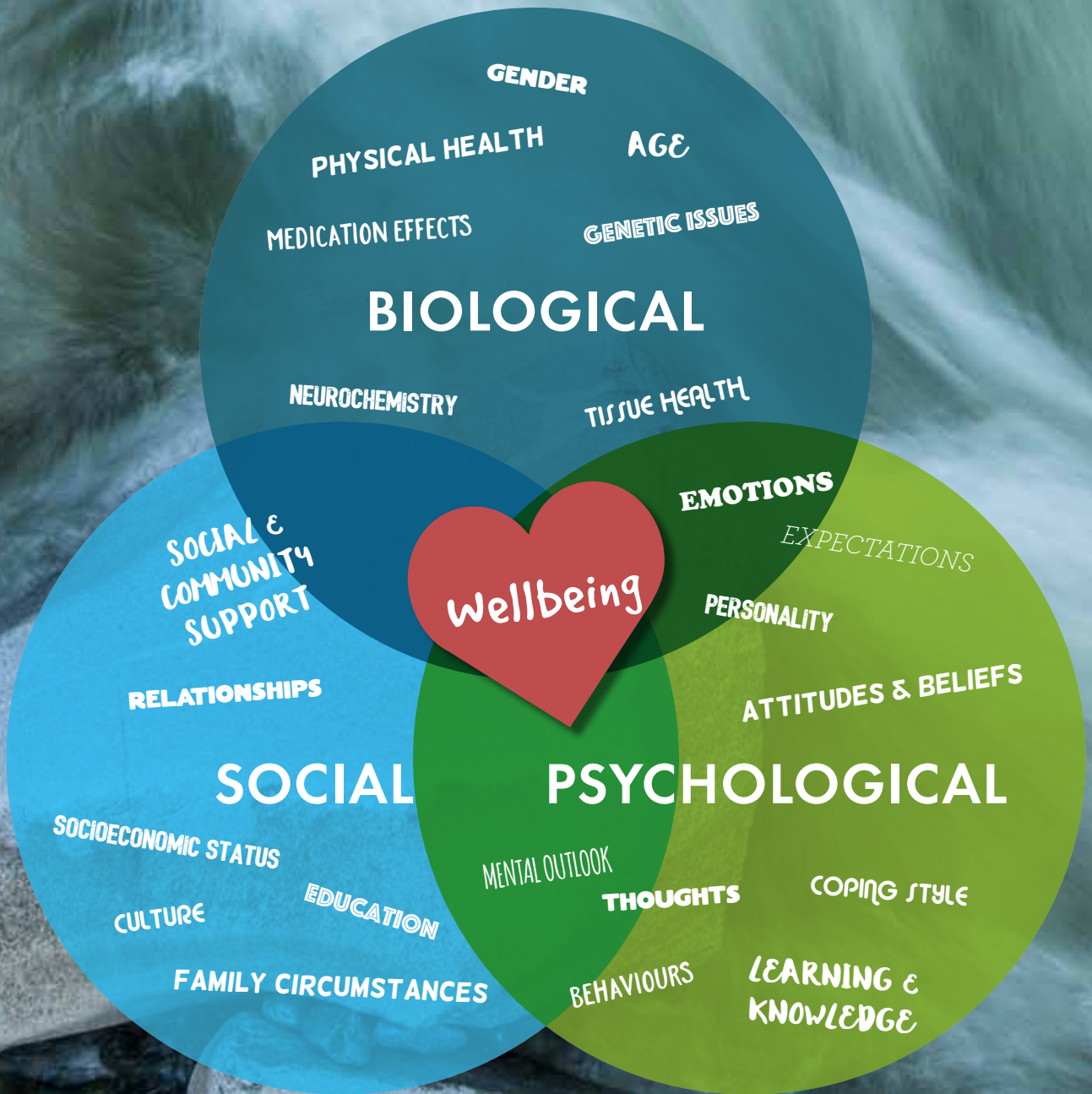
PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

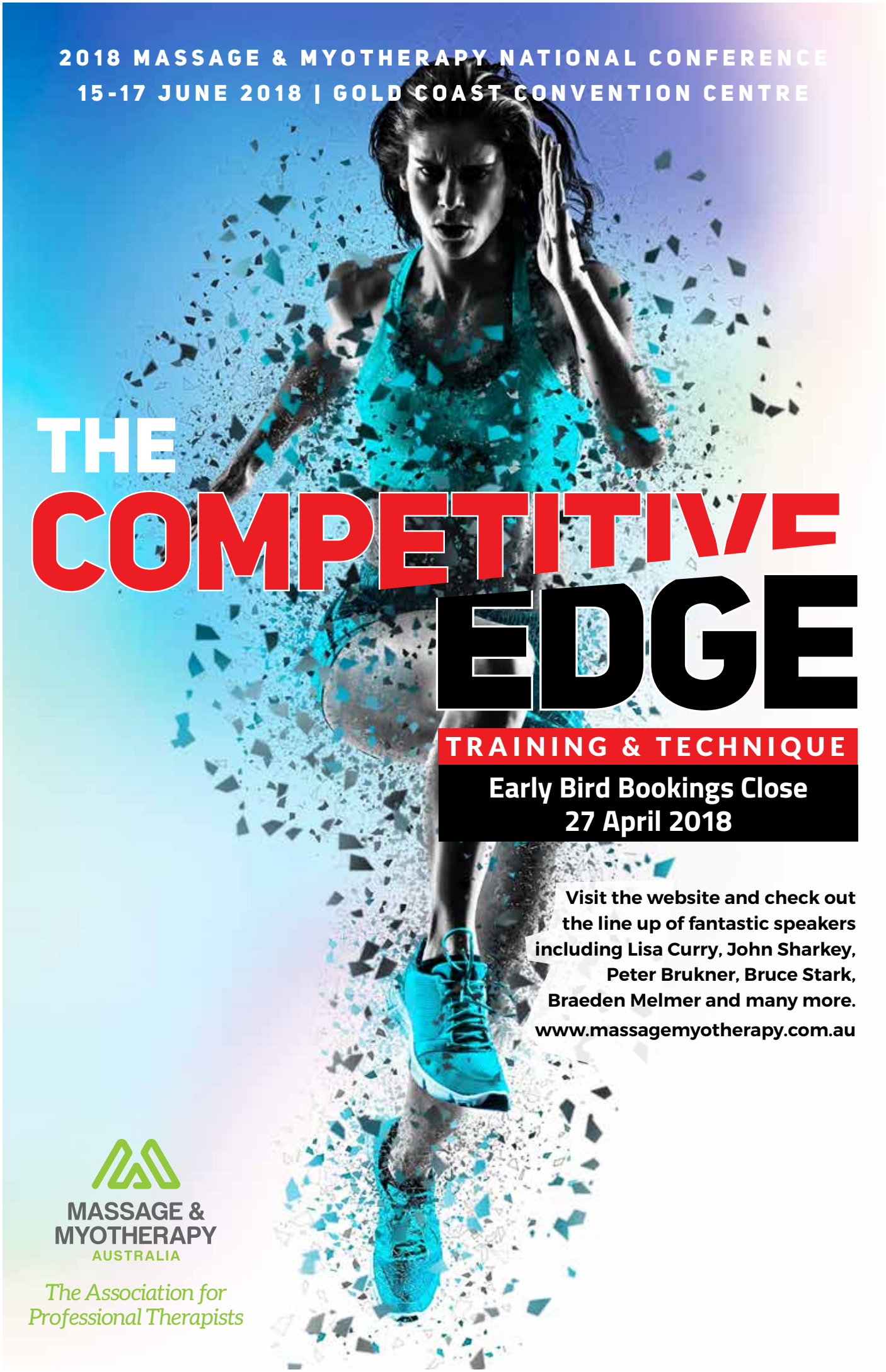
massage new zealand
1ST QUARTER 2018

INTEGRATING A BIOPSYCHOSOCIAL APPROACH IN MASSAGE THERAPY



2018 MASSAGE & MYOTHERAPY NATIONAL CONFERENCE

15-17 JUNE 2018 | GOLD COAST CONVENTION CENTRE



THE COMPETITIVE EDGE

TRAINING & TECHNIQUE

Early Bird Bookings Close 27 April 2018

Visit the website and check out the line up of fantastic speakers including Lisa Curry, John Sharkey, Peter Brukner, Bruce Stark, Braeden Melmer and many more.

www.massagemyotherapy.com.au

MASSAGE & MYOTHERAPY AUSTRALIA

The Association for Professional Therapists

EDITORIAL

For some time within the field of massage therapy, we have been using terms like (w)holistic and integrated to describe our approach. However, another term, biopsychosocial (BPS), may be more relevant. This approach or framework has been a part of the fields of psychology and occupational therapy for some time and is gaining increasing recognition in the areas of manual and physical therapy as well. We thought it timely to dedicate an issue of MNZ Magazine to the BPS approach and how we might go about integrating it into massage therapy.

As you will discover, we have some wonderful, thought-provoking articles on this theme, from a range of health professionals and commentators well versed on the subject. The magazine has a strong New Zealand flavour as well. After all, it is a magazine for New Zealand therapists. We are grateful to the involvement of many locals who have contributed articles, reviews, updates and personal experiences.

Bronwyn Lennox Thompson, lecturer in the Department of Orthopaedic Surgery & Musculoskeletal Medicine from Otago University nicely introduces us to the biopsychosocial approach on page 13. This is followed up by Joletta Belton, co-founder of Endless Possibilities, a not for profit organisation empowering people with pain to live well. Wellington Acupuncturist and advocate of integrative health, Kate Roberts discusses why and how she has set up an Allied Health Professionals Group and how building collaboration among allied health professionals can improve patient outcomes. International educator and therapist Marjorie Brook writes about working with scars in Scar Tissue 101 and Rehabilitation and Sports Therapist Phillip Silverman discusses how the BPS approach challenges biomedicine.

Among the regular columns, we have some interesting and relevant course and book reviews plus a new batch of useful websites to check out in our regular features section. Ruth Werner our international educator and regular massage research columnist summarises several pieces of ground breaking BPS-related research from recent years. There's a range of other interesting and topical articles and commentaries from MNZ members, including MNZ Vice President Teresa Karam writing about her recent experience as a (MNZ) expert witness in a sexual abuse court case, a 'must read'.

We are also excited to bring you two new columns - Graduate Illuminate and Student Corner, which put the focus on the future of our profession here in New Zealand - our new graduates and current students. You could have your profile in the next magazine. Read the columns to find out how.

We welcome member contributions. You may like to write for the next magazine on a technique you find really effective, review a course or conference you attended recently, contribute a case study on a client or a reflection you've made about your practice. We are happy to give some advice and tips on writing for publication. Articles written by MNZ members also accrue CPD hours, so it's another way of boosting your CPD. Contact Carol or Odette to find out how to submit an article.

So, grab a cuppa, sit back and take some time to browse your issue online or print the magazine out for your clinic. We would love to hear about where and when you prefer to read your issues. If you send in a photo of you or your team reading MNZ Magazine we might just share these in the next issue!

We hope you enjoy this first issue for 2018.

Carol Wilson & Odette Wood

Find us on MNZ and @Massage_N_Z

MNZ MAGAZINE Q1 2018 CONTENTS

REGULAR FEATURES

FEATURES

ADVERTISING RATES AND INFORMATION

ADVERTISING RATES

Valid from Feb 2017. All rates are GST inclusive.

MNZ Magazine: Now ONLINE only

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

All adverts are in full colour

Casual advertising rates:

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

Package deals (in 4 publications over 12 months):

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

MNZ Website:

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

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

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

MNZ Magazine and Website Annual Bulk Advertising Packages:

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

Package 1 includes:

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

Package 2 includes:

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

Email Advert to MNZ Members:

Provides a one–off mass email blast to membership.

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

SUBMISSION DEADLINES

The MNZ Magazine will be published:

Q1 2018 (deadline end Jan 2018)
Q2 2018 (deadline May 1st 2018)
Q3 2018 (deadline Aug 1st 2018)
Q4 2018 (deadline Dec 1st 2018)

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

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

Requirements of advertisements:

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

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

ADVERTISING BOOKING AND SPECIFICATIONS

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

Emailed advertising forms are no longer accepted.

Magazine Page Sizes

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

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

PAYMENT

FULL PAYMENT MUST ACCOMPANY EACH ADVERTISEMENT

Methods of Payment:

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

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

ARTICLE SUBMISSION GUIDELINES

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

Editor - Carol Wilson

magazine@massagenewzealand.org.nz

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PRESIDENT & EXECUTIVE REPORTS

PRESIDENT

A new year is upon us and I'm filled with determination that MNZ will become a voice for its members with the public and will continue to lobby Government to be recognised as a voice for the massage industry as a self-regulated body.

MNZ will be sending out a survey shortly to see if members want their executive to pursue regulation under the HPCA or remain a self-regulated body. There are pros and cons to regulation and these will be laid out for your consideration. Cost to the practitioner is certainly something to be aware of, as well as the amount of work it would take to achieve this.

There has been some publicity recently about a court case in which a massage therapist was convicted of indecently assaulting clients. Following on from this, several members have been in touch with me, offering to contact the media to see if we can get traction with wider publicity for the organisation and the protections it offers both clients and practitioners. This is greatly appreciated and makes it feel like this is a real team effort from all dedicated massage therapists who care about the industry as a whole.

My email inbox is always open and I welcome input from members with their ideas and/or concerns.

Helen Smith

VICE PRESIDENT

Greetings everyone and welcome to 2018! I believe (and hope) there are winds of change in the massage industry heading towards more regulation. Being a part of Massage New Zealand already adds credibility to us as therapists, but obviously regulation, in terms of mandatory registration takes it to the next level.

I deal with complaints from across the New Zealand as part of my role with MNZ and find it so interesting that the general public EXPECT us to be fully regulated – once something has gone wrong with a treatment. During my tenure it has been fantastic to see that all complaints received have been about non-registered therapists, however it leaves the complainant wanting to a point. They expect me to commence our disciplinary process, but unfortunatly we can't unless it pertains to an Registered Massage Therapist. I will give them other options at this point, and always advise them to search our 'find a therapist' section for their next massage.

Regulation aims to protect the public from a bad experience or under-qualified therapists but also their safety – as we know absolutely anyone can set up shop as a therapist here. We all need to promote MNZ registration, not just with other therapists but to the public by displaying the logo, Code of Ethics and Annual Practising Certificate in our clinics. Having a strong voice while registration is voluntary is vital to driving our industry forward for the future.

Teresa Karam

TREASURER

Happy New Year! I hope it was an enjoyable and safe one!

The combination of Sarah Duckworth looking after the actual finances and myself as Treasurer overseeing is working out nicely. Flexibility and good communication is important and I believe we manage it well.

The IR9 tax return for the year ending 31 March 2017 has now been filed with Inland Revenue. It takes a bit of focus as it is not as straight forward as an individual IR3 or company IR4.

MNZ is tracking well financially versus budget so far. The next job to tackle is the budget for the new financial year.

Happy reading of the new magazine!

Reina Reilly

PUBLICITY OFFICER

Welcome to 2018. Here is to a year with great progress within the massage industry in New Zealand!!

My goal for the year is to continue with the momentum that we gained last year to further build the presence of massage in New Zealand, alongside working towards gaining more benefits for our current and future members of the association. I have become passionate towards educating both the public and new therapists to the industry about the importance of Massage New Zealand. and building the relationships with both of these groups will become a focus as we roll into the year.

I am encouraged by the motivation of the members of the association and I would like to further build on the ideas that have already been suggested to me, if you have any ideas/suggestions that you would like to see implemented into the current year please feel free to email them to me on publicity@massagenewzealand.org.nz

Kind Regards,

Luke McCallum

EDUCATION OFFICER

Happy New Year and I am looking forward to a busy and productive year for 2018.

This year we are going to continue to build our relationship with the education providers, encourage student membership as well as increasing membership for qualified massage therapists. With the RPL process for overseas applicants I have had to become well versed in massage training in other parts of the world and on this basis, I believe New Zealand has some of the most thorough massage training available. This bodes well for the ongoing awareness of the professionalism of our industry.

You will notice in the magazine and advertising through MNZ that there are a variety of workshops on offer. Why not make 2018 a year to pursue something that piques your interest and earn CPD hours in the process. Ongoing education stimulates and re-energises your practice and you can never know too much about the human body.

Rosie Greene

REGIONAL LIAISON CO-ORDINATOR

Happy 2018 everyone!

Since taking on the role of Regional Liaison Coordinator, I have thoroughly enjoyed learning about the nature of this role, discovering all the aspects involved within it and having the feeling that I am "sinking my teeth" into the role more and more.

We have three brilliant Regional Reps (Upper North Island - Annika, Lower North Island - Iselde and South Island - Donya) who have absolutely got their fingers on the pulse in each of the areas that they oversee. They have been such an asset to me whilst i have been in the beginning stages of this role, and such an asset to all of you MNZ members.

Going forward into 2018 our main objectives are to continue to grow the attendance numbers at each regions MNZ meetings and to have regular meetings throughout ALL regions/areas/cities in New Zealand. How amazing would it be to have 80-90% attendance rate every time!? How strong would that make the massage industry in New Zealand?

Excitedly we have seen an increase in attendance numbers in a number of areas over the last few months of 2017. More importantly though, is that the feedback from both new attendees and those of us that have been going along for years is all positive.

If you are in an area that does not yet have a regular MNZ group, i encourage you to put your hand up, get in touch with myself or your regional rep and let us support you in getting a meeting happening. If you have never been to a meeting before, then again I encourage you to pop along to your local one. Quite often they are filled with laughter, chocolate and a cuppa tea.

Tania Kahika-Foote

STAFF REPORTS

EXECUTIVE ADMINISTRATOR

Hi eveyone, hope you have all had a happy and safe holiday break. With the holiday period coming to a close its great that the fantastic weather we have this summer is continuing. I know the 2017/2018 summer in Dunedin will be one to be talked about for years to come.

As I mentioned in the last magazine we had serval people put their names forward to help with the conference. I would like to thank those who have been at our December and January meetings for their ideas and assistance. Sadly, due to the short time frame until September, the high workloads of current committee members and no one in a position to drive the conference, the decision has been made to postpone the Dunedin conference. I look forward to working with the conference committee to bring a successful MNZ Conference to Dunedin in 2021.

On a happier note, it is exciting to see record membership numbers over the 2017/2018 period, with the new renewal period fast approaching I am sure we can make another record year this year.

Nicole Hedges

REGIONAL ROUNDUP

LOWER NORTH ISLAND

Hi everyone.

I hope the Xmas break and New Year have brought you all a welcome break and a chance to unwind!

The last meeting in Wellington was held in Petone – a more central point for therapists from the Hutt and Kapiti to be able to join us for breakfast and the venue had stunning views. We had a solid turn out and some lively discussion and being more of an informal event, all had a good chance to develop the bonds with our colleagues.

