploma level graduates? Massage – “rub and knead muscles and joints of the body with the hands...” Isn’t this description a little limiting? Going one step further, let’s add the prefix, ‘sports’. Typically, all this does, especially within the greater community is conjure up thoughts of an old bloke, who smells of Dencorub, furiously rubbing a player’s calves before a footy match. Is that really sports massage?

A Diploma of Remedial Massage (DRM) graduate, in Australia for example, spends up to two years in full-time study to “rub and knead muscles and joints of the body with the hands...” After two years, full-time, I believe that those graduates have earned the right to be proud of their achievement and be proud of their new profession as a Remedial Massage Therapist. In my experience however, most RMTs actively seek to be identified as something other than a RMT. Most commonly, this will invariably lead to linking their skills and advertising to the ‘sports’ arena, that is, when they are asked what they do they respond by explaining that they do ‘sports and remedial massage’.

Even still, capable graduates are so much more than what is characterised by the term ‘sports massage’. Looking at any quality curriculum in a commonsense fashion, the graduates learn many more techniques that are used in the preparation of sports people, that go far beyond the quintessential definition of ‘sports massage’. So why do we persist with defining ourselves with an inaccurate description of our skill-set? Why do we persist in representing ourselves this way?

In seeking to understand this industry-specific peculiarity, that is, ‘sports massage’, we need to ask ourselves reflective questions and draw on our unique experiences and understanding. For me, I don’t believe I have ever done ‘sports massage’. Others tell me that all I do is ‘sports massage’ – my industry tells me that I am a ‘Remedial Massage Therapist’ who specialises in ‘sports massage’. But I don’t think I do ‘sports massage’, nor am I a ‘Remedial Massage Therapist’ who specialises in ‘sports massage’; so who’s right? In fact, I don’t believe that there any such thing as ‘sports massage’! Quite simply, when a client enters

my clinic, whether they play sports or not, they have one of a number of soft tissue anomalies. I assess, formulate a treatment plan, and then apply my treatment techniques (then re-assess, of course).

This is reflective and representative of us as an industry. What does this say about our industry? Who, and what, is our industry delivering to the unwitting consumer? We're confused and confusing. Every Sunday evening, thousands of weekend athletes end up battered, bruised, and injured after their most recent battles on the sporting grounds of our country. Who, then, do they seek treatment from on Monday?

We must start thinking about the future of our industry and blowing some of the cobwebs off. Can we start with a more accurate delineation between our skill-sets and sub-interests? Does our industry have room for a skill-set defined as a Soft Tissue Therapist (STT), that is, one who practices Soft Tissue Therapy? Furthermore, and with further training, a Sports Soft Tissue Therapist (SpSTT), may be one who practices Sports

Soft Tissue Therapy. It's open-ended yet very descriptive – yes, and invites the practice and use of multiple techniques and philosophies, including, yes, classical massage techniques too!

That would see our industry with the MT, the RMT, and the STT (and/or SpSTT). Why not? It seems that each time we make headway in the industry, our qualifications or titles are either poorly represented by the associations or they are hijacked by any one of a number of other industries.

The terms STT and/or SpSTT are certain to change the ill-conceived perceptions that are rife throughout the greater community, among allied healthcare professionals, and even among therapists in our own industry. And, if asked, "...what is a Soft Tissue Therapist?", we can proudly answer that "...we treat and prevent people's injuries by keeping the body's soft tissues in optimal condition without any drugs, invasive treatments, machines or surgery".

More on this in our next issue.

Bringing together the most effective, influential, and most sought-after remedial massage and soft tissue therapist presenters in Australia is a big call, but well worth the effort. What you see in this Three disc DVD set is the highlights of more than 15 hours of presentations, discussions, and questions – it is a truly vigorous educational experience.

AN ABSOLUTE NECESSITY FOR ALL SERIOUS THERAPISTS

The 2008 Soft Tissue Therapy Conference provides expert speakers on musculoskeletal conditions, assessment procedures, treatment options, working with elite sport, and getting your head around running a busy practice, in our industry.

Brad Hiskins - The stork test: How to perform it correctly and what your findings mean in a clinical setting.

Dr Judith May - Red flags: When things just don't add up, what should you do?

James Walsh - Posture related pain and dysfunction: What do you see when you watch someone walking?

James Barker - Medial tibial stress syndrome: Find out why James is so successful at treating 'shin splints'.

Geoff Walker - Is our industry progressive or are we in a free-fall from which we can not recover?

Tricia Jenkins - 'The pain is all in your head' or is it?

Peter Garbutt - When do we need to refer to a chiropractor?

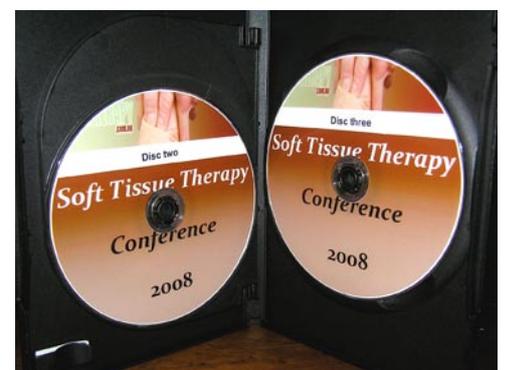
Andrew Curry - Andrew's approach condenses clinical experience, observation skills, and advanced anatomy skills to guide you through assessment, treatment and strengthening for optimal pelvic stability.

Kelly Townsend - Would you like to turn over \$1,000,000 in your massage clinic? Kelly explains how.

Jo Smith - Step one in our industry; find out why people come to our clinics. If we know why, we can work to those strengths.

Stewart Condie - Specificity and sensitivity of orthopedic testing. Are we really relying on some of these tests that are just plain wrong?

Note: While every effort has been made to faithfully record the entire proceedings of the 2008 Soft Tissue Therapy Conference, portions of the DVD have been affected by poor lighting and/or poor sound quality. Where sound quality has been preserved, but some of the video quality has been compromised, those portions remain in the presentation, as the information is of value from an auditory perspective.



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Christine O'Connor:

A life in elite sport soft tissue therapy



Being told, “Christine, you have not been offered the scholarship” (a one-year postgraduate scholarship at the Australian Institute of Sport) was one of the most motivating sentences I have ever heard. Although I had undertaken some service provision with Australian Cycling, it was not enough experience and this left me outside the shortlist. My full focus and motivation was set to remedy this situation and subsequently set my career path.

So I decided that cycling was going to be my path to redemption and focused on my efforts with the sport. First up, I had to secure a position with the team and decided to call the head coach. He was the lucky recipient of my weekly phone calls offering my services as a Soigneur for him and his team wherever need be. Every week, until he decided it would be a good idea to do just that, use my services!

So off to Italy I went with the Australian Cycling team – my first international trip with the team. When working with a cycling team your position is termed Soigneur. Soigneur means (sport) trainer in French and the role includes much more than recovery massage. In essence, it includes:

- Making biddons: drink bottles, water, electrolyte, sometimes warm tea.
- Food before, in between and after the race: this means negotiating international languages, locating supermarkets and employing the omnipresent language of hand signals to interpret various grocery products.
- First aid: being first on the scene, especially in a track or circuit situation. Ongoing care also.
- Map reading: being at the beginning of a race, miraculously appearing in the middle of the same race, on the side of the road (to hand out musettes with drink and food), then being at the end of the race to greet the riders.
- Recovery massage: all team members, every day after the race for half an hour, massaging when not training, which is once or twice a week, and injury management. This is predominantly the job of the Soigneur unless the team also travels with a doctor or physiotherapist.

All in all, it is a 24/7, high volume, demanding position. The days become nights and nights mornings and Monday becomes

Thursday and March becomes May! There are a lot of bikes, cyclists, biddons, hotel rooms, vans, maps, supermarkets and occasionally bed. It is busy and requires 100 per cent and is very rewarding in return.

The role of Soigneur is integral to the function of a good cycling team. I have been lucky to be a part of such teams for 10 years or so. This has also been an exciting time for soft tissue therapy (STT) in general as this role has become a more recognised and valuable part of any team and is intrinsic to integrating medical disciplines.

My initial soft tissue training was in Perth, through TAFE. My TAFE was inundated with great students and great teachers, one of whom was Bernd Adolph. Bernd owns and runs the Subiaco Sports Massage Clinic. An amazingly talented man who helped me start my career with cycling, having worked with teams himself. He also introduced me to Brad Hiskins who, over the years, has been a mentor. Brad was the person to inform me that I needed more experience, all the way back at the start, and therefore motivate me. Which he has done ever since!

After a season of working in Italy with the Aussies, I applied for the scholarship again and this time had enough experience to be awarded it. That broadened my cycling horizons to include working with the track team that year, which were based in Germany – Buttgen in fact, place of folklore, with the great Charlie Walsh as coach.

These were amazing years to be involved with Australian Cycling. Both disciplines, road and track, were doing it tough, laying down the foundations for the now phenomenally successful athletes we have today. It produced some of the great professional cyclists in the peloton that we now watch on television.

There have been some amazing experiences working with these athletes. Watching my first ever hunger-flat athlete come over the

line, holding him and the bike up, wandering how I was going to get him off, single-handed, because he was not able to do anything. Not even hold his head up! Seeing, for the first time, on the track at the Worlds in Perth, one of the boys slam his head and then the rest of his body into the track at super high speed. Picking wood splinters from his entire right side butt for three hours. Of course there has been quality time in hospitals, all over the world, post-crash, and jumping in the back of ambulances to assist with cyclists in emergency care.

High-pressure situations like those are not too common though. Thank goodness! Especially for the riders. Ongoing maintenance, as part of a medical team and also solo on tours is the major component. There is the first aid aspect of wound, illness and general health management. There is also the hands-on, soft tissue management. During a tour this is generally a 'flush' – a light, recovery-aimed massage. In between racing, the work is more treatment-based. This tends to focus towards gluteals, lower back, hip flexors, ITB/TFL and quads, muscles that are highly utilised in any cycling event and regularly fatigued and hypertonic. Interestingly I have done some of the deepest massages I have ever done with some of the track boys! Then on the flip side, I have worked with riders who did not want massage at all, as they believed it 'took the spring out of them'. And with any sport, if that is what the athlete believes, then that is what the protocol becomes. As the years go by and experience increases, I am also more confident at educating the athletes about what type of soft tissue therapy is appropriate and when. It is this experience I wish to pass on as the culture needs to be maintained rather than reinvented.

An often-overlooked athlete within the road cycling team is the domestique. They will take the high profile cyclist, or GC (general classification) rider, the potential winner from the team, over the hills, along gutters, into the wind, through the peleton, fall back to get biddons and then place them in the best sprinting position possible. I really want to mention the domestique as their efforts are too often forgotten, not mentioned or not appreciated. They really are the workhorses of the team.

The track and time trials are a different aspect of cycling. There are team events where, like on the road, every member has a role to play. These events include the team time trial, points score and scratch race. And then there are the individual events such as the sprint and time trial. I was lucky enough to work, in the early days, with the Aussie track program and got to see all these events. The Aussie team was notoriously good. They punched well above their weight and continued to produce new talent as the years rolled on. The track is often ferocious. Sprinters are beasts in the athletic world. Their power is immense and their will is the same. In this time, I met a couple of the most professional and highly regarded athletes that provided Australia with the structure and culture that still influences the sport today. One of them showed the world how to be professional, upstanding, and a downright champion, even in the face of 'mechanical failure' when he slipped his pedal at the start of his Olympic Kilo (one kilometre individual event) race.

It was a heart-breaking moment for us, Australian sport and for world cycling. His reputation worldwide demanded he took that medal home. Alas, he did not. The travesty of sport.

Cycling also took me to Britain. The UK track team were, and

are, a fantastic group of athletes that allowed me to be a part of their team. This was the first time I saw what I like to call 'the look'! Going to the line at the Track Worlds, a cyclist I had been working with for some time, got on the line, gave me a wink, went in the zone, and pulled out his best ride. A world champion ride – the first of many. It is little moments like that that make this job so worthwhile and special. It is amazing to see an athlete bring all their potential and training together and succeed.

Being a part of the British fraternity made me aware of how much good financial support and great technology can assist success. Money certainly doesn't breed potential but it can certainly help develop it. The athlete still has to be damn talented and well-trained as they are, in the end, the ones that push the pedals. But having the money to provide ongoing service provision from many aspects, including technology, medical, and coaching, simply gives those extra couple of percentages that makes a good cyclist great.

Australian Cycling doesn't quite have that money but it most certainly has some of the most gifted sports science medicine personnel on the planet. They are literally renowned. It certainly has been a pleasure, an honour to work with such gifted people as Dave Martin, exercise physiologist – a true champion of the sports science world.

The support structures within cycling are many:

Coaches: often head coach and specialist coaches.

Medical

Doctors: overall medical direction, supervision and consultation, plus supervision of drug testing.

Psychologist: often spasmodic during the year but more concentrated during major events.

Nutrition: ongoing support, sometimes travelling with team, sometimes online support.

Biomechanists: bike technology support.

Physiologists: recovery, performance measures and data collection and analysis.

Administrators/managers: the behind the scenes organising of buses, planes, media, and licenses.

Mechanics: a vital component of any cycling team, even if it's their knowledge of the good coffee shops about Europe.