I've been busy on social media recently and have seen more and more Massage-oriented pages upon which I see a lot of familiar names and suggest to all of you who find it hard to travel to meet-ups, or who live in more isolated areas to connect to the digital communities, there's so much discussion and support and I think the pages are extremely valuable. Check out the list of Massage related pages I follow on Facebook: 'Massage New Zealand', 'Massage Classifieds New Zealand' 'New Zealand College of Massage' 'The Wellington School of Massage Therapy' 'Wellington Massage Therapists' 'Napier Massage Therapists' 'Wellington Massage Group' and 'Massage Therapists' – (an American based group.) It is via these groups I'm making efforts to drum up meetings in the Hawkes Bay but I also value participating in peoples questions and discussions within a safe environment of professionals, and asking my own when they pop up.

This year I haven't heard of any groups having planned any events yet so if you are interested in working with me to organise something for your area get in touch today! There's plenty of time yet.

Iselde de Boam

UPPER NORTH ISLAND

I hope that you are all relaxed and refreshed after your holidays and that everyone is excited to be back doing what we do best! The end of last year was a busy one so here is a little snapshot.

The Northland MNZ group were hosted by Carol Rose at her gorgeous premise The Aromary in Kerikeri on Mon 2nd October. She shared an incredible wealth of knowledge on Aromatic Inhalation. They rediscovered how amazing the olfactory system is and the role the limbic system has when it comes to all things aromatic. They delved into the chemistry of oils and all had a renewed appreciation for aromatic psychology. A fabulous evening with so much

knowledge shared and gained. Five people travelled from Whangarei, one from Russell and two Kerikeri members were also in attendance. The November meeting was postponed, however they will be back into it with the first meeting for 2018 being on the 5th of March.

October's meeting in Hamilton had guest speaker Linley Leuthard who is the only CKTI or Certified Kinesio Taping Instructor in NZ. Linley gave a quick overview of taping, how it works and the developments with it specifically from traditionally muscular to now encompassing EFT taping, fascia, post-surgery, lymphatic etc. She showed a few examples of taping techniques and sent everyone away with some Kinesio goodies and a whet appetite for her more in depth Kinesio tape courses! November's meeting had guest speaker Erica Weerekoon who has a wealth of knowledge both formal training and life experiences in counselling, supervision and mindfulness. Erica had some wonderful mindfulness techniques. Supervision was also discussed and how beneficial it would be to Massage Therapists especially in light of recent events in the media. Supervision is basically a 7 point assessment of any working situation/ experience/case that you want to look into. This is something I recommend we try in our local networking meetings. At the time of writing this, the next Hamilton meeting was scheduled to take place on 13th of February.

Auckland had 25 attendees the November meeting held at the Sports Lab with Aaron Jackson, Podiatrist and Biomechanist. The meeting was well received by those who attended. The Christmas get together in December was on the North Shore and had around 11 attendees chatting about ideas for meetings for 2018. Varying the venue is one thing that was discussed to try and make it easier for more members to attend a meeting. Your feedback is very welcome to help find the best fit for all those attending or wanting to attend.

I'm super excited about new group meetings being held in the Thames/Coromandel region. A big thank you to Lisa Stent for organising this. The first meeting in November had four MNZ members and five 'potential' new members with guest speaker Tolly Gibbons from Peninsula Osteopaths, Thames. If the first meeting was anything to go by, they have a very exciting future! They shared their visions and ideas for the purpose of the group and collectively agreed to focus on being supportive, positive and non-judgemental. Tolly presented in his clear, concise and friendly way, detailing the anatomy of the hip, demonstrating access to deep muscles and discussing common issues where massage would be beneficial. Lisa and the rest of the group welcome anyone else that would like to join in. If you are interested please contact either myself or Lisa Stent directly on stentfamily@xtra.co.nz

I'd really love some members to put up their hand in the Tauranga area to help Georgia Meichtry initiate networking meetings again. In the past this area has had great meetings with many interested in attending so all we need is a few people to commit to helping out. Also, Whakatane has a few members looking to connect with others. Please contact me if this is something that you would like to be a part of.

Let's make 2018 our best year yet!

Annika

MNZ MEMBERSHIP – HOW IS IT GOING?

We would like to keep you up to date so we can see that as a team we are all helping to increase the numbers of members. You will be aware that MNZ is working hard to increase membership numbers so that we have a stronger organisation for working to further legitimise our industry and strengthen our profession. At the start of 2017 we introduced two new initiatives to assist with this. We made student membership free and we brought in a reduced membership rate for new graduates ($100 as opposed to $195 in their first year of practice), to help them get established and maintain the membership they began when they joined while studying.

Currently as at Q1 2018 we have a total of 483 members. This is made up of 382 Registered members, 88 Student members and 13 Affiliate members. As at Q4 2017 we had a total of 475 members (360 Registered, 94 Student and 13 Affiliate). This shows an increase on last year, with a noticeable increase of RMT members (up 22). Student members have decreased (by 6) but with the upgrade to full membership with the reduced membership fee for new graduates in their first year, the decrease in student numbers is to be expected.

Melissa Orchard, General Administrator

MEMBERSHIP AND CPD UPDATE

Is your profile up to date?

Make sure you keep your profile up to date as a lot of the members of the public do look at your profiles to find their next Massage Therapist. If there is something that you need added and you can't access that part of your profile please email membership@massagenewzealand.org.nz to update it for you. You will need to make sure that if you are adding a new modality that you have the paperwork to show for it, this will of course be added in your 'My CPD'.

Speaking of 'My CPD', to log your CPD hours please head to the Continuing Professional Development section in the members area. All the information you need is there. We find the best time to log your CPD hours is when you have completed something, rather than wait for the renewal period. They are all calculated automatically online and dates and hours are taken into account. Do upload any evidence/certificates/paperwork if you have it for your CPD.

CPD is now on a 2 year fixed cycle. Members need to provide evidence of hours spent on CPD activities.

The first cycle runs from April 2016-March 2018 and hours can be accrued at any time over this two year period. There is no limit on the number of hours that can be used on any one activity. A member may choose to use their CPD hours on one activity if that is relevant for their professional growth. There is no requirement for CPD hours to include hands-on training as per previous CPD requirements. However, diversity of activities is encouraged where applicable, as is hands-on training where this is beneficial to a member's professional growth. Any hours over the required minimum cannot be rolled over into a new CPD cycle.

- RMTs (Level 4-7) who on average do 10 or more massage client hours per week need to do a minimum of 40 hours of CPD over this 2 year cycle.
- RMTs (Level 4-7) who on average do less than 10 massage client hours per week need to do a minimum of 30 hours of CPD over this 2 year cycle.

Pro-rata CPD hours will apply. Any new member who enters the cycle part way through will be required to do proportionally less hours of CPD as a minimum. Current members who finished their previous two year cycle in April 2017 will be on a one year CPD cycle of half of the hours required which are 20 hours (if full time) and 15 hours (if part time) CPD for the period 1 April 2017-March 2018 then all members will start a new 2 year CPD cycle together on 1 April 2018.

Renewing your membership for 2018

RMTS

An invoice will be sent out early March 2018, please pay your invoice plus make sure your 'My CPD' is up to date on your profile and that your first aid certificate is current. If it isn't please upload a current one onto your 'My CPD' or email a copy to membership@massagenewzealand.org.nz.

STUDENTS

An email will go out asking you if you would like to renew your free student membership. You will need to provide evidence that you are still a student. This year we will be emailing you a copy of your student certificate instead of posting. This is to help with keeping costs down and to help the environment.

GRADUATES

For those students that finished their studies last year and have upgraded to an RMT membership already, you are entitled to a graduate membership fee of $100 for 2018. You will be sent an invoice to pay and as long as your first aid certificate is current and you are logging your CPD into 'My CPD' then once your invoiced is paid we will renew your membership. For students that still need to upgrade to take advantage of the Graduate membership fee please email membership@massagenewzealand.org.nz.

AFFILIATES

You will be sent an invoice to pay, please make sure your details are up to date and once your invoice has been paid, your membership will be renewed.

WHAT'S ON...

DATE	WHAT/WHERE/HOW TO REGISTER
Northland MNZ Networking Group	**Contact**: Annika Leadley uppernirep@massagenewzealand.org.nz
Coromandel MNZ Networking Group	**Contact**: Lisa Stent stentfamily@xtra.co.nz
Whakatane MNZ Networking Group	**Contact**: Annika Leadley uppernirep@massagenewzealand.org.nz
Auckland MNZ Networking Meeting	**Contact**: Mark Fewtrell mark3massage@gmail.com
Hamilton & Surrounds MNZ Networking Meeting	**Contact**: uppernirep@massagenewzealand.org.nz
Auckland, March 8-11 Visceral Manipulation I Christchurch, June 16-19 Visceral Manipulation I June 21-24 Visceral Manipulation II	**Contact**: Upledger and Barral Institutes NZ Rosie Greene www.upledger.co.nz/courses
Tauranga The Fundamentals - 6 & 7 April Advanced Upper Body - 8 & 9 April Auckland The Fundamentals - 13 & 14 April Advanced Lower Body - 15 & 16 April Nelson The Fundamentals - 4 & 5 May Advanced Lower Body - 6 & 7 May Christchurch The Fundamentals - 18 & 19 May Advanced Upper Body - 20 & 21 May Dunedin The Fundamentals - 25 & 26 May Advanced Lower Body - 27 & 28 May	**Contact**: Beth Beauchamp www.mfrworkshops.com
Tauranga MNZ Massage Group	**Contact**: Georgia Meichtry georgia@willowtherapeutic.co.nz
Hamilton & Surrounds MNZ Networking Meeting	**Contact**: uppernirep@massagenewzealand.org.nz
Wellington MNZ Networking Meeting	**Contact**: Iselde de Boam 021 044 8552 lowernirep@massagenewzealand.org.nz
Christchurch MNZ Massage Group	**Contact**: Volunteer required
Australia, June 15-17 Gold Coast 2018 Massage and Myotherapy Conference "The Competitive Edge"	www.massagemyotherapy.com.au

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

REGULAR FEATURE

GRADUATE ILLUMINATE

Welcome to our new column where we put the focus on new graduates from our education provider partners across the country. Being one of our featured graduates in this column can be a great way of connecting with other therapists throughout New Zealand, getting some publicity for yourself and it's a fantastic way to promote the benefits of undertaking formal training in Massage Therapy and what it can lead to.

If you are a new graduate we would love to hear from you! We aim to feature 1-2 graduates in each issue of MNZ Magazine. Please note that in order to be featured in this section, you must be a member of MNZ, either as new graduate or in the process of upgrading from student to new graduate member.

To kick things off we introduce to you Steve Rolston and Daniela Vega.

STEVE ROLSTON

Dip. HSc (Massage and Sports Therapy), NZCM, Wellington

About Steve

I live with my wife in Whitby, about a 20 minute drive north of Wellington. It is a lovely area next to Paremata and Plimmerton which provide boating, swimming, and fishing, and also the Pauatahanui inlet with lots of bird life. Interests...let's see, photography, tramping, archaeology, and kayak fishing. I also collect old cameras. I do want to train in pregnancy massage this coming year and add that to my portfolio.

My business is Whitby Massage & Bodywork Clinic which I have established in my home. You can find out more about my business at my website, https://www.whitbybodywork.co.nz

Training

I trained at the New Zealand College of Massage (Wellington campus) for the past two years and completed the Certificate in Relaxation Massage, Diploma HSc (Therapeutic Massage), and Diploma HSc (Massage & Sport Therapy) at and graduated on 11th December 2017. I was surprised and honoured to receive the Student Performance Award whilst completing the Dip HSc (Therapeutic Massage).

When did you join MNZ?

I joined MNZ during the second half of 2017 whilst completing my Dip HSc (Sport & Massage Therapy). I was able to take advantage of the student rate and upgrade at the reduced rate once I graduated at the end of the year.

What motivated you to decide to train in Massage Therapy?

I was made redundant from a bank that I had worked at for the past 15 years and was ready for a change from the corporate world. I don't recall how I first came to consider massage but when I knew redundancy was on the cards, I decided to look into it further and found it very appealing. I worked in Risk and Compliance for many years and wanted to get back to a people oriented profession.

What do you enjoy and what you are finding challenging about working as a massage therapist?

I really enjoy learning how the body works and the intricacies of our makeup. Not being exactly young, I found the study a real challenge but we had a great group of students and tutors who were very supportive and encouraging. It is great to have someone get off the massage table and express their gratitude for the difference I have made. I have had great success with a couple of cases of adhesive capsulitis. Working out what may be happening when a client presents with pain or tension and being able to make a plan of care for them is very satisfying and encouraging. At college, we worked with many different groups over the past couple of years but the stand-outs for me were the neonatal unit at Wellington hospital, Mary Potter Hospice (palliative care), and the Wellington Pulse netball team. The biggest challenge I have at the moment is to attract new clients and build my business.

Where do you see yourself going in the profession?

I have established a clinic in my home and am working to build my client base. I love working with people and want to build my clinic into a sustainable full-time practice. At the right time I will consider moving into a commercial premise.

What advice would you give to someone starting study in the field?

Work hard, apply yourself, and keep your eyes on your goal. Take note of the groups you enjoy working with and consider specialising with them if that is what works for you.

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

Whilst I haven't had anyone yet say that they found me through the MNZ site listing, I feel that along with my qualifications, the affiliation with MNZ provides further credibility for my clients.

DANIELA VEGA

Certificate in Relaxation Massage, NZCM, Christchurch

ABOUT DANIELA

My name is Daniela Vega and I live and work in Christchurch, NZ. I work at Body Central, 304 Fitzgerald St.
http://www.bodycentral.nz/therapists/

I am interested in fascia work so I am currently studying Bowen Therapy with Lynn Wilson from Fascial Kinetics. My goal is to finish my training and case studies by June 2018 so I can start to offer this awesome modality to clients in the clinic.

TRAINING

Back in Chile I did a Diploma in Tuina Massage (Chinese Massage) and here in New Zealand I studied at the New Zealand College of Massage in Christchurch.
I attained a Certificate in Relaxation Massage with merit.

When did you join MNZ?

I joined MNZ as a student at the end of 2017 and now I am upgrading to RMT membership as a new graduate.

What motivated you to decide to train in Massage Therapy?

Back in Chile I was studying, training, and working in the wellness industry as well as doing natural healing modalities. I am a Bach Flower Practitioner, Reiki Master, Ovarian Breathing meditation teacher and Tuina massage therapist. I gave classes and workshops on Bach Flower therapy as well as running women's circles.

I was given the chance to come to New Zealand on a student visa and I wanted to study something that was in my line of interest and work, so I chose massage therapy because back home we don't have the amazing training you have here and secondly, I don't see myself doing something else. I think is an awesome job!

What do you enjoy and what you are finding challenging about working as a massage therapist?

I love how people respond to massage, I started doing relaxation massage at 115 Hotel in Christchurch and I saw the effect of massage on people, especially on their mood. With therapeutic massage and sports massage, I just love how clients get relief to their aches and we can contribute to their wellness.

The challenge for me was building up my strength so I can massage for 6 hours, so I have to train myself and keep on top with my self-care and rest.

Where do you see yourself going in the profession?

I would like to combine Bowen therapy with massage and keep learning. Here in New Zealand there are so many courses, it is so interesting. I see myself working for a long time in the massage industry and hope to get into education fields when I have enough experience.

What advice would you give to someone starting study in the field?

Take care of your body, it is your working tool. A good diet, exercise, stretching, and practice what you preach. Anatomy and physiology are important, clients really appreciate when you are able to explain what is going on with their muscles.

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

As a student looking around for future jobs, I knew that in order to get where I wanted I had to subscribe to MNZ. Being a member is really good, you get the latest news about courses, available massage jobs, and all the benefits that MNZ has to offer.

Next issue we will look at profiles from the top students at colleges around New Zealand.

Email magazine@massagenewzealand.org.nz if you have information you wish to share or we will be in contact with you.

Editors

STUDENT CORNER

Welcome to another of our new columns, this time showcasing our current student members from around the country. This column provides our student members with the opportunity to share something about themselves with us and get a bit of promotion at the same time. If you are a current massage therapy student studying at one of the NZQA accredited providers listed on our NZQA Accredited Providers page and would like to have your profile in MNZ Magazine, please get in touch with Odette at coeditor@massagenewzealand.org.nz. Please note that to be included in this section, you must be a current student member of MNZ.

Our first student profiled is:

CAROL WALES

ABOUT CAROL

I'm from Onehunga in Auckland City.

TRAINING

I am studying at the New Zealand College of Massage in Auckland. I have just completed the Diploma of Relaxation and Wellness Massage (Level 5) in 2017 and will continue with the Diploma in Clinical Massage Therapy (Level 6) which equates to New Zealand Diploma in Remedial Massage (Level 6). I will graduate with this in December 2018.

When did you join MNZ?

I joined Massage New Zealand as a student in July 2017 and upgraded to an RMT member as a new graduate in December 2018 even though I am continuing with my studies.

Why did you decide to train in massage therapy?

My motivation is to be able to work in hospitals, hospices, rest homes and private homes to assist people at the end of life through touch and to build on the skills and expertise I have already obtained in this field.

What are you enjoying most about your massage therapy studies?

Understanding myself even more, understanding my learning styles has been a challenge as it is a combination of many styles. Being a mature student, study is very new to me. Connection with others is imperative in life and I thoroughly enjoy working with a mixture of genders, ages and skills.

Where do you see yourself going/ working after graduating?

Initially working in my own clinic, being mobile and possibly sharing with other therapists in a clinic setting. My end goal is to work in hospice, hospitals or rest homes.

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

The things I feel that I get out of being a member of MNZ are the ability to find out about available Massage Therapist positions, access to member discounts and the MNZ Magazine.

WHAT IS A BIOPSYCHOSOCIAL APPROACH?

Bronwyn F Lennox Thompson
University of Otago, Christchurch
Department of Orthopaedic Surgery & Musculoskeletal Medicine

What is a biopsychosocial approach?

In the late 1970's and early 1980's, holistic healthcare was emerging as a paradigm shift away from a purist biological model of disease. Proponents of holistic healthcare pointed out that biomedical approaches neglected complex interactions between people and their physical and social environments, and argued for a broader definition of health (as not merely being the absence of disease). George Engel, a psychiatrist, wrote a blistering critique of biomedical practice in which he proposed healthcare should be considered in terms of what he called a "biopsychosocial" model (Engel, 1977). Some professions embraced this new model of health, notably occupational therapy which is my original profession, while others were not so much resistant as unmoved.

In this article I'll review some of Engel's original writings about his model with my aim to provide an insight into what he intended by it, and how massage therapists can integrate this approach safely within their practice.