Soigneur: the team wouldn't run without them! These guys often do all the above when in a smaller team or financially poor team.

Being a part of this large number of service providers demands an essential understanding of everyone's skill set, their role within the team and their personality nuances. When you are eating, sleeping, socialising and working with the same people, 24 hours a day for weeks, you certainly need to understand each other's likes, dislikes, habits and craziness. Being professional within a team is a large component of making it work, but being a good person on tour binds the team together.

I have worked with great managers and coaches that have shown how a simple word or sentence can facilitate an athlete's winning performance. Shayne Bannan is a great example of this and watching Chris Boardman with the athletes was inspirational. I have also had personal inspiration working with gurus such as

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Robyn Taylor, who is the most rounded and experienced Soigneur to come from Australia.

For years I travelled and worked in the elite cycling environment. A little piece of inspiration in the form of a knockback and years later, I had experienced a lifetime of memories.

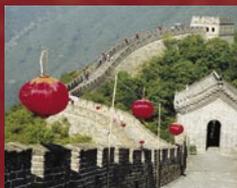
In between all this crazy travelling, my great colleague Bernd, who was there at the beginning, let me come back to his clinic in lovely Perth, to work with and for him while not on tour. This allowed me to interact with a lot of different sports within the Perth sporting network. This was a massive contributing factor to gaining a position at the 2000 Sydney Olympics within the Medical Headquarters for Australia - an amazing team of soft tissue therapists headed by the father of soft tissue therapy in Australia, Rob Granter. Being a part of the whole Australian team was incredible, to say the least, a career highlight I will never forget. The therapists in this team were the best, their cumulative knowledge incredible. It was a very privileged place to be.

Last year, I returned to the Olympics in Beijing, working initially with the cyclists for the road race and time trial, and then transferring to the Recovery Centre.

And for now, after all that, I am back at the AIS, fully employed as an STT. I relish being able to work with so many disciplines and expand my knowledge. The ever-increasing expansion is one of the aspects of STT that I love the most. And did I say how lucky I have been?

Christine O'Connor currently works at the Australian Institute of Sport within the Physical Therapies department.

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The evolution of the Sports Medicine team

Brad Hiskins reflects on the relationship between the various sports medicine disciplines.

After 18 months with a persistent rib injury and a number of therapists and sports physicians under my belt, I thought I would try a chiropractic approach. I had only seen one chiropractor before; my uncle dragged me along when I was a kid. So with memories of trying to relax while someone attempted to rip my head off, I entered with a mild amount of apprehension. I had parked in a 30 minute zone believing that chiros only treated people for a few minutes so I would be fine. Right?

Thirty-five minutes later, after a good history-taking, and a whole lot of soft tissue work – yes, soft tissue work – and the treatment was over. Not one manipulation. Not one high velocity, low amplitude (HVLA) thrust. And I was then given a number of take-home exercises based on restoration of mobility to the local and indirect areas about my rib. Did I just visit a chiropractor?

My confusion left me sitting in my car (I escaped the parking fine), wondering what happened to the HVLA? And just when did chiros start using soft tissue techniques and giving exercises? And why the lengthy treatment? If I hadn't have known the person was a chiropractor, I would have sworn I had just visited a soft tissue therapist, physiotherapist or maybe an osteopath? Moreover, the soft tissue work was pretty damn good!

Of course, this is just a sign of the times and it was my ignorance of a peer group's evolution that caused my surprise. When I considered the situation further, I really had no idea of a chiropractor's education, I had never sighted their competency standard or curriculum and I had never sat in one of their classrooms. I had never been to one of their conferences

or sat in a room with them while they were discussing treatment philosophies. In fact this was only my second visit to a chiropractor in my entire life. So where was I getting my rather misinformed opinion of them from?

Further contemplation revealed my lack of true understanding of most of the other Sports Medicine Australia (SMA) and disciplines. Although I have worked with physiotherapists, physiologists, acupuncturists, biomechanists, strength and conditioning, psychologists and sports physicians for many years, I remain quite ignorant of their fundamental education and what they truly have to offer within a sports medicine team or as an individual therapist. I suppose I have a fair indication from my experience at the AIS over 11 years – well, you would hope so. In that time, I observed the principles of training,

prevention and treatment of all the above disciplines.

Through constant contact and regular meetings, it was inevitable I would develop some form of understanding of how each worked and how they integrated into 'the team'. Three years retired from the AIS and I'm questioning the autonomy these people had in that environment, which may have affected the way they operated and therefore my opinion on the efficacy of their service provision. In this environment, was this the necessary compromise that each individual needed to make to fit into a team, or was this a hierarchical system that suppressed some and stimulated others? Is this what occurs within professional teams around the country? Either way, is this system depriving some disciplines from utilising the skills they possess and therefore best



practice treatment protocols?

The lack of many disciplines at the AIS, such as (but not limited to) podiatrists, osteopaths and chiropractors, left my opinion on their service provision to be based on third party anecdotes and the occasional sports health rag. I'm quite embarrassed now to have developed such opinions based on practically nothing and realise my peers are likely to do the same with myself and my industry. So is it my obligation to research these disciplines, or theirs to educate me? Surely in a 'team' environment, 'we' are obliged to educate and be educated from an industry perspective and individual niches. How else could a team utilise industry specific skills in a best practice manner? How else could a team realise the potential of not only an industry but individual practitioners' niche skills and experience within those industries?

I know most soft tissue institutions invite guest speakers from most disciplines to describe their skill set and philosophy. I have no idea whether this occurs elsewhere. I'm assuming most learn through personal contact and of course through SMA.

Now living in a non-institutionalised world, I find the general practice of the disciplines I worked with at the AIS to be considerably different. In essence, they all practice with a very similar philosophy as those non-AIS disciplines. They assess, treat, reassess, educate the client and form a treatment protocol based on this event and refer if necessary. They are delineated only by application of discipline-specific techniques, some discipline-specific philosophies, time spent with the client and price! However, and it is a big however, are these delineations slowly waning? My experience with the chiropractor would suggest that discipline-specific technique and philosophy are becoming or have become hazy. Some use the word encroachment of one on another? Whatever the case, consumers must surely be confused.

What I see as the main reason for this developing haziness is the explosion of postgraduate education within each discipline. Further education has become a lucrative business as well as a necessity for ongoing points for association membership. And much of

the ongoing education has been based around technique application – the very aspect that delineates one discipline from the next. In my chiropractic experience, I received soft tissue treatment and home-based exercises rather than the traditional (well, in my mind anyway) vertebral manipulation. Of course this ongoing education is not isolated to the chiropractors, not by any means. As a soft tissue therapist, I have watched our industry follow the trend and embrace many non-traditional techniques in the last two decades. Dry needling has become a standard modality, as it has with just about every discipline, take home exercises (basic mobility and stability exercises) are now fundamental in the competency and even some osteopathic techniques (muscle energy technique, for example) have found their way in. There are many other examples of course. But it's just not us, it's every discipline. Physiotherapists have a well organised postgraduate manip's course (traditionally a technique of the chiropractors and osteopaths), courses in Pilates, orthotics, soft tissue therapy, dry needling and even acupuncture, as well as being able to bypass the docs and order x-rays – just to name a few.

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Sports physicians are providing exercise rehab, GPs manipulating spines – and on it goes. To confuse the situation even further, we have the impact of the exercise physiologists on the market and even the explosion of personal trainers, the greatest trend in Australia at the moment.

Is it this further education era that is potentially the reason for each discipline to resemble each other and in many cases cause conflict with regard to encroachment? And if so, can it be stopped? Should it be stopped? And who would stop it? Is it any one discipline's right to deny the professional growth of another? Can one discipline forge ahead with regard to technique acquisition, raping and pillaging what ever lies in their way, while attempting to deny another discipline the same right? Even threaten another discipline? Would we not be all hypocrites?

This situation will not cure itself in the near future. Disciplines will continue to look for the next 'x' factor and incorporate them into their education where they see fit – hopefully with the adequate amount of underpinning knowledge. Disciplines will further resemble each other and our delineation will become even hazier. This, I believe, is inevitable.

In saying this, where does it leave us with regard to our 'sports medicine team'? As president of the ACT SMA branch, I am proud to say that we have an amazingly diverse board. We currently have a sports trainer, sports doctor, sports physician, exercise physiologist, chiropractor, podiatrist, physiotherapist, educator and a soft tissue therapist – myself – on the board. I believe this is a reflection of SMA's philosophy, 'the team behind the teams'. But if this team of disciplines, a congregation of masters of their trade, fades to a collection of 'jack of all trades', will the team remain a team? With integration difficult at the best of times with bias and often uneducated professional opinions, mixed with some ego and a touch of insecurity, what will happen to our team? Will the current sports medicine team hierarchies embrace the evolution of the disciplines and inspire their potential? Will roles diversify or will there be boxes that individuals

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must remain in? And what system is best? What system, what integration and how much autonomy will produce the most effective outcome – player injury prevention and performance?

On a more social setting, where does it leave our 'referral' system? How confident will any of us be referring to the local chiropractor, knowing they will also provide the soft tissue component, or to the local physio knowing they cover most bases now, or the sports physicians knowing they provide many rehab exercises, to the soft tissue therapists who provide beyond soft tissue work, and so on. Confidence must surely be low with the hazy delineations of what defines a discipline becoming ever more difficult to distinguish. And as each grasp for their share of the market, where is all this going? What will happen to our referral system – what there is of it anyway? Will it diminish? Will there be a growth of multidisciplinary clinics to avoid the conflict? Will the more powerful, well-financed disciplines look to push others out of the market? Or will we all mosey on in

an ideal world and fill the gaps that present to us as individuals?

Is this multitasking a good thing or bad? Does this competition produce the most effective, cutting-edge practitioners the world has to offer? Or does trying to cover all bases diminish the art of practical service provision? Can a weekend workshop in MET (muscle energy technique) really match the five years the osteopaths train in this modality for? Can a weekend workshop in orthotics match the podiatrists, a night of massage match the soft tissue therapists, 10 days of acupuncture match the acupuncturists, a couple of days of diagnostic ultrasound match the radiologists, an hour of strapping match the sports trainers? Are we diluting ourselves to the point we become undistinguishable and dumbing ourselves down to the point we are ineffective? Or is all this cross pollination building the therapist of the future? The super therapist? The practice model of future education perhaps?

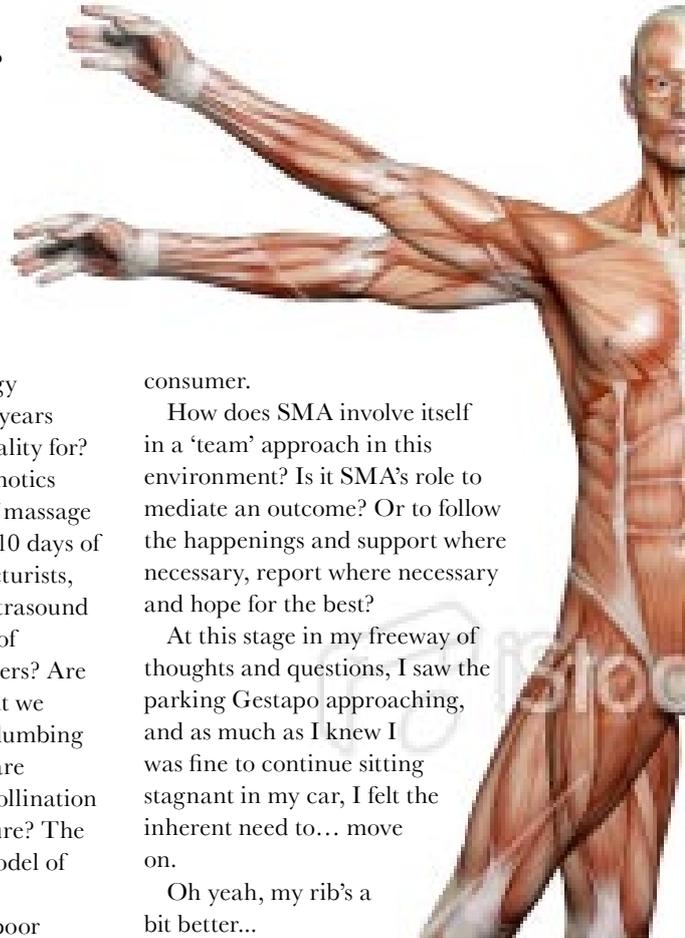
And the consumer. Well, the poor

consumer.

How does SMA involve itself in a 'team' approach in this environment? Is it SMA's role to mediate an outcome? Or to follow the happenings and support where necessary, report where necessary and hope for the best?

At this stage in my freeway of thoughts and questions, I saw the parking Gestapo approaching, and as much as I knew I was fine to continue sitting stagnant in my car, I felt the inherent need to... move on.

Oh yeah, my rib's a bit better...



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Case study: Stress fractures

A 32-year-old male runner presented with pain over the head of his fifth metatarsal. In the previous 10 weeks, he had increased his mileage from 35 km per week to 60 km per week in preparation for a half-marathon. He had not changed his shoes in this time. Pain had started 10 days prior and had worsened over that time. Pain was evident at night while watching television and occasionally during the night while in bed.