Engel's model

Engel described his biopsychosocial model as a scientific model "constructed to take into account the missing dimensions of the biomedical model" (Engel, 1980, p.535). He based his ideas on Ludwig von Bertalanffy's General Systems Theory (GST). The GST proposes that every action in a closed system affects all other aspects of that system, either directly or indirectly – and that systems are organised in a hierarchy, from simple to complex. Engel's main argument against the prevailing purist biomedical model was that by focusing on disease, medicine had neglected to consider the person experiencing that disease. This, in turn, he opined, led the public to believe that scientific medicine is impersonal; failing to understand human needs when care is sought for health problems. Thirty or so years later, the biopsychosocial model is widely acknowledged, along with the term 'holistic' - but how well do we understand what Engel thought was so important?

The groovy 1970's

Engel published his most well-known treatise on the need for a new model of health and healthcare in 1977 (Engel, 1977). As a psychiatrist, he pointed out that at that time, psychiatry was being decried as a "hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought' and other esoteric goals" (Ludwig, 1975, cited in Engel, 1977, p. 129). While Engel agreed with this statement, he went further and argued that "all medicine is in crisis" and that this crisis was the same as for psychiatry: that the way in which doctors conceptualise disease was failing to address the study of illness and the social responsibilities of medicine (Engel, 1977).

Engel was fighting to prevent his discipline of psychiatry from becoming focused only in "behavioural disorders consequent to brain dysfunction" a stance proposed by some psychiatrists of the time (Engel, 1977, p. 129. He argued that the strict biomedical model "not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes" (Engel, 1977, p. 130). He felt this was not enough.

The replacement

Engel wanted to develop a model that would incorporate the advances made by the biomedical model, yet integrate important aspects of becoming unwell. He distinguished between disease (biological changes wrought within the body) and illness (the experience of an individual as they are described, and as they affect him or her). He recognised that people respond to treatments very differently depending on their relationship with their physician, and argued that doctors are very much educators and "psychotherapists". In other words, while doctors treat diseases, they're also responsible for responding to illness – and the latter requires skills drawn from psychological knowledge.

When a person attends any healthcare provider, there exists an interaction between the person and that provider. The person (patient/client) needs to recognise that he or she is ill, choose a healthcare provider, and describe the illness in sufficient detail for the provider to understand what is going on. The clinician, on the other hand, takes on (or is given) the role of determining whether the person seeking help is ill, and if they are, why they are and what is wrong, and then to decide on a treatment to address the problems. Each party to this conversation brings his or her prior knowledge, expectations, experience and awareness to the interaction, and each of these elements is influenced by the prevailing ideas of what is illness and what is not. For example, in New Zealand, the idea of being so concerned about body odour enough to prevent leaving the home for fear of embarrassing others would rarely, if ever, occur. In Japan, however, taijin ky fush is a culture-specific syndrome in which people are afraid they will embarrass others because of their body and bodily function and is thought to have a prevalence of 3 – 13% (James, 2006). One of the most common forms of this syndrome is fear of having an offensive body odour (Feusner, Phillips, & Stein, 2010).

The biopsychosocial model was intended to help clinicians collect information not only about the biological aspects of disease, but within a human relationship also to gather information about what the person does, who the person is, and how the illness is experienced. In other words, to guide the

clinician to understand two critical clinical questions: Why is this person presenting in this way, at this time, to me? And what can be done to reduce distress and disability?

The devil is in the details

Possibly one of the most positive things to come of Engel's arguments for his model of health was that practitioners working in complementary healthcare found a voice. Engel's approach articulated useful and practical ways of conducting healthcare that struck a chord in practitioners who believed that treating a joint or a muscle in isolation omitted crucial contributors to illness. Many clinicians, including massage therapists, think they practice holistically. While perhaps not using the language of Engel, ideas about treating the person rather than the pathology, and giving time for patients to talk about what is really troubling them, is commonplace, particularly amongst complementary practitioners. There are some aspects of this care, however, that suggest there are misconceptions about what constitutes effective biopsychosocial practice.

Training

The first problem arises from training. Cast your mind back to your education and consider what you spent time learning. How much time was about tissue-based pathology? How much was about what people do to contribute to these pathologies developing?

Massage therapists can offer patients/clients an opportunity to be heard, their concerns validated, and to have their confidence enhanced. But - how confident are you to provide these opportunities in your treatments – and remain within a massage therapy scope of practice? I suspect that many massage therapists are worried that if they begin to ask about what a person believes to be their problem, they're likely to open Pandora's Box, or they'll stray into "doing psychology". I also suspect training in communication skills is taught perhaps in the first year of training – but from then it's assumed students are proficient. Even in postgraduate education it's easy to find workshops on various techniques of hands-on therapy, but rare to find one on communicating and listening skills.

Misconceptions

When I read online discussions about manual therapists using a biopsychosocial approach to care, one of the leading concerns I see is that clinicians will step out of scope and think they can treat mental illness. I think this is a misconception of what Engel was trying to achieve with the biopsychosocial model. Although he was a psychiatrist, and mental illness was an integral part of his practice, his intention was to step beyond psychiatric disorders and into understanding why people seek help, and what lifestyle and community factors might contribute to their distress. In other words, rather than asking all practitioners to move into treating mental illness, he wanted all medical practitioners to begin to understand the patient's journey from being well, feeling ill and seeking help.

Scope

When I unpack the "psychosocial" factors most strongly associated with trouble recovering from musculoskeletal pain, these are the things I read about: catastrophising ("thinking the worst") (Wertli et al., 2014); self efficacy (Chester, Jerosch-Herold, Lewis, & Shepstone, 2016); the effects of what clinicians say to patients (Darlow et al., 2013); and patient expectations (Mancuso, Reid, Duculan, & Girardi, 2017). None of these factors are about mental illness, and all of them can be explored as clinicians gather information about why the person has come for help. Indeed, I argue that failing to understand why someone is attending a clinician risks misunderstanding the patient's goals of therapy. Taking a thorough history should, I believe, include asking about what the person thinks is going on, what their main concerns might be, what other people (including clinicians) have said to them, their expectations for the future and from therapy, and what they already know helps them. This is well within the scope of all health professionals.

Pandora's Box

There can be apprehension about asking people to describe their understanding of their problem and to identify their primary concern. One worry is that the floodgates will open and the entire session will be over before treatment has even been started.

I think this misinterprets an active ingredient in any treatment: the interaction between the patient and the clinician. A neurobiologist, Fabriccio Benedetti, describes therapy as a four-step process. 1. Feeling sick; 2. Seeking relief; 3. Meeting the therapist; and 4. Receiving the therapy (Benedetti, 2013, p. 1213). Benedetti describes the doctor-patient relationship as a "unique social interaction" that has emerged during evolution (p. 1211) and explores the neurobiological aspects of this interaction as part of his studies of placebo and nocebo. Meeting the therapist and Receiving the therapy both involve neural systems underpinning empathy, and compassion: inferior frontal gyrus; anterior insula; secondary somatosensory area; temporal pole; superior temporal sulcus; temporal parietal junction; medial frontal cortex; ventromedial prefrontal cortex; anterior cingulate cortex; anterosuperior posteromedial cortex and the posteroinferior posteromedial cortex (p. 1214). Along with these areas, various hormones and neurotransmitters are released by both patient and doctor when they interact: oxytocin is released when we judge someone to be trustworthy; while hope (and conversely, hopelessness) may be related to mechanisms involving serotonin and noradrenalin. Believing that a pain indicates something good (e.g. the pain after curative surgery) is associated with activation of opioid and cannabinoid systems (p. 1218).

Experiments undertaken by Benedetti and others show that what we say, how we express it, and our nonverbal communication influence the effects of our treatments (Benedetti & Amanzio, 2011), and patients highly value the opportunity for someone to listen to their concerns, to validate them or take them seriously, and to facilitate their belief that things can get better (Jakobsen & Lillefjell, 2014; Mathias, Parry-Jones, & Huws, 2014).

If we think about why people see massage therapists, while most will have an expectation of hands-on treatment, at the same time they want to be listened to and understood. Massage therapists have a unique opportunity to inquire about a patient's journey to seek help and to hear their concerns in a way that embraces the whole experience, and not just the "diagnostic bits".

What does this mean for massage therapists?

Although Engel was writing for psychiatrists and medical practitioners, his model of human health has extended to many other professions. He believed that choices and beliefs were as much part of "being healthy" as pathogens and neurotransmitters. He set the context of health and healthcare delivery to be far broader than body parts and diseases.

Today, I routinely draw on Engel's biopsychosocial model as I see people living with persistent pain. Modern research into our experience of pain confirms the value of this systems approach to understanding my two clinical questions.

I think stepping out of scope occurs when clinicians start trying to address problems that are unrelated to musculoskeletal pain. If our clients report difficulty sleeping and they explain that this is due to their worry about their relationship, this is not the province of a massage therapist or occupational therapist. On the other hand, I think massage therapists have time, and the clients may feel more comfortable talking about concerns which in turn allows for either reflective listening or an opportunity to offer support to be referred to another more appropriate clinician.

How do I avoid stepping into territory that's not my responsibility or scope? My take on "psychosocial" factors and allied health professions such as massage therapy, myotherapy, osteopathy, chiropractic and physiotherapy, is that we have a duty of care to answer the two clinical questions to the best of our ability. This ensures we are aware of the issues directly relevant to our treatments, whatever they may be. We do not need to diagnose depression, substance abuse, relationship issues or employment issues – but we do need to recognise them and refer appropriately. We need to understand the journey our clients/patients have undertaken to see us. We need to know why they chose us, why they decided to do something now, what they expect from seeing us, and what they think is going on. That is, I believe, the essence of Engel's biopsychosocial approach to health.

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BIO

Bronwyn Lennox Thompson is the Academic Coordinator for the Pain & Musculoskeletal Programmes in the Department of Orthopaedic Surgery & Musculoskeletal Medicine at the University of Otago, Christchurch. Bronwyn trained as an occupational therapist and since then has completed a Masters and PhD in Psychology.

She has a passion for helping people experiencing chronic health problems achieve their potential and has worked in the field of chronic pain management, helping people to develop 'self management' skills for 20 years.

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A BIOPSYCHOSOCIAL APPROACH FROM A PATIENT'S PERSPECTIVE

By Joletta Belton

When my pain experience first started, I was living the dream. I was working in a career that I loved, a profession that was more than just what I did, it was who I was. If you'd asked me to define myself back then I would have answered "I'm a firefighter'. To me being a firefighter encapsulated all that I was, all that I would ever be.

Joletta on the job

And then, suddenly, I wasn't.

An errant step off a fire engine on a routine call landed me on an unexpected and difficult path of ongoing, worsening pain and a gauntlet of conflicting and unclear diagnoses and failed treatments. Like many others who've lived with ongoing pain, I rode a roller coaster of highs and hope, believing that finally this treatment or modality or therapist would be the thing that fixed me, and devastating lows and disappointment when it wasn't. When promises made weren't promises kept. Promises that were as varied as the promisers themselves, everyone having their theory of what was causing my pain and what would fix it.

The occupational doctors gave their explanations, the orthopedic surgeons gave theirs, which were different, the physios had others, the massage therapists yet more, and on and on and on. Even within professions, those of us living with pain get different answers depending on who we see for the very same pain. It's confusing. It's hard to know what to think, what to believe. All we know is that we're broken somehow, damaged goods. We're impinged, our labrum is torn, our joints are dysfunctional, we're out of alignment, our muscles are weak, our chi is stagnant, our posture is to blame, our bones are degenerating, our discs are bulging, our fascia is stuck. Or, worst of all, it's all in our head. It all eventually stops making sense, if it ever did at all.

My pain eventually led to the end of my career, the end of who I was as I knew myself. It was unimaginable. A devastating, demoralizing, and difficult time. But I eventually found realistic hope and a way forward. A way back to meaningful, valued, active living. Back to me, back to my life. I wish I had found it earlier, which is why I write about my experiences now. By sharing what I wish I was told, the language I wish was used by my therapists and healthcare providers, what I wish I had understood sooner, I hope to help others find their way back to living, back to themselves, sooner. A hope I believe we all share.

RECONCEPTUALISING PAIN

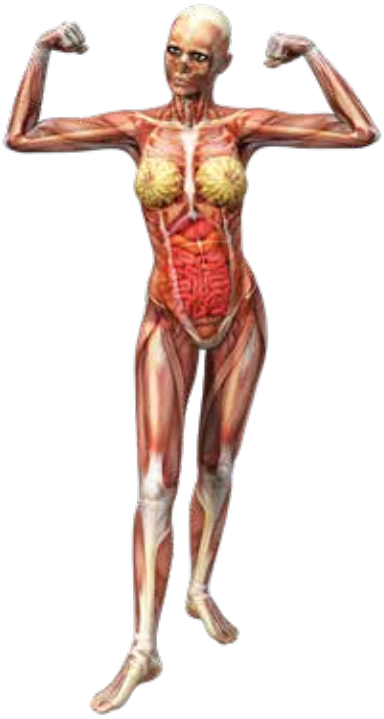
After my medical retirement I went back to school and earned my MSc in Human Movement. Naturally I chose pain science as my research focus as I wanted to figure my own pain out. What I learned surprised me. I had gone in with pretty fixed beliefs about pain. That it was in the tissues, that it was about damage, weakness, and poor biomechanics. I graduated two years later with an understanding that pain is a complex biopsychosocial experience. That pain, especially ongoing pain, does not typically have a singular, linear cause. When our job is on the line, our relationships strained, our financial security threatened, we're stressed or worried or anxious or depressed, and we're unable to engage in meaningful activities, pain is about much more than tissues, anatomy and biomechanics. Rather, pain is an emergent, consciously lived experience that encompasses biological, psychological and social factors.

I felt validated. Things finally started to make sense. My pain was real and more complex, as it is for many people with chronic pain. There were many potential contributors, which also meant many potential ways of changing my experience. I was empowered.

THE VALUE OF A BIOPSYCHOSOCIAL FRAMEWORK

Viewing pain through a biopsychosocial lens provides a more unifying framework to operate within. It allows for more consistent language that can be used within and across professions that can ease some of the confusion and frustration that often occurs when we seek care for pain. It also provides more plausible explanations that demonstrate all pain is real and that pain is modifiable. This is validating and empowering for people living with pain and the people who treat them.

What a biopsychosocial lens means to me is recognizing that all of our human systems are intricately and inextricably interrelated and occur within social environments and contexts that in turn influence those systems. Of course, the state of our tissues and anatomy still matter. They are biological factors, after all. But biological factors also include our nervous, immune, endocrine, and cognitive systems, peripheral or central sensitisation, nociception, inflammation, excessive loads, and genetics, any of which can play a significant role in our pain experiences.



We are more than our anatomy

Our psychology is also underpinned by and influences our biology. Neurons, surrounded by glia which provide constant communication between our nervous and immune systems, are constantly firing and connecting with other neurons as we think, emote, remember, predict, feel, learn, speak, and act. And all of these biological and psychological processes occur within and are influenced by our social contexts: our family and friends, work environments, healthcare and insurance systems, communities, cultural traditions and beliefs, and society at large.

TO ILLUSTRATE HOW IT'S ALL INTERCONNECTED ALL THE TIME

To demonstrate how biopsychosocial factors contribute to our human experiences, let's look at what might happen when someone who detests public speaking has to give a talk to a large audience. Psychological factors include their thoughts (I'm a terrible speaker! I'm not prepared! I've forgotten my speech!), emotions (anxiety, jitters, nervousness), and expectations (I'm going to bomb, everyone is going to be able to tell that I'm a nervous wreck). These cognitions all influence, and are influenced by, biological factors, too.

Their churning stomach, racing heart, sweating palms and armpits, their flushed or pale face and feeling nauseated. It can become a vicious cycle, where the physiological changes reinforce the cognitions and ramp them up which in turn ramps up the physiological symptoms. Pretty soon they're running to the restroom before walking on stage. This is all linked to that particular social context: the stage, the audience, the professional pressure, the desire to maintain or improve social status.

So even something relatively simple and finite like a public speaking gig involves biological, psychological and social factors. It's no wonder, then, that something like pain, an experience that doesn't have a set start and end time, involves complex interactions between biopsychosocial factors, too.

WHAT DOES THIS MEAN IN PRACTICE?

Imagine if our public speaker has a calming influence at their side, speaking in a relaxed voice, providing reassurance that they will be successful, that they're capable and are going to nail it. Now imagine they have the opposite influence at their side. Someone who is equally nervous for them, speaking in a rushed, clipped, loud voice and reinforcing all of their worries and fears and doubts.

That is to say that language, and the manner in which it's delivered, matters. Words are neurological events, packed with meaning. This is as true for public speaking as it is true for pain. The words we use influence the way we understand our world and our experiences. A mere word can conjure up memories of the past or thoughts of the future, can give us hope or lead us to despair. A single phrase can lead us to bouts of laughter or to a good cry.

Words, and how they are delivered matter for many reasons, not least of which, in a therapeutic context, is that what clinicians believe and say influences what their patients think and do (Darlow et al., 2013). For good or bad. The good is when clinicians' words and actions increase understanding and lead those of us with pain to become more confident, more actively engaged with movement because we know it is safe, more able to pursue meaningful activities, and more connected with our lives. When the words and manner make us feel strong, resilient, adaptable, and capable, rather than broken, dysfunctional, damaged, and to blame.

That is powerful stuff! Meaningfully connecting with another human can be immensely therapeutic. Especially so when we're in pain for a long time. When you experience ongoing, unrelenting pain, pain can become all there is. It steals our attention and uses up all of our resources. It dominates our thoughts, affects our emotions, and colors our world. The experiences we value, the people we love, the parts of life we most enjoy, readily fall by the wayside. It can be very dark and lonely.

To be in a safe environment where we feel heard and understood, even without words, where we are touched with care and compassion, reminds us that we are valued. That we are human and worthy. That is no small thing. And when it is paired with plausible, evidence-supported, consistent information that touches upon the complexity of pain and is filled with empowering language, we are set up for success.

IT'S COMPLEX, BUT ALSO SIMPLE

There is so much we don't yet know about being human and being a human in pain, but the there is so much we can do with what we do know. There is realistic hope. We can calm protective systems down through creating safe environments, listening and

validating people's stories, and helping them make sense of their experiences in ways that are more accurate and more relevant to their lives. We can recognize that pain is not in a person's tissues, that it is in their lives, their very being. We can empower with language that emphasizes courage, strength, persistence, and adaptability.

It may sound simple, but it's not. It's less common than you may think, than we all may hope. This is what I wish I had experienced sooner along my own pain journey. I'm grateful for this opportunity to share my thoughts. Thank you for reading.