The red flag was for a stress fracture of this site – especially considering the pain at night and the area of pain being consistent with common stress fractures of the head of the fifth metatarsal. The client was referred to a sports physician for further investigation.

Confirmation of the stress fracture was shown.

The runner was to have seven weeks off running, with three of those completely non-weight bearing.

There are three common stress fractures in the foot in runners.

Navicular, second metatarsal and the head of the fifth metatarsal are those three. The structure of the foot will predispose the runner to particular stress fractures.



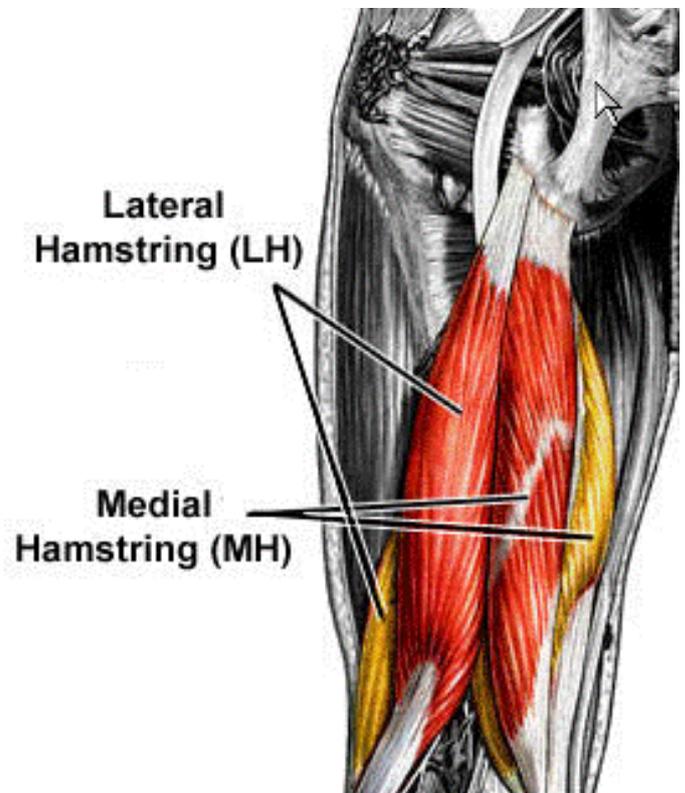
Case study: The effect of soft tissue therapy and eccentric loading on fibrosis of the sciatic nerve in a chronic groin injury

A 46-year-old female presented to a soft tissue therapy clinic with a 10-month history of a right groin injury. The injury was sustained when she caught herself immediately after tripping on an uneven surface. She had immediate discomfort in her right buttock and difficulty walking for 10 days. Three initial physiotherapy treatments improved her pain. Over the next four months, her condition regressed with tingling in her medial foot with referral to her medial calf. She had persistent pain in her right groin aggravated by external rotation and prolonged sitting. She was unable to perform a single leg bridge test (extending hip while supine – heel on stool/therapist shoulder) without substantial pain and loss of control.

An MRI was performed showing a small degenerative tear in the hip labrum. A subsequent ultrasound showed extensive fibrosis to the deep gluteus maximus and proximal hamstring tendon. The sciatic nerve could not be visualised due to the fibrosis about the nerve. There was also contusion to the mid-portion adductor magnus.

A soft tissue therapy plan combined with eccentric training for the adductor magnus and hamstring tendons was applied for eight weeks. One treatment was performed weekly and eccentric exercises once per day. Soft tissue treatment consisted of mobilising areas of scarring and addressing consequential factors such as pelvic anomalies due to muscle imbalance. The patient was advised to continue exercises through mild to moderate pain to the area.

Pain and function improved rapidly with no pain after four weeks on sitting or walking. Functionally the patient reported no cases of flare-ups or exacerbation with ADLs. Her strength improved as indicated by the single leg bridge test and external rotation improved markedly to pain-free. After eight weeks of treatment, the



This portion of the Sciatic Nerve was obscured to the Ultrasonographer due to the excessive fibrosis of the proximal Hamstring and Gluteus Maximus.

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client was able to decrease her treatment to one per fortnight and decreased her exercise regime to 3 x weekly.

A follow-up ultrasound was performed with an improved appearance to the initial ultrasound. Short segments of the sciatic nerve were now visible and a large percentage of the rest of the nerve were showing visible fibrotic changes. Other areas about the pelvis that initially showed pathological fibrotic changes were also showing improvement according to the ultrasonographer.

No injection was needed for symptomatic pain or fibrosis

tethering to the sciatic nerve. Hence soft tissue therapy in conjunction with eccentric muscle training may be a useful adjunct for the treatment of scar tissue mobilisation. Further case studies are needed to ascertain the value of such treatment and the repeatability of results.

James Barker has developed an excellent rapport with his local sports physician and radiologist. Without this relationship, clinical findings like this would go unnoticed and our industry would not develop within the health system. Congratulations to James for his efforts in bringing this information to us.

Case study: Lateral elbow pain

A 32-year-old woman presented with a 16-week history of left lateral elbow pain. Pain was worse in mornings and was exacerbated when typing. She had been in her administrative job for nine months in a static posture before the onset of this pain. No workstation assessment had been made since the onset of pain. No medical assessment had been made. Current treatment was laser therapy from a chiropractor and self-massage every second night using a massage ball (to her forearm flexors/extensors). The client had seen no change in eight weeks of this treatment. No anti-inflammatories had been trialled.

Assessment showed pain on resisted extension and hand grip (shaking hands). Pain was over the lateral epicondyle specifically. Radial nerve bias test was positive suggesting a strong component of nerve irritation. Palpation showed pain directly over the epicondyle.

A workplace assessor made adjustments to the client's desk set-up. Voice activated software was suggested. The mechanical interface to the radial nerve was addressed that gave immediate pain relief and strength increases. This was followed up at home with radial

nerve glides. Due to the longevity of the pain, an eccentric exercise program for the forearm extensors was implemented to address any possible tendinosis and extensor weakness. Two easily palpable trigger points that referred to the lateral epicondyle were dry needled.

After three treatments, the client's pain was 70 per cent alleviated according to the client's own assessment. Although the eccentric exercises gave extensor stiffness, the client persisted with good first fortnight results. Pain after extensor eccentric exercise was centred about the muscle belly rather than the epicondyle. Radial nerve stretches helped dramatically in the first week. The second week showed a plateau of result with this stretch. This correlated with clinical findings of radial nerve irritation.

Take home message: Always address the causative factor of the pain, in this case, the desk set-up. Always assess for differential diagnosis such as nerve irritation. Consider chronic tendon pathology such as tendinosis in lateral epicondyle pain and address accordingly. Refer if no success with conservative treatment.

Case study: Shoulder pain

A 48-year-old female with a history of nine months of left shoulder pain with associated headaches presented after seeing numerous health professionals. Her symptoms included:

- Pain in the left shoulder area, diffuse, post-Boot Camp;
- MRI, bone scan, ultrasound and x-ray all negative with regard to any significant findings;
- Cervical manipulations via chiropractic adjustments, physiotherapy exercises and facet joint injections all failed to show any significant improvement in pain or function;
- Pain exacerbated by house duties, heat helped alleviate pain;
- Pain specifically about left upper trapezius and associated trigger point referral.

Initially the suggestion was made to identify and remove all factors that exacerbated pain. This would be assessed by a pain diary kept over two weeks. Strength exercises were considered as this hadn't been explored adequately.

Upon physical assessment, it was obvious that her left shoulder was markedly protracted. This had not been considered as a factor

in her cervical pain.

When retracting the shoulder passively, the client noticed an immediate decrease in her upper trapezius tension and her headache.

The client had a marked decrease in her left shoulder external rotation that seemed to be dominated by the clavicular head of her pectoralis major. Soft tissue work to this muscle and stretching to the same made a considerable difference to her external rotation and consequentially the position of her scapula.

A home exercise program focusing on pec and lat stretching was developed and diligently followed for two weeks before follow-up. Subsequent treatment showed an excellent increase in external rotation of her left shoulder that correlated with retraction of her left scapula. This also correlated with a noticeable decrease in her pain.

This is an excellent example of therapists focusing on the very site of pain and not treating the obvious signs that present to them. Simple postural examination can be the key to many successful treatment plans.

Peter Smeaton

Case studies: Referral pain

A 36-year-old male presented with a six-week onset of left hip flexor 'tightness' and burning pain. There was no trauma. The region was progressively getting worse and stretching only tended to alleviate a percentage of the condition and for only short periods of time – 30 to 40 minutes. There was a history of gluteal tightness and nerve pain down the posterolateral left leg for two to three years.

On objective assessment, there was notable TFL palpable tightness plus decreased range of motion on modified Thomas test. There were no notable femoral nerve signs. The hip was limited into internal rotation with a sharp impingement type pain at end of range.

Treatment was initially focused on increasing internal hip rotation. This made immediate changes that alleviated both the rotation deficit and the presenting symptoms.

Follow-up treatment showed that this only lasted a short period. Further assessment suggested that the posterior hip was a major contributor to the hip flexor condition. There were positive nerve signs in straight leg raise and slump test. Considering the longevity of these signs a referral was made to a sports physician for their opinion and direction. An ultrasound was ordered to assess for sciatic nerve tethering or pathology. Findings showed no tethering but chronic inflammation and swelling about the sciatic nerve just below the quadratus femoris for approximately 6cm. This was injected with cold saline to numb the nerve and then Celestone to rid the inflammation and swelling.

What was noted by the client when the injection was made was an immediate referral to the hip flexor region and a reproduction of all symptoms felt over the previous 6-8 weeks.

In summary, this is an example of the numerous means the body can refer pain. In this case, an inflamed sciatic nerve causing a referral of pain directly over the TFL that ended in a 'tightening' of

local muscle and fascia.

The take home message is when typical treatments and treatment results for what you would consider as 'usual presentations' are not sustainable, consider differential diagnosis for the many possible referring tissues.

A 29-year-old male runner presented with three weeks of left TFL stiffness and mild pain. There was no apparent trauma. Training had not increased significantly nor was there any change in training type. No history of this pain was recorded. Pain had increased in intensity over the past 10 days that had forced the runner to seek help.

Assessment showed mild pelvic anomalies that were easily altered with treatment. The TFL itself was notably tight on palpation and Thomas test showed lateral deviation on the affected side. Pain was not reproduced with any test.

Treatment to the pelvis and then locally to the affected TFL (soft tissue techniques and dry needling) alleviated symptoms for the runner for 6-8 hours. Pain then returned. Running continued to increase pain.

One week after the initial treatment the runner complained of night pain. This red flag suggested a possible stress fracture. A 'hang test' was performed that was positive for pain about the mid femur. Referral to a sports physician and then for a bone scan showed a mid-shaft stress fracture to the femur.

Six weeks of rest was suggested. During this time the pain about the runner's TFL slowly diminished. At six weeks the runner returned slowly to running without any reoccurrence of TFL pain or discomfort.

This is another example of tissues that can refer pain well away from the site of pathology – in this case a bone stress reaction of the femur that refers pain to the TFL.

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Case study: Gluteal and hip flexor pain

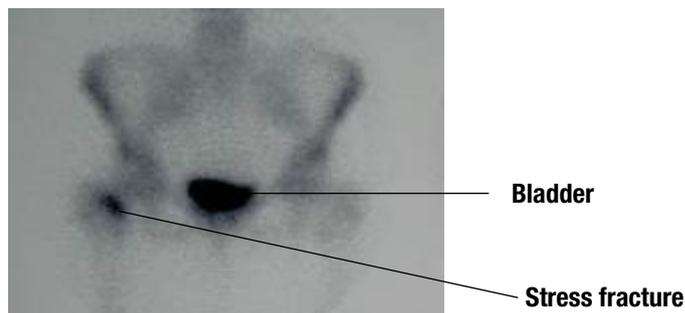
A 23-year-old male triathlete presented with a two-week history of right gluteal and hip flexor pain. He had just finished a six-week running set that saw him completing up to 80 km per week. Pain began in the last week of this running training. Running surface was generally flat. He had not changed his footwear or running surface. He had increased his mileage and intensity. Swimming and bike training remained constant throughout this time. There was no trauma. There was no night pain or pain at rest.

Upon assessment his pelvis was unremarkable except for a positive squish test (SIJ glide) on his right. His right TFL was noticeably hypertonic on palpation. His lunge test showed some very minor hip flexor pain. On hop test, however, he experienced noticeable pain about his right TFL and mid gluteal region.

Treatment focused on the right squish test that was noticeably tight. Psoas and TFL made a considerable difference to his squish test and took at least 90 per cent of pain from his TFL on hop test. Gluteal pain remained. STT work to the posterior edge of his

gluteus medius took the remaining stiffness from his SIJ squish. This took all pain from gluteal on hop test but the pain in his TFL returned and was apparently worse.

Due to the atypical nature of this condition, the client was referred to a sports physician for examination. He was referred for a bone scan which showed a stress fracture of the neck of his femur. Two weeks on crutches before a gradual increase in weight-bearing activities was suggested.



Case study: Scoliosis

A 15-year-old female presented in 2003 with right-sided thoracic pain and discomfort. The pain and discomfort was aggravated with exertional type activities, including soccer, and with prolonged periods of sitting combined with studying for high school exams. The quality and intensity of the pain and discomfort varied. The pain and discomfort intermittently wakes the client from sleep and she then finds it difficult to fall back to sleep because of the pain and discomfort. The client has described the pain and discomfort as numb, tingling, deep, stabbing, aching and/or tightened.