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BIO

Joletta Belton is the co-founder of the Endless Possibilities Initiative a nonprofit with a mission of empowering people with pain to live well, and pain blogger at MyCuppaJo.com. Both projects were born of her own experiences living with ongoing pain, which forced her into medical retirement from the firefighting profession that had defined her.

She went back to graduate school and earned her MSc in Human Movement, making pain science her research focus in order to make sense of her own pain. Now she shares what she has learned of the science through her own story to provide hope and empowerment to people living with pain and insights into the lived experience of pain to practitioners.

You can reach her at the above websites or at jo@epicolorado.org.

Joletta snowboarding again, in the environment she loves.

INTERVIEW WITH KATE ROBERTS – ADVOCATE OF COLLABORATIVE CLINICS

Odette Wood recently interviewed Wellington acupuncturist, yoga teacher and lecturer at the New Zealand School of Acupuncture and Traditional Chinese Medicine Kate Roberts (PhD Candidate, MHSci (TCM), PG Cert(PsychMed) BHSci (Acup), MAcNZ) about a local Allied Health Practitioners Group she has set up in Wellington.

Kate thanks for talking to MNZ Magazine. Can you tell us what prompted you to set up an Allied Health Professionals group and why you think it is more valuable than just networking within one's own profession?

Thanks Odette, as you mentioned in your introduction I am involved in my PhD at the School of Medicine at Otago. My research is looking at communication and collaboration models between acupuncturists and General Practitioners. What I have found out over the last three years of my research is that the health system in New Zealand is very fragmented with some barriers around communication between primary and allied and complementary health providers.

Integrative models that encourage collaboration combine a matrix of health and healing with a focus on finding the least invasive methods that enable change in health status and quality of life. While there are significant barriers to engagement, there is also the potential to impact on provider satisfaction and patient wellbeing. [1] The term 'integrative care' still continues to illicit inconsistent viewpoints [2-4] but most agree it involves bringing some form of Complementary and Alternative Medicine (CAM) or allied health into a relationship with biomedicine. Most integrative models seem to be emerging on a fairly ad hoc basis and range from referral models and in house CAM providers to primary care units offering some form of integration. Whilst integrative health models exist with varying success, profession interaction still appears relatively unsuccessful.[5]

So that being said, I am determined, not only through my research, but also as part of my professional practice, to approach my clinical practice as part of a team. The competitive or isolated model of care that seems to be the norm for many allied and complementary health providers does not necessarily put optimal patient outcomes at the forefront. I think we need to change this.

Another reason this group was set up is to offer professional support. Many of us are working in isolation with no formal professional supervision, support or mentorship. To continue to develop professional practice and also to enhance provider safety, I think this is important.

What professions are represented in the group and how might the group help them in their practice?

This group is very much in its infancy, but so far, and I'm really excited about this, we have the following professions represented; acupuncture, massage, chiropractic, osteopathy, physiotherapy, music therapy, clinical psychology and energy healing.

What do you think Massage Therapy brings to the group and how do you think this field can be best integrated into a multidisciplinary approach?

The evidence base for massage therapy is very sound for many conditions. What we know is that the development of a therapeutic alliance in combination with the healing power of touch is a powerful tool. I often work with massage therapists to offer a combined approach to injury recovery and prevention. At our first meeting a few weeks back we shared stories of how we have successfully worked together; a story that was interesting that stuck with me was the clinical psychologist who said her treatments were more effective when patients had also seen a massage therapist, as their body was more relaxed and receptive to her work. I think this is true, that the body and mind cannot be isolated and need to be treated in tandem. We need to acknowledge our strengths and limitations and continue to work at the top of our scope to achieve the maximum patient outcomes.

Do you think that this is the way forward for Allied Health professionals, to build stronger networks between professions and work more collaboratively for better health outcomes for clients?

Yes, I do. Management of interactions and adverse events should be monitored through a joint approach to care. Conflicting advice between therapists may add to confusion among patients and ineffective application of therapies. It is vital that patients feel comfortable discussing their therapeutic choices with all their therapists. This open model of dialogue needs to be modelled by the therapists themselves. Additionally, to establish the most effective use of public and private health funding, integrative models could ensure that money spent is maximised on the best possible therapeutic outcome. This requires constant review and dialogue between therapists to determine a model of care that is suitable for each individual patient.[6] Increasingly patients believe a combined approach of CAM and conventional medicine is better than either on its own and more and more patients have the desire to discuss CAM with well-informed practitioners.

Patients' use of CAM may influence whether they choose appropriate western biomedical treatment; first there is the risk of interaction and second, adverse events can occur with concurrent therapy usage. Specific concerns continue to be raised in the literature that over 60% of the CAM users do not realise that alternative medicines may react with conventional medication.[7]

For us to ensure both our patients and our practice is safe, we need to encourage our patients to both talk to us, but also for the communication channels between therapists to be open and non-judgemental.

What would you recommend to others who may be interested in setting up a similar group in their area?

My approach was fairly non-scientific! I did a google search of therapists in the area, sent out emails, started a closed Facebook group, organised an initial meeting and also had a few one on one coffee catch ups for those who were unable to attend the group meeting.

I then asked people to invite those who they thought might be interested. There is an absolute open door policy and no hierarchy of providers. We are all in this for the same reason, to help others, in the way that resonated with us personally. I still have a lot of work to do, it always comes down to time and availability, but I think it is worth it and I would encourage others to reach out to providers in your area. It can strengthen your practice, offer you professional support and help your patients. What have you got to lose!

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BIO

Kate Roberts graduated with her Masters in Traditional Chinese Medicine from the University of Technology, Sydney Australia in 2001. She continued her study in 2014, completing a post-graduate certificate in psychological medicine, and is currently enrolled in her PhD at the Otago School of Medicine, Department of General Practice and Primary Care.

Since moving to New Zealand in 2002, Kate has been working at the New Zealand School of Acupuncture as a lecturer and clinical supervisor, and has taught both clinical and theory subjects for 1st year through to Masters level students. Kate is also on the Council of Acupuncture New Zealand and the Chair of the Acupuncture for Mental Health Clinical interest group (AMH).

In addition to her teaching, Kate runs a private clinical practice in Island Bay Wellington. Kate's clinical practice specialises in the treatment of mental health, musculo-skeletal conditions, and gynaecology and fertility.

THE BIOPSYCHOSOCIAL MODEL OF HEALTHCARE: A CHALLENGE TO BIOMEDICINE

By Phillip Silverman

Within an evolving era of evidence based practise the field of massage is in its infancy of scientific investigation. While there is much discussion for the need to do more 'research' it may be worth taking a step back and discussing the basis from which this research is developed. In this regard the field of massage is in a good position to learn from the extensive history and challenges of researching healthcare, particularly in aligned areas such as psychology and psychiatry where some parallels may be identified. The biopsychosocial model is likely a good point of discussion in this area. This article will cover a few key aspects relating to the model, beginning with its history and why it was proposed. We can then follow on by looking at some of the discussions that have arisen, which includes research, and the proposal of the World Health Organization (WHO) to implement a framework for the classification of dysfunctional health based on this model.

THE ORIGINS OF THE BIOPSYCHOSOCIAL MODEL

The original paper was written by Engel, who was in opposition to the argument that psychiatry needed to return to a biomedical foundation to re-establish credibility. It was proposed that the field had "become a hodgepodge of unscientific opinions" (Engel 1977, p.129). In contrast Engel proposed, "that all medicine is in crisis and, further, that medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for scientific tasks" (Engel 1977, p.129). To understand this argument it is worth discussing two key intertwined aspects of healthcare, namely theory and research. We will start by looking at a brief overview of some of the ideas in the evolution of the biomedicine, to provide a context for the biopsychosocial model and Engels argument for change.

BIOMEDICINE: THE DEMAND FOR OBJECTIVITY IN MEDICINE

In the 1500's Vesalius wrote what is likely the first complete anatomical atlas of the human body based on dissection. Vesalius may be seen as a pioneer of evidence based medicine with his observational method that uncovered many errors in the prevailing medical writings and questioned the key authority of Galen. This is consistent with a number of fields where growing skepticism developed around knowledge claims, which led to the demanded for experimental verification. Vesalius work formed part of the foundation to an objectively verifiable pathological basis of disease that would allow medicine to obtain scientific objectivity. Historically disease had been contextually defined as the interaction between a numbers of factors leading to an element of subjectivity. In contrast, a pathological basis meant disease could now be defined as an objective reality in its own right that would lead to a direct mechanistic explanation.

The overriding assumption was that all diseases could be reduced to biology and intervention at this level would lead onto resolution in associated areas such as psychological and social aspects of the disease. To understand how this position contrasts with the biopsychosocial perspective, it is worth discussing the modelling process or the development of theory in science.

MODELLING

A model can be defined as a simplified representation of something that retains the key elements. The value of the process is that it allows better comprehension as much of the detail is removed. An example could be a model aeroplane, if done well the model will retain just enough detail that it provides an accurate representation. This could then be used to develop theories such as how planes fly. A word of caution would be that if our model was missing a critical element such as the wings our subsequent theories would likely be distorted and be a misrepresentation. Academically this process has classically been done via reductionism, where phenomena is reduced to its most basic elements, once objectively verified these can then be reconnected to establish the whole. The idea being that each aspect of the model holds up to scientific investigation.

More recently there has been further discussion around how the modelling process influences our understanding. This has led onto different approaches such as systems theory, where there is a shift away from individual components and move toward studying interaction. To quote Wilden (2003, p,203) "A system is distinguished from its parts by its organisation. It is not an aggregate. We may consequently say that the 'behaviour' of the whole is more complex than the 'sum' of the 'behaviour' of its parts". In simpler terms a systems theorist would argue that you need to study the global level first and then look to the elements second, which are contextually defined as they relate to each other. This difference is one of the key points of distinction between biomedicine and biopsychosocial models. We can now discuss the difference in practise.

EVIDENCE BASED MEDICINE

Evidence based medicine has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (Sackett et al. 1996, p.71). In the Vesalian tradition biomedicine has been extremely appealing in this area. Disease is objectively defined, and therefore measurable. Research such as randomised control trials can then accurately quantify the effect of intervention on pathology. Why the concern then? While biomedicine may be logically appealing, there has been some challenge as to whether it reflects clinical reality in many areas accurately, or specifically if some critical elements are missing. To quote medical anthropologist Kleinman, "it has become the conventional wisdom that the increased dissatisfaction, in the face of the manifest

improvement in medical effectiveness, stems from the very success of technology achievement. Doctors, it is alleged, have lost the human touch precisely because their preoccupation with laboratory tests and technical fixes obscures their awareness of the patient as a person. Is there evidence for the proposition that doctors are less sensitive to patient needs because they are more competent in curing disease?" (Eisenberg & Kleinman,1981, p.2).

The sign of a good model is its capacity to explain phenomena. In this regard research has identified some challenges to biomedicine. The below table provides statics for people presenting with musculoskeletal complaints to general practitioners within New Zealand.

Some points that can be taken from the table. Regional and back pain account for some 78% of presentations, that is, for approximately 4 out of 5 people the pathological or biomedical explanation of the complaint could not be identified. Further analysis identifies that some pathologies listed are present in the asymptomatic population, that is people who do not present with a musculoskeletal complaint. The concern raised is that many complaints cannot be explained. In those that are provided with an explanation it is possible that the pathology identified may not be producing the symptoms. Ultimately this indicates that biology may not be the only critical element in musculoskeletal complaints.

As Sternman notes, often "models fail because more basic questions about the suitability of the model to the purpose weren't asked, because a narrow boundary cut critical feedbacks, because we kept the assumptions hidden" (2002, p.521) In the case of biomedicine it is assumed the biology can fully explain all health predicaments, evidence such as the above table question this position and whether the model should be universally adopted to all areas of healthcare. It may be that part of the answer lies in the so called 'soft' sciences such as psychology and sociology, while these areas may be harder to quantify there removal may led to distortion within the model.

THE LESSON OF BACK PAIN

Low back pain (LBP) is of serious concern, often having dire consequences and being extremely common in the general population. Consequently the Accident Compensation Corporation (ACC) have put a lot of resources into understanding LBP and specifically its prevention and management. One key area investigated has been predictors of chronicity i.e. factors that can predict long term problems. Of interest, the strongest predictors are psychosocial rather than biological, which contrasts with the prediction of biomedicine. Put more simply in relation to LBP ' "most of the known risk factors are psychosocial" (ACC 2004, p.27). As a consequence ACC has implemented a yellow flag system to acknowledge the psychosocial influence on par with the red flag system for pathology. This has led to major changes in the recommendation that ACC has provide clinicians, as it has been identified that ignoring psychosocial factors leads to poor recovery outcomes.

As Sternman has noted "omitting concepts because we have no numerical data is a sure route to narrow model boundaries, (and) biased results" (2002, p.523) and this may be the lesson of LBP. The argument is not to trivialise pathology but open the possibility that psychosocial aspects also need to be taken just as seriously, rather than being seen as a 'consequence' of biology. Many areas that are psychosocial may be hard to quantify but as with the lesson of LBP, by omitting them this can led to a distorted model and subsequent theory of clinical reality. This is a point of discussion that has come up in regard to the research method of randomised control trials (RCTs), which are often proposed to be the 'gold' standard. The psychologist Seligman has write about some of the challenges and key points he makes are likely relevant to research in massage. Some examples include the fact that RCTs do not acknowledge participant preference whereby people actively chose the treatment they receive rather than being allocated, that the therapeutic relationship is not acknowledged as a factor within the treatment, and that the often non-standardization of treatment is ignored.

As Moyer (2004, p.4) has noted "Unfortunately there has been little emphasis on theory in the massage literature." Moyer goes on to state "It is interesting to note that, among the theories that are commonly offered to explain MT effects, the most popular theories are the ones least supported by the present results" (2004, p.14). A review of massage research identifies a biological focus, but there appears little discussion on why. It is likely this reflects an attempt to legitimise massage practice via a biomedical perspective. Like the plane without wings it maybe that this model is not fit for purpose, and may in part explain

Table 2. Identified cases consulting with a general practitioner at least once over 12 months

	Total number of cases	Consultation rate (95%CI) as percentage of the study population n=29152	Adjusted OR (95% CI) for Maori ethnicity	Adjusted OR (95% CI) for male gender
Rheumatoid arthritis	230	0.79 (0.69-0.89)	0.75 (0.43-1.30)	0.63 (0.47-0.83)*
Osteoarthritis	422	1.44 (1.31-1.58)	0.94 (0.62-1.42)	0.94 (0.77-1.15)
Gout	403	1.38 (1.25-1.51)	3.54 (2.84-4.42)*	3.54 (2.84-4.42)*
Regional pain	4014	13.8 (13.4-14.2)	0.79 (0.69-0.89)*	1.05 (0.98-1.13)
Back pain	2094	7.18 (7.48-6.89)	0.84 (0.72-0.98)**	1.07 (0.98-1.17)
Spondyloarthritis	43	0.14 (0.10-0.19)	0.65 (0.18-2.29)	1.27 (0.70-2.33)
Connective tissue disorder	192	0.66 (0.57-0.75)	0.84 (0.48-1.48)	0.61 (0.45-0.83)*
Nerve compression syndrome	230	0.79 (0.69-0.89)	0.63 (0.36-1.08)	0.81 (0.62-1.06)
Joint surgery	131	0.45 (0.37-0.53)	0.91 (0.45-1.84)	0.99 (0.70-1.41)
Osteoporosis	98	0.34 (0.40-0.27)	0.17 (0.02-1.28)	0.13 (0.07-0.26)*

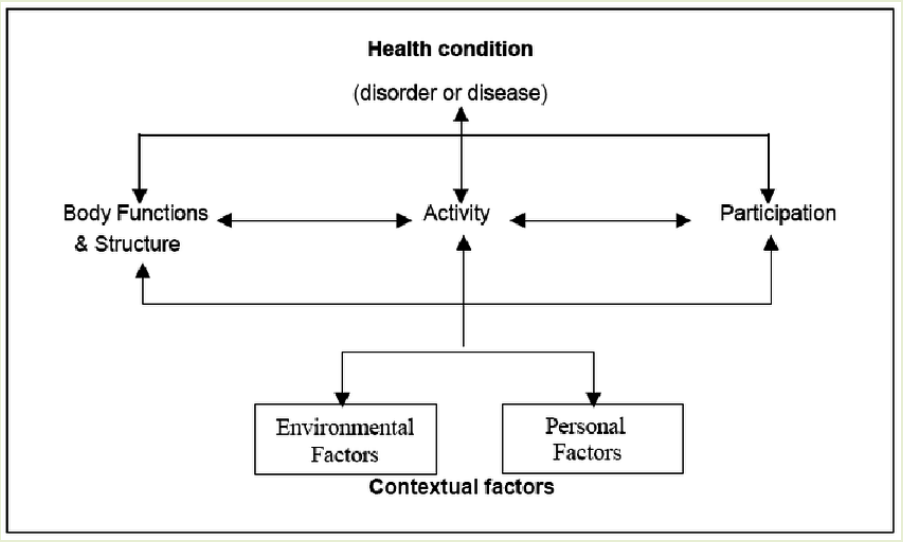
(Taylor et al., 2004, p.117)

the common criticism of 'methodological problems' common in massage research. Of interest, it is noted in a modest qualitative review that a lack of clarity in some basic concepts relating to massage was identified (Silverman, 2014). This raises a question around whether massage has a strong enough theoretical foundation to build from. Moyer (2004) suggests that it may be worth the massage field looking to psychology, for some direction forward. An example may be the common factor theory that looks at consistent features of different therapies such as the therapeutic relationship. It is likely that a biopsychosocial basis for massage would provide a better foundation for the exploration of such concepts.

Below is WHO's classification system that is based on the biopsychosocial model of health care and is offered for consideration. The body function category acknowledges the biological basis of the problem, however further categories are incorporated for psychosocial aspects that allows more individuality in defining the health predicament. It should also be noted that the arrows go between all factors indicating a systems-based approach and that it is acknowledged that each area can only be understood in regard to how it is interacting with the other areas. This framework is now well established and it is suggested is likely a good framework to be explored within the massage field both in clinical practice and research.

CONCLUSION

Much has been written on the biopsychosocial model, the point of this article was to try and highlight a few key points. Evidence based medicine (EBM) and evidence based practice (EBP) are often used interchangeably, a point of distinction maybe that EBM was established in biomedicine and EBP was the extension to aligned health providers. As Dew (2003) has noted there are key differences in how health is defined between complementary and alternative medicine versus biomedicine, specifically the later may have a grander notion of health that incorporates optimisation rather than just the resolution of disease. For reasons such as this it is proposed that further discussion on areas such as the biopsychosocial model is of great value to the massage and allied fields.



(World Health Organization, 2001)

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BIO

Phillip works as a teacher, practitioner and researcher in the areas of rehabilitation and sport. His research areas of interest are research methods in complementary and alternative medicine, the accuracy of published medical research, and functional anatomy. Phillip works clinically with athletes and those seeking rehabilitation, using both soft tissue and exercise strategies.

SCAR TISSUE 101.

By Marjorie Brook, LMT

Scars - to some people they are trophies, war wounds to be proud of, reminders of traumas that they wish to forget, and to many, just something they have already forgotten. The truth of the matter is scars, and the restrictions they cause, can affect every system in the body. Recognizing them can be the key to unlocking mysterious pain and other issues that have been interfering with the body's ability to function and balance.

Historically scar tissue has been ignored or been viewed as having no consequence by the medical world. With all of the current ongoing research and information compiling on the importance of fascia the medical world is starting to recognize the significance of scar tissue in the body. As with most new fields of interest there have been many new versions of therapy popping up, which for the most part is a very good thing. Unfortunately, the negative side of new frontiers is that many therapies are being administered without proper understanding of the subject matter.

I have been a massage therapist specializing in scar tissue release for over 20 years. In this time I have seen Scar tissue work go from being dismissed by doctors and a general population completely in the dark as to what is really causing their issues, to consideration by the medical profession that it may be a problem to some extent. Still there are many doctors ignoring the affects, while some have taking to using it as an excuse: "I know I told you it would take 6 months for recovery but you have developed scar tissue." Trust me on this – I get at least one phone call a week with that one.

The internet is now flooded with inaccurate information about scar tissue and ways to cure it. Therapies are being applied with total lack of understanding of the physiology of scar tissue. There is little or worse no knowledge behind the events that caused the scars i.e. surgeries, accidents and what the corrective procedures actually did to the body. No attention is paid to the psychological & emotional trauma surrounding the event. Few look for the possible compensations the body may have complied in response to restrictions and what releasing those restrictions without proper rehab would do. Honestly it is terrifying to me.

So I thought we could take a moment to clear up some of the misinformation:

1) SCAR TISSUE CANNOT BE BROKEN DOWN NOR CAN IT BE REMOVED. Anyone who claims to breakdown scar tissue does not understand what scar tissue is. Scar tissue replaces normal tissue that is damaged. If you break it down you are essentially saying that you are causing a new wound. The only person who can remove scar tissue is a surgeon who is literally cutting it out – only for new scar tissue to form.

The goal of working with scar tissue is to release the adhered layers, attempting to re-establishing homeostasis, releasing and correcting the compensations from fascial restrictions all the while being acutely aware of possible emotional release.

2) SCAR TISSUE IS DEAD FIBROUS TISSUE. This could not be further from the truth. Scar tissue composition and structure are different than that of the normal tissue it replaces. Because of changes in the relative amounts, type and structure of collagen, it is inferior in function.

- Scar tissue has less elasticity.
- Scar tissue is not as strong as normal tissue.
- Scar tissue does not oxygenate well, creating a low (acidic) PH:
- Scar tissue is different neurologically.
- Scar tissue does not contract.
- Scars are less resistant to ultraviolet radiation.
- Scar tissue does not contain sweat glands and hair follicles.
- Scar tissue is prone to injury.

3) SCARS ARE ONLY AN AESTHETIC ISSUE. Most people are only concerned with how the scars alter their appearance and have no idea how their scars and adhesions are affecting their bodies on so many different levels, or that scars are can be a major trigger for PTSD.

4) ANYONE CAN TREAT A SCAR. Acknowledging that scar tissue may at the root of the problem is the first step in any therapy. After that simply massaging the affected area will bring about change. However, that being said I want to

caution therapists. You need to thoroughly understand the event which caused the scar i.e. surgery, accident etc. and all the goes with it. This includes emotions, all of the physical ramifications for the body, what type of rehab will be need once the massage is done.

I am not saying that one should never massage a scar I am saying that as with all diseases, disorders and dysfunctions (yes scar tissue is a cause of dysfunction), you need to understand what you are working with before you lay hands on.

5) PHYSICAL SCARS CANNOT AND DO NOT SHOW HOW MUCH PAIN OR SUFFERING A PERSON HAS EXPERIENCED. Every scar has an emotional history surrounding it.

- Shock
- Guilt
- Failure
- Loss
- Detachment
- Trauma
- Anger & Resentment
- Low Self Esteem
- Fear
- Hopelessness/ Depression
- Disgust when seeing or touching the scar
- Sadness about the limits the scar places on everyday life
- Humor - yes there can be funny stories behind accidents

The emotions surrounding the physical scars can and do have a direct emotional and psychological effect. It can bring about significant self-image issues and lower self-confidence. Research on the after care of burn survivors or those with severe facial scarring has proven this. In the cases of patients with severe scarring suffering from depression (between 13-23% of cases) or post-traumatic stress disorder (between 13-45% of cases) have been documented.

6) TOOLS. There are many instruments and tools out there that are effective on scars but they are not the end all be all. Rather they should be considered part of the therapy.

An example would be cupping. When a cup is placed on the scar tissue and its surrounding areas, the vacuum lifts the scar tissues above and below the skin, essentially pulling them apart so that fresh blood and lymph can circulate freely through them. This improved circulation in turn makes movement easier and as a result, healing of the scars is induced.

It is a great tool but again you should not just cup over a scar without full understanding of what you could be opening up (both emotionally and physically) and how altering that scar will affect the person in the long run.

7) SCARS AND ADHESIONS ARE THE SAME THING. Not true as you can have adhesions without scars but you cannot have scars without adhesions. Both need to be recognized and treated.

8) ALL SCARS NEED TO BE RELEASED. A very dangerous statement indeed. What if the only thing holding that knee replacement together is the adhesions formed around it? Something to consider before pulling out that cup or edge tool.

9) ALL SCARS ARE A PROBLEM. Not necessarily, but all scars have a potential to be one and should be considered and examined.

10) SCARS ONLY AFFECT THE TISSUE. Again not true, but even if it is was, this is still cause to treat them. Scar tissue can affect every system of the body:

- integumentary
- muscular-skeletal
- nervous
- circulatory
- lymphatic
- respiratory
- endocrine
- urinary/excretory
- reproductive
- digestive

Understanding how each of these systems can be affected by scar tissue can lead you to unraveling the mysteries of the pain and frustration your client/patient has been suffering, in some cases for years.

If your chosen area of therapy is to give relaxation massage then more power to you. Not every massage need be a medical one and everyone needs to take time to release and relax. But if you are administering a medically oriented therapy then it is imperative that as a therapist you know who the person is, what they went through and how they came to be on your table before putting your hands on them. Once you are informed of the specific surgery the client/patient has had your next step should be to watch videos of that type of surgery to see the extent of the damage done. You need to consider all of the possible emotional, psychological trauma you are tapping into before working on the scar. Most importantly you need to be prepared for the possible reactions and how to handle them for the protection of your client/patient and yourself.

There are so many wonderful forms of therapy available today to help people on their journey to balance health & wellness. No one is better than the other, rather we have to find the right one, or combination thereof, that works for each individual. That being said, there is nothing more important than recognizing the effect scars are having on a person. In order for any therapy to be fully affective you have to clear and release any and all scars that are impeding the body's function. In other words, scar tissue release is the first step then you may proceed with any and all therapies that resonate with the patient.

BIO

Marjorie Brook, International Educator, Therapist, Author and creator of the STRAIT Method™ is one of the most dynamic instructors in the manual therapy world today. A sought-after speaker, consultant and practitioner, Marjorie's seminars have received glowing reviews from attendees of all experience levels.

For more information on Marjorie and her continuing education courses in Scar Tissue Release, Integrated Therapeutic Stretching, and Body Mechanics. www.marjoriebrookseminars.com

‘EXPLAIN PAIN SUPERCHARGED’ – PROVIDING A BPS CONTEXT

Reviewed by Carol Wilson RMT

November 2017, Christchurch and I find myself sitting in a full conference room of over 200 health professionals: Doctors, Osteopaths, Podiatrists, Psychologists, other Health Professionals and 7 massage therapists at “Explain Pain Supercharged” presented by David Butler and Lorimer Moseley. This was a chance to gain deeper knowledge and understanding of the biopsychosocial (BSP) pain model in a NZ forum investigating the themes: Pain is very normal and is a protective mechanism, nerves are loaded with mechanical, thermal, and chemical sensors, danger detection sensors can adjust their sensitivity, pain is an output of the brain not an input, pain and nociception are not the same thing, health practitioners can be important educators about pain for their clients, the words we use are powerful at helping or hindering recovery.

David Butler is the Director of the Neuro Orthopaedic Institute (NOI) which runs over 200 seminars educating health professionals and educators about the biopsychosocial approach to pain science per year worldwide. As an Adjunct Associate Professor with the University of South Australia and an Honoured Lifetime Member of the Australian Physiotherapy Association, his professional interests focus around the integration of neurobiology into clinical decision making and public and professional education in pain, stress and performance management.

Lorimer Moseley a clinical and research physiotherapist, Professor of Clinical Neurosciences at the University of South Australia in Adelaide and Fellow of the Australian Academy of Health and Medical Sciences (AAHMS). He has made pivotal contributions to the understanding of persistent pain disorders and the role of brain processes in the causes of conditions and their treatments, while also generating new fields of research and clinical practice. Moseley assists on NOI workshops to make the biological links.

Massage Therapists Back Row: Carol Wilson, Andrea Richey, Stacey Harris, Rachel Ah Kit. Front Row: Joanna Tennent, David Butler, Odette Wood (absent from photo Heather Wright)

David Butler – thorn between 2 roses…(jokes)

Together, Butler and Moseley’s treatment processes are considered best practice and are recommended in pain management clinical guidelines internationally.

Lorimer Moseley began session 1, challenging our thinking, especially theories.

Applying theories that do not hold up is poor science in his opinion. Theories we continue to base our work on for example could be the Gate Control Theory or the theory that limited joint range reflects short muscles. Theories provide a framework to hypothesise and develop new theories but hypotheses must be testable and are often written to be proven wrong (Moseley, 2017).

The Moseley/Butler team aim is to encourage all health professionals to transition from a structural/pathology model of pain to the Biopsychosocial (BPS) model.

Lorimer Moseley in full swing

If we truly embrace a biopsychosocial model of pain, careful observations of the client in pain taking into account all their complexities will lead to better outcomes for them and us, as the therapist.

George Engel's definitions from the 70s (Borrell-Carrió, Suchman & Epstein, 2004) were used to help define each component of BPS. Engel says biological factors are tissue states outside of the safe homeostatic zone, psychological factors are from what we believe, say, feel, predict, all that is driven by the brain and social factors relate to the interactions with others or roles one has in their social world.

To assist in understanding the biology of the BPS pain model, the term 'neurotag' was coined to explain a pattern of neuron activation which creates a certain brain output. Think of taggers leaving their mark, their unique signature on buildings and fences. Neurotags are like a unique message in the nervous system. They may share many cells, so activation of one neurotag may also influence other cells e.g. if a neurotag is activated, the group of member cells that are influenced will then activate other member cells.

Think of it like this - once a danger message arrives at the brain, it has to answer a very important question: "How dangerous is this really?" the brain responds by using all information it has previously been exposed to including – previous fear, cultural influences, knowledge based on memories, other sensory cues – the list is endless.

Neurotags have two main groups: action neurotags - influence output systems that exert effects outside brain matter such as muscles or consciousness. Modulation neurotags - exert their influence only within the brain such as visual data, proprioceptive data, homeostatic state. As danger increases, the neurotags exposed increases also. Lorimer and Moseley (2015) called these "Danger in me neurotags" (DIMs) e.g. limping, I can't, the physio should have helped, whereas "Safety in me neurotags" (SIMs) such as " I can bounce back", "My osteopath really knows what they are talking about" – may exert a positive influence and reduce the danger level at which pain is experienced.

Moseley & Butler's current thinking about pain is: "We will experience pain when our credible evidence of danger related to our body (DIMs) is greater than our credible evidence of safety related to our body (SIMs). Equally we won't have pain when our credible evidence of safety is greater than our credible evidence of danger" (Moseley and Butler 2015, pp14).

7 main varieties of DIMs and SIMs from the NOI – make a list of your own. (Neuro orthopaedic Institute www.noigroup.com)

As a tutor in this field, my key take home messages are that when teaching pain information it is important to begin with the concepts - Pain is a protector, not an informant. Pain is aiming to keep you safe, not telling you what is wrong. (Moseley & Butler, 2017 Pg 31). Nociception and pain are not the same thing. Nociceptors have a high level of activation which means the stimulus must be high before signals are sent to the brain for the brain to assess - really they are danger receptors not pain receptors. Moseley and Butler stress strongly that the whole system is about protection and not about conveying an accurate indication of the state of the tissues. (2017 Pg 31) Pain really is a biopsychosocial experience involving; current emotional status, belief systems, past experiences, fear, stress and nociception among many other factors.

It really is worth reading the book " Explain Pain" which is aimed at clients and therapists alike before attempting "Explain Pain Supercharged". The first question to your client once you yourself are educated and feeling excited about the knowledge is – 'do you want to learn?' It can be easy to overlook the fact that not everyone will feel the same. Society and culture will have influenced what a client will expect from your profession before they arrive, and there's a good chance they're not expecting education. (NOI Group, 2018)

To ensure the client is educated on pain begin to find out what their DIMs may be. For example:

Are they experiencing recent sleep changes, are they tired all the time, do they have a short fuse, do they have recurring infections, are their relationships strained, what is bothering them at the moment? Pain is just one of the protective mechanisms. Awareness of DIMs can begin to weaken them.

At the same time it will be useful to power up the SIMs – encourage doing several SIMs at one time e.g. a walk on a beach with a trusted friend, mindfulness or relaxation, good sleep hygiene, positive self talk about 'my body is looking after me'.

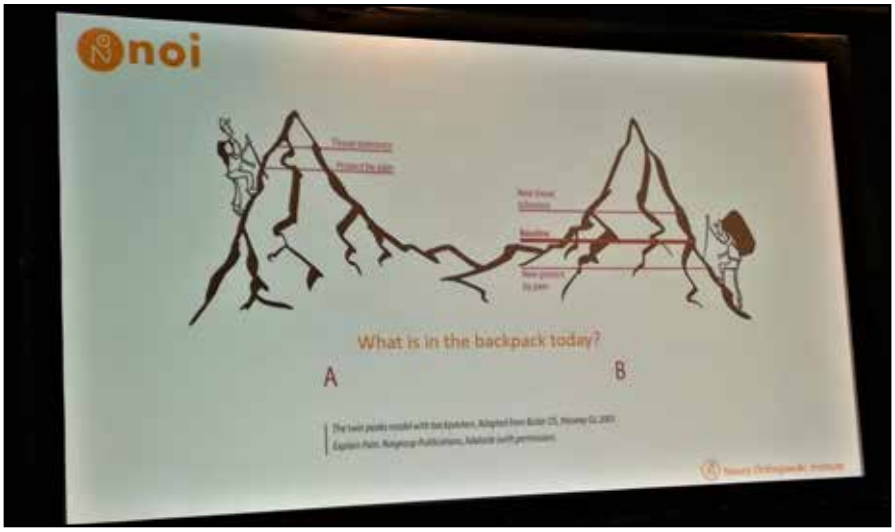
Let your clients know that you can see why their body has made these changes - honour where they are at. Discussion of - overprotection, bioplasticity, DIMs and SIMs will help to educate and set

realistic short and long term goals, which can really help to break the pain cycle. Helping someone to understand why they hurt and what they can do about it is front line to pain management, and as massage therapists, we can have an important role to play in this through our interactions with our clients. The seven steps to better care for clients outlined by Moseley are:

1. Learn more about pain
2. Observe clients carefully –attend, encourage, watch their movement and behaviour
3. Reassure by delivering SIMs
4. Inspire them
5. Encourage movement
6. Encourage exercise
7. Resource them for their recovery

To understand more fully the biology of the system and the wider psychosocial input I truly recommend you check out Lorimer/ Moseley youtube clips, the NOI website for up to date modern thinking on pain and Body in Mind, a site developed by Moseley to promote better understanding of the clinical pain sciences. It is important we embrace this shift to BPS.

NOI http://www.noigroup.com/en/Home, Body in Mind https://bodyinmind.org/



The Twinpeaks model with backpackers shows the Tissue Tolerance adjusted depending on how much baggage is in the backpack today (slide from workshop)

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SEXUAL ABUSE COMPLAINTS – A PERSONAL ACCOUNT OF ACTING AS AN EXPERT WITNESS IN A COURT CASE

by Teresa Karam MNZ Vice President

Part of my role as Vice-President includes dealing with complaints. One such complaint arrived in my inbox at the end of March 2017 from a senior constable from the Adult Sexual Abuse division of Auckland Police. They were investigating allegations against a male massage therapist operating in Auckland and wanted some questions answered to assist with this.

The questions were:

- Is it ever appropriate to kiss a client's body during a massage?
- What is appropriate in terms of a male client asking a female client to undress/ be completely naked?
- What is appropriate language dialogue for a male client to use to a female client e.g. "you're gorgeous"?
- Do you have to be qualified to practise massage in New Zealand?
- Is this monitored/regulated?
- Can therapists from overseas start work/ operate a business here?

I'm sure you can appreciate the nature of my answers. They acknowledged my response and that was the last I heard. Then in September 2017 I received a call from a Crown Prosecutor to ask if I (under Massage New Zealand) would be willing to appear as an expert witness as a massage therapist had been charged and the trial would begin in November.

My first instinctive response was YES as I'm very passionate about this subject. However, the next and very prompt gut instinct was "oh heck, I'm likely to be cross-examined", which I admit is quite a daunting thought (admittedly in my head I was replaying ghastly courtroom scenes from The Good Wife). That aside and after a conversation with our President, Helen Smith, the decision was made to go ahead.

Straight away I had to provide a comprehensive CV and estimated costs in terms of time, loss of earning and travel etc. This was submitted to the Crown for approval to engage me as an expert witness. This was accepted in due course. The solicitors then formally instructed me on expert witness expectations, requirements, code of conduct and confidentiality, which I had to duly sign and agree to.

The next stage was for me to read all the witness statements. There were 14 and some were up to 10 pages long. It was appalling to read the experiences these women had with this therapist. Their statements began from when they booked the massage on Grab One (very cheaply), how the treatments took place after hours in a deserted office building in an industrial area. The way the therapist would slowly build "trust" with both dialogue and apparent professionalism. And how important it was for them to remove all their underwear so he can heal them better. The "vital" need to expose and massage their breasts, work up the inner thigh to the genitalia, kissing the client's back, lack of any draping, comments loaded with sexual innuendo. I wondered, why did they stay on the table? Why didn't the alarm bells ring earlier on? Many of us therapists know exactly how a treatment is conducted, however some of these women hadn't had many massages before – if any. They completely put their trust in this man as they purchased the treatment off the reputable Grab One site. They had already spent their money. It can be difficult to get up and walk out when you are vulnerable, in a state of undress, the therapist is in the room and you're in an isolated area. It was sickening. But I could clearly see the common denominator in how he systematically conducted his treatments.