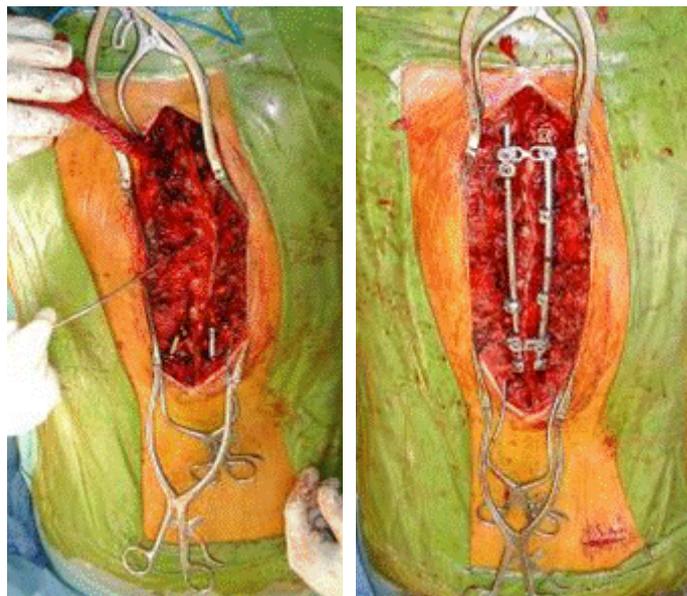
The client has been under the care of a medical specialist for a marked scoliosis (right side convex) since 2000. The medical specialist recommended the surgical insertion of Harrington Rods to remedy the scoliosis. The client did not want a surgical intervention.

The client has had various physical treatments in an attempt to alleviate pain and discomfort. The client is ambidextrous and is able to alternate writing between left and right hands to alleviate pain and discomfort, as required. Panadeine Forte and NSAIDS have been used sparingly to treat pain and discomfort.

Assessment demonstrated that trunk flexion, extension, and side flexions had been impacted upon by the thoracic scoliosis. Likewise, thoracic rotation bilaterally was diminished and cervical extension caused pain and discomfort at the C7-T1 junction.

Shoulder girdle ranges of motion were both restricted to 70 per cent of expected values. Breathing patterns were shallow and the client had difficulty and “restriction” in taking a full, deep breath.

In March 2004, the client’s medical specialist report indicated that the scoliotic curve had increased from 41 degrees to 45 degrees in the previous two years. By December 2004, the pain and discomfort was becoming “unbearable” at times. The medical specialist again recommended Harrington Rods as treatment.



Treatment focused on the alleviation of pain and discomfort. Treatments focused on decreasing muscle tone and improving and/or maintaining spinal joint integrity. The treatments included soft tissue techniques, FFT®, posterior chain strengthening exercises, breathing exercises, and self-management strategies.

The client had Harrington Rods surgically fixed on 5 January 2006. Soft tissue treatments resumed on 27 January 2006.

Treatments initially focused on desensitising the entire back, particularly the surgical scar sites. Subsequent treatments have focussed on alleviating pain and discomfort at the “bolt sites” (T2-3 and T11-12), at the C7-T1 junction and at the right quadratus lumborum region.

Ongoing treatments aim to allay pain and discomfort and to maintain the remaining mobility of the thorax.



The golfer who lost his swing

Fascia. It's all the rage at the moment in the soft tissue industry. As therapists we are only beginning to appreciate what fascia is, what it does, how it moves or doesn't, and how central it is to a wide variety of musculoskeletal conditions we are presented with. But if client education is one of the four guiding principles in our industry, then the biggest challenge we are faced with, in that regard, is that most clients wouldn't have a clue what fascia is, nor have any inkling that it can so dramatically affect their form and function. How can something so thin and seemingly insignificant be a cause of pain and a hindrance to even simple daily activities? This paper will attempt to shed light on this obscure tissue and its part in neuromuscular holding patterns, using a 78-year-old male golfer as our case study.

Our golfer is right-handed and has been playing golf three times a week for 50 years. He suffered a heart attack a year ago following the death of his wife of 60 years, but is now in very good general health and maintains an active lifestyle. He complains of discomfort in the lower back and the neck, particularly at night, which results in an interrupted sleep, leaves him feeling fatigued the next day, and affects his golf performance. He admits he doesn't drink much water, nor does he stretch after playing golf. Observation of his posture reveals a fairly obvious rotation of the trunk anterior to the right. From behind there is a distinct fascial band about 7cm wide that extends from the left postero-lateral iliac crest to the inferior angle of the right scapula. Similarly, from the front there is a protrusion of the lower angle of the ribs on the right hand side and a fascial pull from there across to the left inguinal region. There is no distinct internal rotation of the right shoulder. While lying prone, this rib cage rotation is even more apparent. Active trunk rotation is reduced to the left, and is confirmed by the client to feel stiffer in that direction compared with rotation to the right, with a 'pulling

sensation' on the left posterior iliac crest and across the vertebrae of the lower thoracic spine. Palpation of the myofasciae of the back indicates that the fascia is indeed restricted in the observed band from right shoulder to left hip. The restriction is less palpable on the front of the body, but is apparent around the angle of the ribs on the right hand side.

So how can we explain, in terms of fascial restriction, what's going on in this golfer's posture? Which muscles are tight and which are weak? How do those patterns of muscle tonicity correlate with trains of fascial restriction? And how can repeated motion, such as a golf swing, lead to a reduction in that range of movement? In order to answer these questions, we need first to understand the workings of fascia.

Fascia's fluid connection

Fascia is a connective tissue that intertwines continuously throughout the body. This suggests that fascia 'connects' structures in the body to each other, and rightly so, because it is

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essentially one huge compartmental envelope. It pervades muscle bellies, surrounding muscle fibres and bundles, giving them shape and directional force. It also surrounds, separates and gives cohesion to organs, fat, blood and lymphatic vessels, nerves, and bones. Fascia provides our bodies with stability and postural balance and is essential for transferring load throughout the body by creating "...lines of pull... which transmit strain and movement through the body's myofascia around the skeleton" (Myers, 2001: p 5). Without the tensional integrity ("tensegrity") provided by the soft tissue networks of the body (not only fascia, but ligaments, tendons and muscle), the body would not be able to withstand even the slightest of forces (Levin, www.biotensegrity.com, 29/04/07).