I was asked to read the 75 page written transcript of the police interview with the defendant. He certainly had the 'gift of the gab' but his talk about his healing powers and how much he can transform the lives of his clients wasn't quite working with the interviewer.

The next step was for me to write a statement which was to be submitted as evidence. This

had to cover my qualifications, massage experience, current work situation/clinic set-up, type of treatments I offer, to whom and how often. I then had to outline industry standards, massage to sensitive areas (when/why/how?), areas we never treat, how to drape, client comfort and modesty etc. This was amended back and forth a number of times to get it right.

All through this process there were numerous emails and conference calls with Kate (the Crown Prosecutor) and team. As the date of the trial got closer, I was thoroughly briefed on what I would be asked and the approach the defence might try to take. The Prosecution also needed to know my answers so there would be no surprises.

Finally, the day of the trial arrived. I had a face-to-face meeting with Kate at the Auckland District Court at 9am on Monday 13 November. It was actually nice to meet her in person before taking the stand later that morning. I then had to wait for roughly an hour as I was the first witness called. This hour turned into the whole morning! The defence tried to prevent me testifying at all, so the judge had to consider this before we could start. This only added to the already growing swarm of butterflies in my stomach!!

Then the phone call came to say the judge had given his approval for me to testify. I was relieved, all this for nothing would have been so disappointing. The jury was seated straight across from the witness box and it was interesting noting their reactions. Surprisingly I then felt good to finally be there. As Kate's questioning started I gained my confidence, composure and realised that I did know my stuff. I had to remember not to use my hands to help describe techniques or how to drape. I had to be very verbally descriptive as the extremely fast typist has to record everything, so demonstrations by hand are no good! The questioning was mostly an expansion on my written statement. Many references were made to Massage New Zealand and I was thrilled that our Code of Conduct was submitted as official evidence.

During lunchtime we found an empty room and I was asked to draw on A4 paper "no-go zones" for a relaxation treatment and shade area where the draping would be. Another for remedial/sports massage treatments accessing muscles and trigger points near sensitive areas i.e. piriformis, hip flexors, proximal hamstring/origin, adductors, pectoralis – where these points are and how to drape to maintain client comfort and modesty. This was a subject that had come up during questioning. These were then submitted as official evidence.

It was then over to the defence. In all honesty I was dreading this and was expecting a very aggressive and ruthless attorney ready to tear me to shreds. However, he wasn't actually that intimidating. I did feel that he didn't really have much of a leg to stand on - and I think he knew it. The questioning was quite general to start with. He then questioned that I am not really an expert on relaxation massage (which is how the defendent advertised himself on Grab One) because I had already stated that I mainly do remedial/sports massage. I then explained studying Swedish/Holistic Massage with A&P was a prerequisite to Sports/Remedial Massage. I further mentioned this had included 24 case study treatments, 100 logged practise hours before graduating, and working for 12 months doing relaxation massage while studying for the next stage.

The next tactic was that I didn't study in New Zealand (it was in the UK). I explained MNZ's thorough Recognition of Prior Learning (RPL) process. He seemed surprised we are that professional and organised.

Discussion also went into the fact that it's not against the law for anyone to come to New Zealand and start a massage business. The answer to that is there are DEFINITELY industry standards in place set by Massage New Zealand, and every approved and reputable massage training college that produce trained massage professionals. The problem is there is no LEGISLATION to UPHOLD these standards for therapists that are not registered. Of course, this led to the issue that registration is voluntary. All I could really do here is agree, but state briefly the benefits of registration and that we have hundreds of therapists registered throughout New Zealand.

By the time I stood down, I felt a little drained to say the least. The rest of the trial then ensued over the next two weeks with all the victim's testimonies. The defendant was remanded in custody until sentencing which was on the 11th of January 2018. Operating under the business name of "Soothe Me Massage", Raijinder Paul Singh was found guilty on 20 counts of indecent assault and sentenced to four years imprisonment.

This is a great result for the victims. It is also great for our industry and has not only raised the issue of mandatory registration/more regulation, but also companies such as Grab One being more prudent on who they list on their website. Hopefully this is also a step towards professionalising the massage industry in New Zealand.

HIGH PERFORMANCE SPORT NEW ZEALAND UPDATE

Hi Everyone. Last year I indicated that HPSNZ was looking at developing an internship programme for massage therapists interested in working in the HPSNZ environment. This is still in the development stage but we hope to progress it over the next few months. In April 2018, three massage therapists (Clint Knox, Hans Lutters, Annette O'Connor) will be part of the NZ Health team at the Gold Coast Commonwealth Games. The process of being appointed to such a position is highly competitive with understandably, some therapists feeling disappointed at their non-selection. The following article was written by Dr Bruce Hamilton (HPSNZ Medical Director) Fiona Mather (HPSNZ Physiotherapy and Rehabilitation Manager) Jordan Salesa (HPSNZ Key Physiotherapy provider) titled "Preparing for an NZOC Health Team Role: What is involved?".

It is a great summary of the issues and reality of the selection process of all health team members for campaigns such at the Olympics and Commonwealth Games. Hopefully it will answer questions that some of you will have and provide some insight into the process involved. In the meantime, we wish Clint, Hans and Annette all the very best for what promises to be a very busy but exciting and successful Commonwealth games and I will keep you updated as to progress around the "internship" concept.

Wishing you a successful start to 2018.

Pip Charlton,

HPSNZ Massage Advisor

COMMENTARY

Preparing for an NZOC Health Team Role: What is involved?

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INTRODUCTION

2017 marks the start of a new Olympic cycle, with athletes and sporting organisations refocussing on what it will take to generate medal winning performances in Tokyo 2020. After a period of transition and reflecting the continuous nature of international competition, the New Zealand Olympic Committee (NZOC) has recently completed a recruitment drive for doctors, physiotherapists and massage therapists to participate in a range of international multisport events in 2017 and 2018 - including the Commonwealth and Winter Olympic Games. The NZOC received well over 100 high quality applications for these roles, making the selection process a challenging exercise in discrimination. Charged with determining the selections (BH/JS), the authors recognise both the privileged role we play in deciding who will attend these prestigious events, and the potential influence our decisions have on careers and life experiences. Unfortunately, there are only limited opportunities to represent NZ as part of the health team at these pinnacle events. This brief manuscript is written with the goal of supporting those who may harbour ambitions of working in the Olympic sports medicine environment.

BACKGROUND

In 2013 High Performance Sport NZ (HPSNZ) and the NZOC collaborated to appoint a joint Medical Lead (subsequently evolving into the HPSNZ Director of Performance Health and NZOC Medical Lead). A unique role among international sporting and Olympic organisations, the goal of this joint appointment was to streamline the health management of the elite athlete, from the training ground to the international competition arena. Aligned with this appointment, since 2012 HPSNZ has provided sports medicine support to carded Olympic athletes through an increasingly centralised model. By far, the majority of funded athlete programmes are based around either the National Training Centre or Regional Performance centres, where athletes may train, recover and receive comprehensive multi-disciplinary support. Reflecting the centralised approach, the clinical needs of many elite athlete groups are increasingly being met by practitioners supported by HPSNZ to be immersed (albeit to varying degrees) within National Sporting Organisation (NSO) programmes. Working within the centralised HPSNZ structure provides a unique opportunity to practice in a truly multi-disciplinary manner, and to broaden skill sets beyond clinical work alone. However, concurrent with the increasingly centralised delivery model for sports medicine support, there has been a corresponding reduction in opportunities for practitioners around NZ to be routinely engaged with elite Olympic sport. Furthermore, since athletes competing in pinnacle events consistently report the value of having recognisable and trusted practitioners incorporated into the traveling team, international team support opportunities for practitioners not working within the centralised system have potentially declined. As a result, both HPSNZ and the NZOC have recognised that articulating a pathway for sports medicine providers into the arena of sports medicine care for elite athletes is essential to ensure the ongoing availability of high quality, experienced practitioners (Figure 1). Establishing a process that encourages and develops capable and enthusiastic practitioners to choose the care of elite athletes as their career (or as a component of their career) is a crucial element in sustaining the standards of care for elite athletes in NZ, and thereby optimally support athletes at pinnacle events such as the Olympic Games.

SPORTS MEDICINE FOR ELITE ATHLETES

There is often animated discussion as to whether providing sports medicine support for elite athletes poses unique challenges in comparison to caring for the "weekend warrior". It is our contention that while there is significant clinical overlap, operational elements of the two scenarios are distinct and increasingly divergent. Specifically, community based sports medicine support (and in this discussion we will arbitrarily consider this as including physiotherapy and medicine) is typically reactive, time constrained and consultation room based. While inter- and cross- disciplinary referral is utilised, it is not necessarily the immediate default approach, and funding for services provided is based around either ACC, private health insurance or user pays. In this necessarily business model approach to sports medicine, data collection is often limited to professional and legal requirements, research is rare and the application of novel treatments have both commercial and clinical considerations. By comparison, the provision of centrally funded sports medicine care to elite athletes allows for ease of access and an expectation of inter-disciplinary care. Funding and support is not determined by external funding bodies, and as a result clinical options are determined by knowledge, acquired skills and resource availability. Incumbent in the latter approach is a complex accountability to multiple parties, including the coach, athlete (patient), National Sporting Organisation (NSO), discipline and HPSNZ. While there is significant overlap in required clinical skill sets, the two environments are structurally and organisationally distinct, and success in either environment is characterised by the ability of practitioners to continuously learn and adapt.

CARE OF THE OLYMPIC ATHLETE AT PINNACLE MULTI-SPORT EVENTS: CORE REQUIREMENTS

The clinical care of the elite athlete during international camps and competitions is a

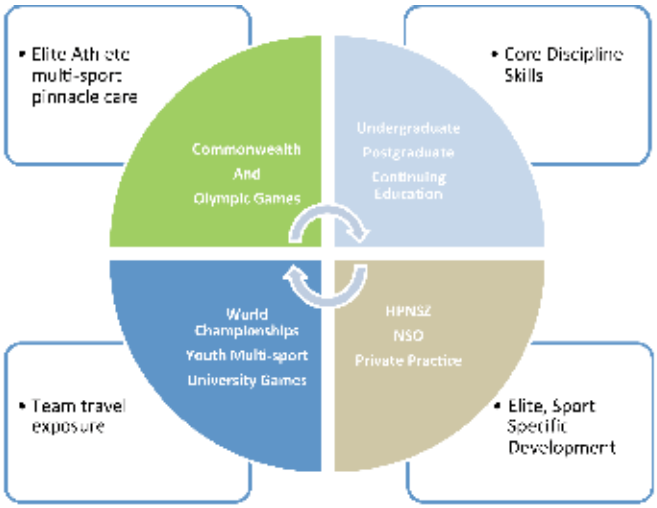

Figure 1. Schematic representation of evolution of individuals involved in Health Team representation at Olympic and Commonwealth Games

relatively unique feature of sports medicine support. The Olympic Games is considered the pinnacle of multi-sport events for athletes (notwithstanding the significance of individual sporting code world cups or world championships), and is often held in similar status by practitioners with respect to their individual career ambitions within sports medicine.

Paradoxically, while the Olympic Games is a highly charged and pressured environment, it may not have the challenges that are imposed by many smaller events, where a practitioner of any discipline may often be the sole health care provider and event medical support may be limited. Hence, traveling with elite athletes to all levels of events impose quite distinct demands on practitioners, with unfamiliar environments, conflicts of interest, scope of practice extensions, long working days and clinical isolation all creating challenges that must be adapted too in order to be successful. Like all clinical skills, team travel is a capability that must be learnt. The health team for a pinnacle multi-sport event such as the Commonwealth or Olympic Games is required to support athletes and support staff through a broad range of potential situations. Critical attributes of team members are found in table one.

PINNACLE EVENT: TEAM CAPABILITY AND FUNCTION

In addition to the individual capabilities described above, an individual's selection and ultimate role within a multi-sport team is also determined by the overall capability of the health team. Thus, team considerations such as the specific skill set mix, sport specific experience, communication, leadership styles and gender mix, all play a role in the final health team formulation. Furthermore, ensuring an appropriately skilled future team, through careful planning for succession, is a critical function of any multi-sport health team, and this further complicates the team selection matrix (Figure 2).

As a result of the large number of individual and team factors implicated in selection, and the extremely limited number of positions available, securing a role at an Olympic or Commonwealth Games team for NZ is challenging (but not impossible).

PREPARING FOR SELECTION TO AN NZOC HEALTH TEAM

In 2017, over 120 applications were received for opportunities to be part of the health team for the World University Games, Youth Commonwealth and Olympic Games, Winter Olympics and Commonwealth Games. From this long list, 42 applicants were ultimately interviewed and 39 traveling and reserve positions were appointed. Thus, getting through the initial selection phase is critical, and the following observations are made to assist those wishing to enhance their chance of being involved in future NZOC health teams.

- If you are unsure whether to apply – apply. As illustrated above, multiple factors are involved in determining the ultimate team make-up, and you never know what factors may be in play at any given time.
- Be realistic in your assessment of your experience and capabilities.
- Be clear and honest on your career aspirations and your motivations.

Table 1. Attributes of individual health team members at a pinnacle multi-sport events

Clinical Reasoning for Health and Performance impact	Applied and detailed understanding of specific aspects of individual athlete management, including the impact of illness or injury upon wider performance variables. Established ability to collate multiple clinical and non-clinical factors in the formulation of a management strategy, in a time compressed environment and in the presence of potentially conflicting imperatives.
Event experience	Experience and proven capability at an international competition level, preferably multisport event. May be developed through individual sporting federation world championships, or junior events such as youth Olympic and Commonwealth Games.
Proven ability to work in a complex team environment	Established record of effective inter-disciplinary team involvement in the management of elite athletes
Advanced communication skills	Effective communication of timely, relevant and accurate information to inform multi-disciplinary decision making under pressure of time and conflicting imperatives.
Skills under pressure	The ability to remain positive and effective despite the challenging multi-sport environment. The ability to recognise individual limits, work within your scope of practice and respect colleagues.

commentary

Figure 2. Summary of factors involved in NZOC multi-sport health team selection

Remember, those selecting the team are interested in what you can do for the team, not just that you are really enthusiastic (which is universal)– it's about the team, not the individual.

- Be clear on what makes you special. What can you bring to the team, that differentiates you from other practitioners? While an important part of your application preparation, this should also be part of your career planning – if you want to work in this environment, what do you think is going to be needed, and how can you make yourself the best person for that role?
- Be able to illustrate where you have made a difference. Most practitioners are able to provide illustrations of where they have positively influenced an athlete's outcome – what have you done that has had a long term sustained effect on groups, sports, systems, beliefs and practices? Can you articulate clearly why would this be useful to the NZOC health team?
- Be prepared to provide illustrations of soft skills such as team work, collaboration, critical observation, problem solving, adaptability and conflict resolution.
- More (or less) experience is not necessarily better. What is the quality of what you have been doing and how does it differentiate you from others? For example, having attended 25 conferences may not reflect development or progression of "non-clinical" competencies as much as teaching or lecturing on a few courses (or contributing to organisations such as SMNZ, or contributing clinical articles in local educational forums such as the SMNZ journal).
- Take opportunities to work with NSO's and HPSNZ. If you have a passion for a particular sport, look for opportunities to showcase and develop your expertise. HPSNZ is regularly advertising for practitioners to work in the centralised hubs, or travel with teams. In the last year, HPSNZ Performance Health Team has established a sports medicine fellowship for sports physician registrars, and is currently finalising a physiotherapy internship.
- Prepare your curriculum vitae. Ensure that it is up-to-date, does not include typographical errors and does not include multiple colours or fonts! The pieces of your CV that you consider important and relevant to your application should be highly visible on a quick perusal – that may be all the opportunity you get.
- Prepare for the interview carefully by researching and asking questions of those that may have experience – try to avoid the trap of making assumptions on what may or may not have occurred before. Be primed with examples for a range of potential scenario's that illustrate your strengths and weaknesses.

CONCLUSION

Being a member of the health team in an NZOC multi-sport pinnacle event is both challenging and highly rewarding. Quite appropriately given the nature of the event, membership of this team is highly sought after and given the size of the team, selection is highly competitive. Despite the increasingly centralised approach to the provision of health care to elite NZ athletes, both HPSNZ and the NZOC are committed to supporting the development of practitioners with the right skill set and desire to work with elite athletes. As illustrated above, health team selection involves consideration of multiple factors and is increasingly challenging. Those charged with its selection take the responsibility seriously, recognising the significance of the appointments, and are committed to transparency of process and development of individuals in this inspirational area of work.

As with athlete selection, selection to an NZOC pinnacle multi-sport event health team requires years of commitment, sacrifice and hard work. It doesn't come easy for anyone. However, working at one of the great spectacles, alongside talented and committed colleagues and athletes, makes that hard work worthwhile.

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POSTGRAD STUDY ALLOWS MASSAGE THERAPISTS **TO SPECIALISE IN PAIN MANAGEMENT**

By Rachel Ah Kit

When I completed my Diploma in Massage Therapy in 2010, I'd spent 2,000 hours sitting in classrooms, pouring over books, learning the hands-on techniques, practicing on friends and family at home, and slaving over assignments. I thought I knew a lot about the human body and about the art and science of massage therapy. When I started my massage practice, I felt well prepared for dealing with people's ache and pains.

But I soon realised I needed to learn more. I set about doing lots of professional development. Over seven years I racked up hundreds of CPD hours, well over the minimum required by MNZ and mostly hands-on training. I travelled to the USA in 2016 to attend the International Massage Therapy Research Conference where the theme was "Integrating Therapies for Pain," and it was there I had my mind blown.

Of all the presenters throughout the conference, most of whom were massage therapists, over 80% had a qualification of at least Master's level and several had gone on to do their PhD. Including Jo Smith, past-President of MNZ. She was the final keynote speaker of the conference and something she said really resonated with me – Jo talked about how we massage therapists all do so much training for our hands and our hearts, but very little for our heads. After Jo received a standing ovation from the attendees, I talked with her and explained I wanted to do some higher-level training. She was very quick to encourage me and told me to keep in touch.

When I returned home I presented what I learned to a group of local massage therapists – and at the end of my 90 minutes, I declared that I was going to do my PhD too.

Once you make things like that public, you really must follow through. So, I did. I researched what was available and was excited to see that the University of Otago, Christchurch offers a distance learning programme that allowed students to specialise in Pain and Pain Management.