The term 'connective tissue', however, is somewhat of a misnomer when it comes to fascia. Yes, it connects everything in the body, but it also, critically, lubricates those structures as they contact and move past one another to enable an unrestricted, fluid motion (Rosen, www.osteodoc.com/fascia.htm, 29/04/07). This lubricating function is facilitated by the maintenance of the distance between the collagen fibres suspended within the ground substance of the extracellular matrix (ECM). If the ground substance becomes dehydrated, by loss of the glycosaminoglycans (GAGs) that bind water, it can no longer effectively separate the collagen fibres suspended in it causing them to adhere to one another and form microadhesions. Ageing can also affect the function of our fascia as the collagen fibrils thicken and the number and quality of GAGs declines (Chaitow, 2006: 16). Either way, the result is effectively a 'drying up' of the ECM which reduces its lubricating properties, thereby increasing the friction between structures. In turn this leads to the formation of cross-linkages between the collagen fibres that restrict fascial mobility.

Cross-linkages between collagen fibres are important for maintaining the tensile strength of fascia, but when there are excessive amounts of fibres due to increased production of connective tissue, it can result in too much tension. In other words, the more cross linkages there are within fascia, the less elastic it becomes. The production of new collagen may be in response to an increased load in an area, be it postural or mechanical, or it may occur as part of the healing process following an injury. In the case of our golfer, his patterns of fascial restriction

have developed in response to the repetitive and unvaried motion of his golf swing. But why does that happen? Wouldn't all that repeated movement keep him flexible and his fascia mobile, at least in the range of motion that he is constantly doing? What ever happened to the 'use it or lose it' theory?

Perhaps we can adapt this catchcry to refer specifically to the effect of repeated motion on the flexibility of fascia: 'use it TO lose it'. According to Chaitow (2006: 46-48), the normal response for a muscle under stress is an increase in tone. This usually results in the retention of metabolic wastes, localised ischemia, oedema, pain or discomfort in the muscle. Eventually a perpetuated pattern of local irritation or inflammation is under way. The central nervous system (CNS) is bombarded with afferent messages from the local area that "...jam the normal patterned transmission from the periphery" (Chaitow, 2003: 4) and leads to a heightened neural response. There is an increase in macrophages, vascularity and, most importantly, increased fibroblast activity that leads to an increase in connective tissue production, hence the formation of cross links which lead on to restricted local fascia (*ibid*). In addition, antagonist muscles are inhibited by the hypertonic muscles, further exacerbating the presentation of irregular postures. Gradually, with a perpetuated stressor such the winding-up motion of a golf swing, more cross links are formed, not only locally but more distally (as fascia is a pervasive and continuous connective tissue). This can lead to the observable and palpable bands of tension, as in the case of our golfer, and ultimately result in limitations along those lines of movement. It is then that dysfunction and pain can occur.

What we are seeing in our golfer's anomalous posture began with increased muscle tone along specific lines of pull, a concept commonly referred to as 'anatomy trains' (Myers, 1997). This concept illustrates the body's continuity by approaching the soft tissues not just as individual muscles, but a series of interrelated myofascial chains that can contribute to patterns of pain and dysfunction. There are several patterns of myofascial tension in the golfer that correlate directly with the mechanics of his golf swing. In places they overlap because no one particular line of muscles is working independently of the others during such a complex movement. As Myers points out, "movements along these lines often sweep across the fans of muscle and sheets of fascia" (2001: 6).

Our golfer is right-handed, so the swing is driven by the left back functional line (BFL) that extends from his left shoulder down across his back to the posterior-lateral side of his right knee (via the latissimus dorsi, thoracolumbar fascia, gluteus maximus and vastus lateralis). As his right gluteal muscles, hamstrings and lumbar extensors contract to extend his hip and power the pelvic rotation, it creates a fascial pull on the sacral and lumbodorsal fascia. This tension supports the contraction of the left latissimus dorsi which stabilises and facilitates the retraction of the left shoulder. The observable fascial pull is most evident along this BFL, but it is not the only myofascial train engaged when swinging a golf club.

As the pelvis rotates anteriorly to the right, the rotation of the upper body is facilitated by the contraction of the muscles of the right spiral diagonal line (SDL). Hypertonic muscles are palpated from the right suboccipital ridge (R splenius capitis and cervicis) down across the spine (L rhomboid) to the contralateral ribs (L serratus anterior) and moving anteriorly and inferiorly around to the abdomen (L external obliques, R internal obliques). Fascial tension is palpable in the muscles of the right thigh (R quadriceps, TFL and ITB that extend, internally rotate and abduct the hip) and in the posterior thigh (biceps femoris contracting with the gluteals to extend the hip). There is also involvement of the right superficial back line (SBL), with increased tone in the gastrocnemius muscle and the plantar fascia of the right foot due to the combination of plantar flexion and pivoting during the initiation of the swing.

But what is the clinical significance of all of that? Just going by his age alone, we can assume that our golfer's fascia is far less elastic than it used to be. So every time he swings his club, the unidirectional action has the effect of winding his fascia up. Each time it does, it sticks a little bit more in that wound-up position, which makes it harder to return to a neutral position. He is essentially being held in a fascial 'bear hug' that forces him to endure a cyclical pattern of stiffness, leading to pain, which leads to increased stiffness and pain. Ultimately the whole process ends up leaving him

feeling frustrated and exhausted. Chaitow summarises this perfectly:

"... Due to prolonged stress of a postural, psychic or mechanical type, discrete areas of the body become so altered by the efforts to compensate and adapt, that structural and, eventually, pathological changes become apparent... identifiable physical changes, which will themselves generate further stress, such as pain, joint restriction, general discomfort and fatigue" (Chaitow, 2003: 5).

Our aim as soft tissue therapists, in cases where myofascial stiffness is contributing to pain and dysfunction, is to redistribute the tensional forces along the myofascial tracks. We must also aim to restore the tensional balance between agonist and antagonist pairs, thereby reducing the neural feedback loops that perpetuate these fascial holding patterns.

Conclusion

Fascial restrictions do not just occur on their own, independent of other presenting factors. They are usually found in the company of a myriad of other happenings in the body. They can be related to postural habits, limited or unvaried ranges of motion, hypertonic muscles and neural feedback loops, emotional/psychological issues, or they can be injury or pain related. Many people who present to soft tissue therapists do so with vague or inexplicable patterns of pain, rarely isolated to one particular muscle, and as a result can exhibit complex patterns of compensation. Even in cases of known injury, the interconnectedness of the myofascia means that pain can be experienced distally to the site of injury. Both of these are key points to recall when assessing clients because it can lead to a more successful treatment in a shorter amount of time. It is essential that soft tissue therapists have an awareness of common fascial lines and the patterns of pain they can illicit, so they can more thoroughly, expediently and successfully assess and treat their client's presenting condition.

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Tracey currently works in Canberra, Australia for Clinic 88.

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