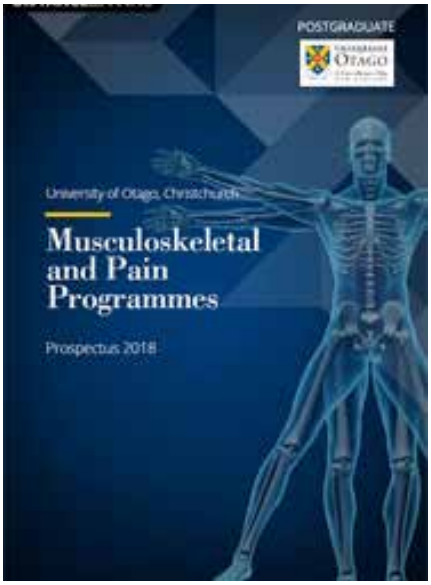


Fig 1 Prospectus for the pain programme

This programme, which is a staircase through Postgraduate Certificate, Diploma, Master's and on to PhD, is designed to be undertaken part-time, by health professionals in clinical practice, who deal with clients and patients in pain. It is "designed to present an understanding of the importance of pain to the individual and to society, and how best to optimise its management. It provides candidates with the necessary skills to better understand and manage pain problems that pertain to their particular discipline within health care." (http://www.otago.ac.nz/christchurch/study/postgraduate/otago012371.html)

The programme provides both a thorough understanding of pain and pain management theory, based on scientific evidence, as well as practical skills that can be applied in a massage clinic. Importantly the whole programme works within the biopsychosocial framework and is endorsed by the International Association for the Study of Pain (https://www.iasp-pain.org/Education/EducationOpportunityDetail.aspx?ItemNumber=5949) Since it's part-time and distance learning, I can still work full-time with no need to travel for training.

Fig 2 Online lectures and discussion groups are key to distance learning. Classmates included physiotherapists, osteopaths, GPs, nurses, Occupational Therapistss and several other health practitioners.

The programme has transformed my practice. I now look further afield than a biological cause for pain. I ask more questions about my clients' overall health, workplace and home life stressors, emotional state, their understanding of pain, what they've been told by other practitioners and what they think that means. I still make sure to cover off injuries and potential conditions and will still refer out if needed. But I've now had a few referrals from GPs and other healthcare practitioners, who are familiar with my work, for clients who have "non-specific chronic pain" – pain that no one can find a biological reason for. For some of the clients I'm working with, just the fact that I believe that their pain is real, and not just "in their head" helps them. For some clients, gentle work has helped them more than any previous deep-tissue work has, and for some clients, being very careful about my use of words has made a difference. This programme is one that I would recommend to any massage therapist committed to extending their knowledge.

To get accepted on the programme, you require a health professional qualification with at least three years' full-time tertiary

study. However, the University will also consider those, like me, who don't meet this criteria, on a case-by-case basis. They assessed my massage therapy diploma and previous business degree transcripts, and I had to outline my experience and ongoing training. I was then permitted to take one paper, as a Certificate of Proficiency to prove I could study at this level. I passed with a good grade and now I am two papers into the Postgrad Certificate, and will carry on through the Diploma and onto a thesis-based Masters. I have found the study to be incredibly valuable to my practice and has completely changed my thinking in terms of client suffering, understanding of pain, treatment options and assessment. I have a huge body of evidence to call upon to extend my knowledge and it has also made me realise, just how much I don't know.

To find out more about the programme check out: http://www.otago.ac.nz/christchurch/departments/orthomsm/postgraduate/

Or feel free to contact me if you have any questions.

BIO

Rachel Ah Kit is Clinic Director and Massage Therapist at Bodyworks Massage Therapy in Christchurch, a practice in which she contracts a number of therapists. Bodyworks Massage Therapy is located at 24 Nairn St, Spreydon, PO Box 7129, Sydenham, Christchurch 8240. Rachel is a MNZ member with a Diploma in Massage Therapy (Level 6) from the Canterbury College of Natural Medicine. Rachel can be contacted via email at rachel@bodyworksmassage.co.nz

TAKING THE HEALING DIMENSION TO PAPUA NEW GUINEA

By Donna Roy

My partner Dave, works in Goroka, Papua New Guinea (PNG) on a month-on month-off basis. As he was flying out just before Christmas, he suggested that I travel with him and stay for two weeks over Christmas and New Year. It would give me a chance to see where he works and I would have the experience of visiting a different country. I didn't hesitate to say YES!

I suggested to Dave that I volunteer at the Goroka Hospital to fill in my days while he was working. He was horrified! "People only go to Goroka Hospital to get sick" he said. I said "Don't worry about it, I'll glove up and take sanitiser and I'll be fine". Fortunately, Dave's boss is also Chairman of the hospital board so he arranged that I could work there.

So, on 20 December we flew off to PNG. Goroka is a town of about 20,000 people in the Eastern Highland Province. Its up at 5,500 feet and access is by aeroplane or helicopter as there is no road from Port Moresby. Suddenly you realise you're in the third world. The roads have huge craters in them, there is mud everywhere and most of the houses are corrugated iron shacks. We stayed in a company-owned house in a compound surrounded by barbed wire fencing with security guards on the gate.

On my first day, two of Dave's staff took me to the local produce market to get food supplies. His staff looked at my sandals and asked me if I had gumboots – I didn't. I ignored my mud-covered feet because I was so fascinated by all the amazing fruit and vegetables available, most of it I recognised but there were some things I'd never seen before. I got about five day's supply of fruit and vegetables for around NZ$20. Later we went to the supermarket which doesn't have much but there are a few basic items. I was glad we had taken some food with us. Dave gave me strict instructions not to leave the compound unaccompanied.

The following day, Dave's boss Mal took me to Goroka Hospital and introduced me to the CEO and Chief Nurse. It is a 400-bed hospital which services the Eastern Highlands Province. In one glimpse I could see that it was seriously under-resourced. There are only 36 nurses so at night there is only one nurse on duty. I saw a doctor (wearing a Rangitoto College sweatshirt) doing a ward round once. It was filthy, rodent-infested and there was no running water in the surgical ward. On some days there was no running water for the whole hospital. The few items of equipment the hospital has have been donated. There is an X-ray machine but no other diagnostic equipment at all. There are no blood-pressure machines and thermometers are the old-fashioned ones that you tuck into an armpit.

I was introduced to the Physiotherapy Team and they were told to look after me. They work with patients who have fractures, babies with club feet and adults and children who have had meningitis (sometimes combined with typhoid and tuberculosis). PNG has a huge problem with violence – inter-tribal fighting and domestic violence – and there are lots of car accidents as the roads are so bad.

After a few days of being with the physios I felt like they'd accepted me. The head of the department asked me to do a training session and delegated one of the staff to walk me out to the carpark and wait with me until I got picked up each day. "You are important to us, Donna" he said. He started talking about next time I come there. I felt like a line had been crossed.

Entrance to Physiotherapy Dept

My first two patients were a woman with a broken hip that had been in traction for six weeks, her leg was swollen above the knee and an elderly man with prostate cancer – his naked, skeletal body lying straight on the vinyl mattress because no one had thought to bring him a sheet. In Goroka there is next to no cancer treatment. Those with money can fly to Port Moresby, Lae, or Australia, but most people don't have any money. At Goroka they do mastectomies for breast cancer, but without any follow-up treatment.

A lot of the patients are in hospital for a long time and often have bedsores.

Over the two weeks I also worked with:

- A 10-year-old child with a high temperature and swollen abdomen from a bowel obstruction – the only surgeon was sick and the theatre was closed. He was in a lot of pain. I hope he's still alive.
- A woman with a full rectal prolapse – very common as women have lots of babies.
- A young woman, perhaps 18 years old, whose husband had attacked her with a machete, all the wounds had become infected. One of her father's wives had accompanied her on the helicopter flight from her remote village to Goroka.
- A man who had been attacked with a machete in a fight.
- A diabetic woman with a huge leg ulcer.

Each patient has a family member, or guardian, with them. This person washes the patient, brings them food, does their laundry, interprets as best they can and sleeps on the floor beside the (circa 1900) hospital bed. In PNG there are 800 languages – in Goroka a lot of people speak Pidgin and quite a few speak English. Having a conversation with a patient was often a three-way interpreting exercise as the patient spoke with their guardian in their own language, the guardian translated into Pidgin for the physio, who then interpreted into English for me.

I was also included in the club feet clinic on Wednesday mornings. A lot of babies are born with club feet in PNG, mostly boys. It was interesting to see the Ponseti method of treating club feet in action. Little babies, some with both legs plastered, coming in each week to have the plaster soaked off, the feet manipulated into position and re-plastered. By the time these babies are old enough to walk they can.

Also seen in the Physio clinic were children and adults who have had meningitis being strapped onto a bed with big leather straps and tilted upright to strengthen their legs. The physios assure me that they have these people, especially the children, walking again.

I decided to do the training session on Manual Lymphatic Drainage as there are a lot of patients with swelling around

MLD training session

fractures and women with lymphodema after mastectomy. It was well-received and the young physios were delighted to have a new technique to use.

One day a woman walked into the Physio Department with a broken arm, the X-ray showed both radius and ulna completely broken through and her forearm was at a very bad angle. She had broken it two months prior and it had been set at that time but after a fortnight she had decided to take the plaster off. The head physio's attitude was that it was her own fault but he would help her out. He grabbed her arm and wrenched it, she screamed with pain. He proclaimed that he could re-set it for her and save her 1000 kina (about NZ$500) by doing it here and now. She agreed. I gulped, this was going to hurt! He sat her on a chair and as an aside to me said "Sometimes we have to go in the back door, I'm saving her money, it is a kindness really, these PNG women have a high pain threshold". So, I stood behind her with my hand on her back and watched as she wailed in agony as he re-set and re-plastered her arm. To give him credit, after another X-ray I could see he had re-set it almost perfectly. She was to come in the following week and he would cut the plaster and re-traction it for her. She left smiling.

PNG is a brutal place. There is no kindness or compassion for other human beings. Even though I tried to explain how to put some love into a massage and to listen with your hands to what a body is telling you, I don't think they really got it at all.

Memories include watching the mice run across the room, watching the cleaner mopping mud from one side of the floor to the other, being the only white person in the whole hospital and seeing staff do the best they can under extremely difficult circumstances. I enjoyed making a difference for the patients – it was especially rewarding seeing a patient relax and find sleep as their pain was reduced by touch. I know that although I could only work with a few people, healing energy was filling the whole hospital.

The head physio's farewell speech really touched me. He said what a privilege it was to have had me there and that he'd noticed that I was happy to touch black people. I replied that I felt it was a privilege to have had this opportunity and to me we're all people living on Earth together, it doesn't matter what colour our skin is.

I came home and bought them a TENS machine – it was second on their wish list for equipment. Dave will take it back with him on his next trip. First on their list is an Ultrasound. They call it their "Ghost List" as they don't believe they'll ever get any of the items on it. I've also got some Tui Balms massage wax for them as they were using baby oil.

During the fortnight I was in Goroka, Mal took me on a helicopter flight to a remote

Farewell to the Physiotherapy team.

village near Chimbu. We had four little girls on board, one was returning from boarding school in Adelaide. We landed on the playing field in front of the Catholic Church. Armed security guards looked after the helicopter while we drove down the road, people surrounding the car, so Mal could open a water project he'd funded. A dam had been constructed above the village, water had been piped to a holding tank and then piped down to the village. Some houses now have their own tap – what a difference this will make. The villagers had decorated their taps with flowers and wanted Mal to turn officially their tap on. There were lots of speeches in Pidgin and we were treated like royalty. It was amazing to fly across the highlands and see the steep terrain. On that trip I really understood Mal's love of the PNG people.

Would I go back? Yes, I hope to go again and I would definitely volunteer at the hospital again. It was a special experience that will stay with me always.

BIO

Donna M. Roy graduated from the NZ College of Massage in 2008 with a Certificate in Relaxation Massage and subsequently completed a Certificate in Allied Therapies. She is also a Spiritual Healer and Reiki Master and last year qualified in Oncology Massage and Manual Lymphatic Drainage.

Donna had a practice in Lower Hutt for eight years and has had her practice "The Healing Dimension" in Christchurch for almost two years. Some years ago, she worked at Refugees as Survivors working with refugees who had experienced torture and extreme trauma. Now, Donna enjoys working with clients in emotional crisis and with those that are very stressed.

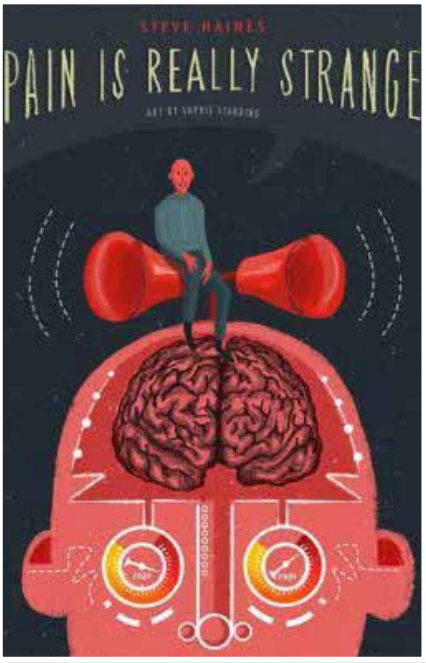
Working from home in a small private practice allows her time to study towards a BA in Religious Studies. Donna likes to travel and to make her overseas experiences meaningful.

EDITORS NOTE -

Anyone interested in making a contribution towards the clinic in Goroka could contact Donna on donna.roy63@gmail.com

BOOK REVIEWS

By Odette Wood



PAIN IS REALLY STRANGE

STEVE HAINES, ILLUSTRATED BY SOPHIE STANDING

Published by Singing Dragon, 2015

Price: NZ$16.22 (paperback) from Book Depository (free shipping)

https://painisreallystrange.wordpress.com

I came across this book when looking for pain science literature last year. Going to the website and checking out some reviews, it looked like it was a good book to have and upon ordering it, I wasn't disappointed. The book is just a small one (36 pages long), illustrated in the comic book style. But don't let this put you off. Not only is this small book visually engaging, its content is very evidence-informed, it has loads of references to good literature about pain and it really engages the reader and gets a great deal of important and sometimes complex information across in a short space. It answers questions such as how can I change my pain experience, what is pain and how do nerves work. It gives some strange stories about pain (the Olympic 400m runner who finishes a race with a broken leg), covers neurotags, the brain connection and has a very BPS approach to understanding and dealing with pain. The book is also accompanied by a very good website which has a comprehensive list of references. The author, Steve Haines, knows his stuff. He has himself been a bodyworker for 30 years working with people in chronic pain and he is an educator, teaching Trauma Releasing Exercises (TRE) and Cranial work internationally.

If you are new to learning about pain science and are after some handy resources to have in your library along with gems like Explain Pain and others in that stable, this is a great book to add. I like to have a variety of resources that I loan out to clients and my clients with chronic pain have really found this book informative and fun to read. I recommend this book to anyone new to understanding pain or grappling with the science, massage therapy students and anyone living with chronic pain.

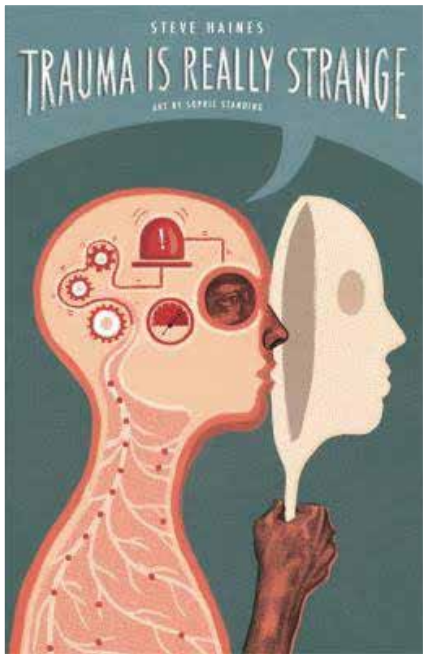
TRAUMA IS REALLY STRANGE

STEVE HAINES, ILLUSTRATED BY SOPHIE STANDING

Published by Singing Dragon, 2016

Price: NZ$14.97 (paperback) from Book Depository (free shipping)

The companion to Pain is Really Strange, Trauma is Really Strange is written in the same vein. With the same graphically appealing and evidence-informed content it looks at what happens in the nervous system and the body when we experience trauma. You might think that the topic is too serious to try and address in this way, but like its predecessor, it does it in a way that does not diminish the message or make light of trauma. Topics covered include what is



trauma and how it can change the way our brains work. It looks at dissociation, shaking related to trauma, fight-flight and freeze responses and how can we overcome it through changing the body's physiology. A thorough list of references is included at the back to direct you to further reading.

It is an excellent introduction and broad overview to trauma and the effects on the human. I also use it as a loan resource and clients that I work with who have PTSD have found it very helpful in assisting them to understand a little more about what is happening in their body. I recommend this to therapists who are beginning to work with clients with PTSD or who want to understand a little more about it. Its style will also appeal to younger clients who might be interested in reading about the topic if it affects them. It is not at the same level as books like Peter Levine's 'Waking the Tiger' or Bessel Van Der Kolk's 'The Body Keeps the Score' (both are essential reading for therapists working with clients who have experienced trauma), but it is a neat little addition to your library and certainly provides a BPS-informed viewpoint.

At the time of writing these reviews, a new addition to this series from Steve Haines was added with "Anxiety is Really Strange", also available from Book Depository.

USEFUL SITES AND PAGES

The purpose of this column is to provide readers with a list of useful websites, facebook groups and other forums, podcasts, youtube videos and webinars that are of interest to massage therapists. We aim to cast the net wider than just massage therapy – to other manual therapy disciplines, other fields of health and wellbeing from neuroscience and psychology to nutrition and movement, and other areas such business, marketing and more. Anything we find that we believe will be of relevance to massage therapists can be found here, with a brief description. We invite readers to send us links to useful sites they come across, so that other members can access a wider range of information and tools.

WEBSITES

PainScience.com
www.painscience.com

What massage therapist hasn't come across this site at some stage, either in their training or practise. Run by Paul Ingraham, an ex-massage therapist and now science writer from Vancouver, Canada. PainScience.com provides loads of information on treatment options for many common painful problems, delves into pain science with masses of articles and self-help guides. The information is very evidence-informed, continually updated and revised, readable for anyone with pain (or wanting to know more about it) and also well referenced for health professionals. Ingraham writes articulately and with humour, but he doesn't pull any punches when it comes to outdated beliefs or un(scientifically) supported 'evidence' about various forms of treatment, painful conditions and what is going on in the body. Prepare to have your knowledge and beliefs challenged and in turn become more informed.

Greg Lehman
http://www.greglehman.ca/

Greg Lehman is a physiotherapist, chiropractor and strength and conditioning specialist. He teaches continuing education courses to health and fitness professionals throughout the world on reconciling biomechanics with pain science. His site provides free downloadable resources on recovering from pain, blog posts on a range of related topics, information about the courses he runs worldwide (at the time of writing this, Greg was scheduled to teach in Auckland in late February) and links to his Youtube channel.

Pain Research Forum
https://www.painresearchforum.org/about

A free site launched by the International Association for the Study of Pain (IASP). The Pain Research Forum (PRF) is an interactive web community dedicated to finding treatments for untreatable pain conditions. The forum provides access to the latest research papers and discussions on pain across a vast range of disciplines.

BLOGS

Health Skills
https://healthskills.wordpress.com/

A blog by educator Bronnie Lennox Thompson. The blog offers health care providers thoughtful commentary and resources so they can help people with chronic pain develop their skills for living well, while respecting individual values.nce.

My Cuppa Jo
http://www.mycuppajo.com/

A blog by Joletta Belton, contributor to this issue of MNZ Magazine on the lived experience of chronic pain. Joletta shares her thoughts and insights on movement, mindfulness, nature, creativity, science, love, simplicity, pain and stress management, photography, and living an authentic life to help others living with chronic pain and provide information and a patient perspective to practitioners working with clients in chronic pain.

Trust Me I'm A Physiotherapist
https://trustmephysiotherapy.com/blog/

Developed and run by Nils Oudhuis a Physiotherapist and MSc in Manual Therapy from the Netherlands. Nils' site is mainly targeted at physiotherapists with the aim of sharing and increasing knowledge in the profession. However, it has a great deal of information relevant to massage therapists. He adds regular blog posts on a range of topics – injuries and tendinopathies, pain science, the biopsychosocial approach, health literacy and more. It's worth checking out his blog and seeing what he has to say.

FACEBOOK GROUPS

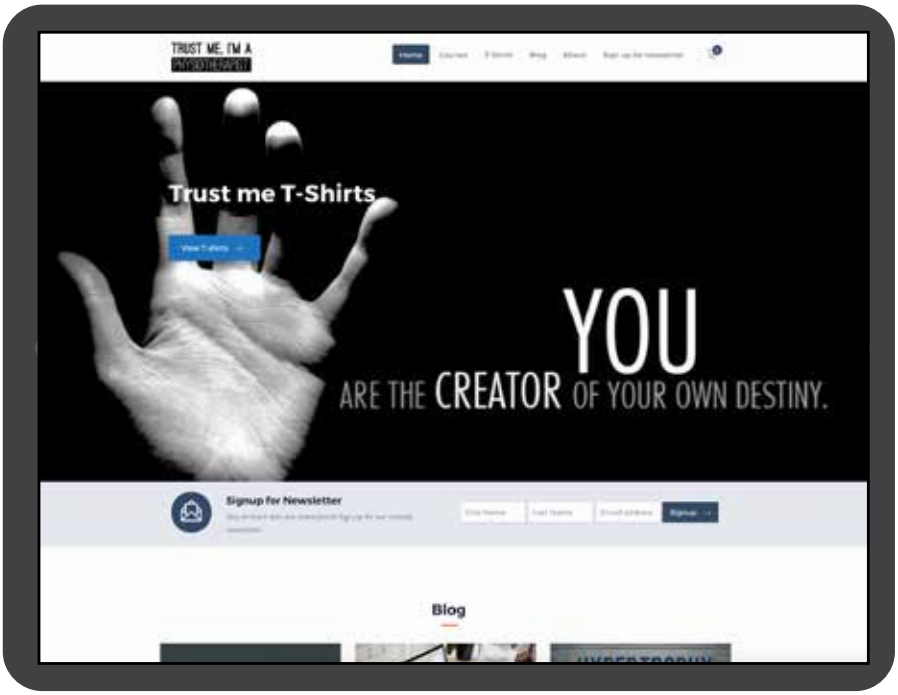
The Massage Therapy Evidence Weave: weaving evidence into massage practice
https://www.facebook.com/groups/737387403010299/

Established by Wellington Massage Therapist and MNZ member Odette Wood, this Facebook group is a forum for Massage Therapists to share and discuss international and local (New Zealand) research of value and interest to massage therapy. It is still in its infancy but members are encouraged to participate in discussion and share research and other relevant and interesting articles. We welcome more members from around the country. The group is a closed group but people can easily join by submitting a join request. Membership is only open to individuals, not groups or pages.

PODCASTS, WEBINARS AND VIDEOS

Massage Therapy Journal Club
https://www.patreon.com/ChristopherMoyer

An online interview series run by Pyschologist and Massage Therapy researcher Christopher Moyer, discussing specific research articles with a featured guest. Links to the article being discussed are provided in each episode link and there is a Youtube link to the interview itself. The journal club sessions unpack research articles of relevance to massage therapy in a way that helps massage therapists to better understand research.



Brain Science with Ginger Campbell MD
https://www.podbean.com/podcast-detail/2h53s-2ef61/Brain-Science-with-Ginger-Campbell-MD-Neuroscience-for-Everyone-Podcast

We came across this podcast series recently and it has some very interesting podcasts on it. The series explores how recent discoveries in neuroscience are unravelling the mystery of how our brains make us human. Of particular interest and relevance to massage therapy are the ones on placebo research, interoception, pain and neuroplasticity.

MASSAGE THERAPY RESEARCH UPDATE

January 2018

Welcome back to another Massage Therapy Research Update. For this edition, the editorial team at Massage New Zealand asked me to focus on the biopsychosocial (BPS) model of pain, and relevant research for massage therapists.

I am happy to comply because this is a fascinating topic, but from the outset I must offer the caveat that research specifically on massage therapy in this context is thin. However, some of the pioneers in the field of the BPS model of pain are in a closely connected profession—physical therapy—and their findings have implications for our work as well as theirs.

Before we dive into the articles I have highlighted for this discussion, let's take a look at this term, "biopsychosocial" and how it applies to the experience of pain.

BIO

It's exactly what you think: it has to do with the physical body. Pain is often a response to an initial injury or other pathological change in tissues. But perceptions of pain may outlast any damage. Followers of the BPS model have a legitimate concern that many conventional medical providers only look as far as biological contributors to pain, and this leads to incomplete, and often unsuccessful treatment. However, it is also possible to "throw the baby out with the bathwater" and prematurely dismiss the biological aspects of pain—which also leads to incomplete treatment.

PSYCH

This refers to the mental and emotional state of the patient, along with their belief systems and expectations of outcomes. We know that pain—acute or chronic—changes the ways we think and feel about our world and our place in it. Our mood impacts our experience of pain, and pain impacts our mood. In the right circumstances our mood states can perpetuate the experience of pain. Without addressing a person's mental and emotional state, any attempt to treat pain—especially chronic pain—is not likely to be successful.

SOCIAL

And finally we see that a person's social connections also have profound impact on their experience of well-being (or lack thereof). The social part of the BPS model addresses a person's sense of support—from family, friends, colleagues, and their health care team. We see that an experience of chronic illness or pain can be damaging to relationships. People with health challenges may become increasingly isolated, which means they are also less likely to take care of themselves in ways that promote their recovery.

All in all, the biopsychosocial approach recognizes that a person's experience of pain is the product of their physical state, their mental, and emotional situation and belief systems, and their sense of connectedness in their community and culture. The experience of pain is attached to personal interpretation and meaning. Health care providers who do not address this whole-person approach to pain management are short-changing their patients.

Does any of this sound familiar? Those of us (like me) whose involvement in the massage therapy and bodywork field dates back a few decades, might recognize that the biopsychosocial approach to pain and health has a lot in common with the holistic health approaches that emerged from the human potential movement of the mid 1960s. In those days we talked about the "body-mind-spirit" triad, and mind-body integration (as though those two entities could possibly be separated). The BPS approach is not a perfect match to the body-mind-spirit paradigm, but there are enough overlapping concepts that to a geezer like me it looks like a case of "everything old is new again."

I don't say this dismissively—I am thrilled to see awareness of the BPS model begin to infiltrate massage therapy practice. Think about it: we spend an hour or more touching our clients' bodies; they trust us to create a space where they feel safe, and they expect to enjoy their experience; and although our boundaries about personal relationships must be tended with care, we inevitably become part of their social support network. **It's as if the BPS model was developed**

by describing massage therapy practice! I encourage us to learn more about this approach so that we can apply it with purpose instead of haphazardly by accident.

In this column we will look at three articles that provide some context for the BPS paradigm. We will begin with an article co-written by one of the earliest pioneers in pain science, Ronald Melzack, who reviews the history of how we have tried to explain pain, and then describes the neuromatrix theory. This sets up the biopsychosocial model of pain management.

Then we'll look at a description of a study that is currently underway that is comparing two biopsychosocially-informed methods of helping people with non-specific chronic low back pain: one method involves one-on-one highly individualized sessions of an approach called cognitive functional therapy, and the other is non-individualized group classes with pain education and exercises.

Finally, we'll look at a paper that outlines specific recommendations for how we can best educate our clients with chronic pain: it is essentially a best practices guideline for teaching clients about their situations.

MELZACK R, KATZ J. PAIN WILEY INTERDISCIP REV COGN SCI. 2013 JAN;4(1):1-15. DOI: 10.1002/ WCS.1201. EPUB 2012 OCT 4.

NOTE: Reading this article is a lot like eating a whole cheesecake: every bite is delicious and rich, but after a while it becomes hard to take any more in. I will provide some highlights here so that readers have some context when you're ready to undertake the whole article, which has much more to offer.

The authors begin with a brief history of pain science, beginning with Descartes and the development of a concept they call specificity theory.

Specificity Theory: In this concept, which was prevalent in medical thinking up to the mid 1960s, the assumption was that an injury activates peripheral pain receptors and fibers. These project signals to the spinal cord, and then up to a "pain center" in the brain. The brain's role here is to be a passive receiver of information. But the specificity theory leaves much unexplained, including that there's no such thing as a single "pain center"; the central nervous system is plastic and adaptable; and it doesn't address phenomena where pain appears to be not connected to tissue damage (think of phantom limb pain in amputees, for instance).

Gate Theory: In 1965 Melzack proposed a new idea about pain. He suggested that transmission of nerve impulses from afferent (sensory) fibers to spinal cord is modulated at the dorsal horn by a gating mechanism. He found that large diameter afferent fibers inhibit (close) the gate; and small diameter afferent fibers facilitate (open) the gate for pain sensation. This understanding led to some new pain treatment options focused on spinal cord transmission of signals, including the invention of TENS units for pain control.

The gate theory cleared up some questions about the experience of pain, but it wasn't yet a complete explanation. Melzack continued to work and eventually developed the neuromatrix theory.

Neuromatrix Theory: To begin to understand the idea of the neuromatrix, first we must let go of the idea that pain is a sensation. Pain is a response to a message from nociceptors about the possibility of damage.*

Melzack and Katz describe the neuromatrix as a network of neuron loops between the thalamus, cortex, and limbic system. These loops are repeatedly activated, creating some predictable patterns or neurosignatures in sensation. This network is genetically determined, but sculpted by a history of sensory inputs.

In this model, input (i.e., incoming sensory information) is a trigger for interpretation, but the source of the interpretation is the brain. The neuromatrix allows us to be aware of many sensations all at once, and it allows us to respond to those sensations through multiple pathways.

In short, the neuromatrix theory suggests that our experience of pain (and other sensations as well) is multifactorial: it is the culmination of sensory inputs as looped through several areas of the brain to compare and derive meaning, and to provide interpretation. For people with chronic pain, this means their pain may feel like it arises from their fragile spine, or arthritic knees or even amputated limbs, but in fact it is being generated entirely in the brain. And if they can learn some new coping mechanisms, which incorporate the biopsychosocial approach, then that pain changes its quality and its meaning: it can become something other than debilitating.

So what is the best way to apply the neuromatrix theory and the biopsychosocial approach for patients with chronic pain? This team is conducting a comparison of two BPS approaches:

O'KEEFFE M, PURTILL H, KENNEDY N, ET AL. INDIVIDUALISED COGNITIVE FUNCTIONAL THERAPY COMPARED WITH A COMBINED EXERCISE AND PAIN EDUCATION CLASS FOR PATIENTS WITH NON-SPECIFIC CHRONIC LOW BACK PAIN: STUDY PROTOCOL FOR A MULTICENTER RANDOMISED CONTROLLED TRIAL. BMJ OPEN 2015;5:E007156. DOI:10.1136/BMJOPEN-2014-007156

This article describes a clinical trial that is currently underway. The authors are comparing two different interventions (both of which incorporate principles of the biopsychosocial approach to pain management), to see which might be superior.

Patients with non-specific chronic low back pain who met specific inclusion criteria were recruited at three physiotherapy facilities in Ireland. If patients chose to be involved, they were randomised into one of two groups: the primary intervention group and the control, or usual care group.

The primary intervention group (n= 107) received individual one-on-one sessions with a physiotherapist using an approach called cognitive functional therapy, for a customized length of time, depending on the needs of the patient.

**For a truly wonderful exploration of the difference between nociception ("harm alarms") and the experience of pain, I recommend that readers view this TED Talk by Australian neuroscientist Lorimer Mosely: https://www.youtube.com/watch?v=gwd-wLdIHjs.*

Cognitive functional therapy is a patient-centered intervention that addresses multiple factors that are recognized in a biopsychosocial approach to pain. It is highly customized to each patient, helping them to find pain and movement solutions specifically designed for their activities of daily living.

The control or usual-care group (n = 107) attended a series of six classes over 6-8 weeks. Each class included 30 minutes of education, 40 minutes of exercise, and 5 minutes of relaxation. Educational topics included current pain science, the multidimensional nature of chronic low back pain, common myths about chronic low back pain, and others. Exercises included step-ups, squats, jogging in place, lumbar flexion and rolling, and others. Patients were encouraged to move at their own pace, and to do the exercises on their own once a day.

Measures of both groups were taken at baseline, at the conclusion of the intervention series, six months later, and again twelve months later.

The authors in this study are especially interested to compare patient reports of functional disability (in other words, can the person do the things they want to do?) and pain intensity, as averaged over the preceding week. In addition, they want to track expenses, including treatment and tests, hospitalisations, medications, special equipment, employment status, and work absenteeism.

All of the data will be self-reported by the patients, and analysed by blinded assessors who won't know which arm of the study each patient was enrolled in. When it is completed, this will be the first randomised controlled trial to compare cognitive functional therapy with a combined education and exercise class for people living with chronic low back pain, and if there is a clearly superior approach for patient outcomes and costs, that will influence future treatment recommendations.

One of the resources made available to everyone associated with this study is www.pain-ed.com. The mission of this website is to inform the public and health care providers about the latest pain research, and the vision is to bridge the gap between the science and clinical practice in musculoskeletal pain. It has blogs by patients and providers, patient education videos, and an enormous amount of easily accessible information on pain science. Full disclosure: some of the organizers of this website are also authors on this paper.

Our last article takes some of these concepts and puts them into practical application with guidelines for educating patients about their pain and what they can do to cope with it. This article is targeted at physical therapists, but some lessons here are valuable for massage therapists as well.

NIHS, ET AL. HOW TO EXPLAIN CENTRAL SENSITISATION TO PATIENTS WITH 'UNEXPLAINED' CHRONIC MUSCULOSKELETAL PAIN; PRACTICE GUIDELINES. MANUAL THERAPY 16 (2011) 413-418.

This article makes the case that many cases of persistent musculoskeletal pain indicate some changes called central sensitisation. This is a complex situation, and I think this is one of the most succinct and clear explanations that I have seen. In a nutshell, central sensitisation is:

> "Chronic musculoskeletal pain characterized by alterations in CNS processing: the responsiveness of central neurons to input is augmented, resulting in ... generalized or widespread hypersensitivity."

In other words, in central sensitisation the central nervous system changes the way it processes incoming signals. It is more likely to interpret inputs as pain, *even without tissue damage*. In addition, the perceived painful field becomes less and less specific—the pain appears to spread. Further,

> "Once established... any new peripheral injury may serve as a new source of bottom-up nociceptive input, which in turn sustains or aggravates the process of central sensitisation."

But, the authors note, it is difficult to put this understanding into practice. Patients often have a concept of what causes their pain that is both inaccurate and scary—who wants to exercise or engage in fun activities, if they envision their disc "slipping" out of place, or "bone on bone" in their knees? In at least some of these cases, healthy pain perception, which induces us to rest while the tissues heal, has become dysfunctional. The pain perception is real, but it is no longer related to specific musculoskeletal tissue damage. And to recover from this type of pain takes more than rest and painkillers; it takes relearning how to move, coming to a new understanding of what pain signals mean, and assigning them the significance they deserve (which is probably less than what they're getting). All of this allows patients to reduce their rumination on pain, to lessen their catastrophisation of their experience, and it promotes their adopting new activities and setting new goals that can be achievable with patience and knowledge. (Can we see a role for massage therapy in here?)

The link to the biopsychosocial approach in this tactic is that patients must develop a new understanding of their physical experience. The meaning of their pain is being misinterpreted (that's the psycho- and -social parts of the picture), and they must develop some new coping strategies.

Nihs et al. outlines a specific educational program with at least two one-on-one sessions and some homework for the patient to complete. The topics covered in this educational program include...

- Acute vs. chronic pain
- Purpose of acute pain
- How acute pain originates in the central nervous system
- How pain becomes chronic
- Sustaining factors of central sensitisation

They created this program based on data regarding patient education best practices. It culminates with a plan of action for dealing with a hypersensitive nervous system, and adaptive coping mechanisms.

Again, the program described in this article was developed for physical therapists, and there are some aspects that are outside most massage therapists' scope of practice. That said, I think we can find a lot of value here in looking at the emphasis on stress reduction and coping skills for people who are challenged by chronic pain. If we are careful with our language and our technique, we can definitely contribute to a happy outcome for our clients who live with this issue.

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,

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WHAKATAUAKI – MAORI PROVERB

by Stanley Williams (Iwi Liaison)

"Tama tu, tama ora; tama noho, tama mate."

He who stands lives; he who sits, perishes. – Maori whakatauki (proverb).

When you get up in the morning, think of what a priceless privilege it is to be alive – to breathe, to think, to learn, to love – and then make the day count! This whakatauki enunciates perfectly Maori whakakaaro (understanding) when it comes to hauora or health – physical, mental, social, environmental, intellectual and spiritual.

Having observed over the years, it seems the more a person is inclined to offer gratitude in each of their areas of health, the less likely they are to be depressed, anxious, lonely, envious, or unbalanced.

Bottom line: Consider how very fortunate you are. Consider it every morning. The more you count your blessings, the more blessings there will be to count, and the happier you may be.

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