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Breaking news! Breaking news!

How did we get here?

From Mel Cash

The beginning

Our journey began in September 1989 when LSSM started the first Sports Massage qualification in the UK. It was based on the first book on Sports Massage I had authored and had published the year before. It was a six-month course, and although it was called 'Sports Massage', it already included some advanced techniques such as Muscle Energy Technique and Soft Tissue Release. It was also the first externally validated qualification of its kind.

In those days, Sports Massage was a good fun job and we were kept very busy because there were not many of us around. But that soon changed as other schools jumped on the bandwagon, still teaching basic routine massage but with a bit more 'force', and then calling that 'Sports Massage'. So there were more and more therapists chasing the same amount of work. We were also realising that although it was a fun job, because clients mostly wanted treatments in the evenings and weekends, this wasn't giving us such a good personal lifestyle.

From 'Sport' to 'Remedial' Massage Therapy...

As Sports Massage Therapists, we were not trained to treat injuries, but this wasn't stopping injured clients turning up for treatment. LSSM were the pioneers of this new profession while we were still learning and developing our clinical skills. To be able to treat injuries, we were told we had to become Physiotherapists, Osteopaths or Chiropractors, but our injured clients had often been to see these therapists already, yet had not found their treatment effective (not to imply that these therapies don't work, just that they don't always work). So why should we have embarked on training in the same way, only to fail the same people? We needed to find our own solutions.

We further developed our clinical skills so we could better meet the needs of the injured clients who were coming to see us, and with this we found ourselves achieving better results with a broader range of musculoskeletal problems. This opened our doors to a much wider clientele, with more and more non-sports people seeking our help. This was also offering us a much better lifelong career potential. So, in 1995 we extended the course to nine months (ten classroom weekends), with more advanced clinical skills and we re-named it 'Sport & Remedial Massage' (BTEC Level 4).

'Soft Tissue Therapy'

The dawn of the 21st Century brought further changes, with financial pressure on the NHS making it less able to fund treatment for minor and chronic musculoskeletal injuries. At the same time, there were also changes in the way Physiotherapists were being trained, with reduced focus on hands-on skills and instead, greater emphasis on 'exercise prescription'. And with fewer referrals from the NHS, this resulted in less accessibility to treatment for minor and chronic injuries. So people with these problems were finding it harder to find good, effective treatment.

In response to this, we continued to develop the Diploma Course qualification, and in 2008 extended it to a one-year formula (twelve classroom weekends) and BTEC upgraded it to Level 5. Since then, we have further refined it with additional assessment, treatment, and rehabilitation subjects, and in 2015 the qualification was renamed 'Soft Tissue Therapy'.

This new title more accurately reflects what we now do, because we are no longer defined by the word 'massage'. We use an extensive range of alternative handson techniques and, when necessary, can perform highly effective treatments without using any 'conventional' massage strokes. We also include a lot more exercise, movement, and active lifestyle advice. We now offer a new level of therapy that can successfully address a wide range of physical issues for people of all ages and from all walks of life.

So where do we go from here?

Our Soft Tissue Therapists are now the only ones in the UK who are adequately trained to treat minor and chronic injuries using this range of advanced hands-on methods. Gradually more and more of the general public should recognise this and be able to benefit from it. Doctors who see patients with these injuries have limited options within the NHS. Most are aware that a long wait to see a Physiotherapist who is exercise-orientated and offers limited hands-on treatment, if any, may not be the best answer. They should be encouraged to consider referring these patients to our Soft Tissue Therapists, who have both the time and the skills to provide the best care for them.

Shaping the future – our collective and individual responsibility

What we need now is a sustained and widespread effort in raising awareness, through as many media channels as possible. Only we, with our knowledge of the profession and our long-term future at stake, can deliver this. We all need to 'spread the word' – through delivering treatments of the highest quality, and promoting the benefits of our profession. Virtually everyone in society suffers with minor and chronic injuries from time to time and they need to know that we are the only therapists out there now who are trained to treat them effectively with traditional hands-on skills.





Editorial

From Tanya Ball

Welcome...

A very warm welcome to all to our December 2018 ISRM Newsletter. A special welcome to any new students or graduates for whom this is their first Issue. We hope that you will find this publication informative, beneficial, and inspiring enough to contribute a story/article in the next edition!

For the benefit of recent members and anyone who might have missed the happy news, here it is again!



In this Issue...

New features alongside existing ones in the following pages will, I trust, add further variety and interest to the already broad range of contributions in this edition.

With LSSM having reached its 30th birthday, **Mel Cash** has dedicated his page, not so much to **'Breaking News'**, as to a first-hand account of the School's eventful history, from its humble beginnings to the firmly established training provider it has become today. The story demonstrates how LSSM has had to adapt and at times re-invent itself to retain its reputation as a pioneer and proactive and leading force for the profession.

Obituary: we pay tribute, immediately below this Editorial, to Leon Chaitow, one of Complementary Therapy Research and Practice's greatest pioneers and mentors, who sadly passed away last September. **LSSM Southampton on the move!** After fifteen successful years of high quality delivery of the LSSM STT Diploma course in Southampton University's Health Sciences building, the course relocated to the same Department's new premises 'just down the road' in September 2018. Details and photos of the superb new venue feature below, just ahead of the Feature articles section.

Feature articles include **Jon Tilt's** heartwarming story of his experience of a family reunion in Nepal, and first-hand account of receiving Soft Tissue Therapy from LSSMtrained local Therapist Ramji, from the charitable project Seeing Hands Nepal.

Having graduated over four years ago, **Tanya Boardman** tells of her exciting but at times testing transformation from 'student' to 'professional therapist', sharing valuable tips, ideas, and her 'can-do' attitude that should encourage and inspire any recent graduates or those perhaps a little apprehensive about resuming the profession after a break.

Another therapist with entrepreneurial flair, **Sue Wells**, narrates how a prestigious career in the Ballet world and her fascination for human movement eventually led her successfully to completing her BTEC L5 Diploma qualification in STT, and then discover the potential and appeal of Manual Lymphatic Drainage or MLD. Her story continues with her successive qualifications in Levels 1-3 in MLD, which enable her to work with severely affected lymphoedema or lipoedema patients, including NHS referrals.

Event Work: As always, readers can catch up on and draw inspiration from 2018 sports events supported by onsite ISRM volunteer soft tissue therapy teams. These include first-hand accounts of the 2018 London Marathon and of the inaugural London Landmarks ½ Marathon. A big thank you to **Sarah Dunkley** and **Libby Palmer** for these. A selection of photos from various participants reflect the buzzing atmosphere and range of emotions of these events. A huge 'thank you' as always to all who helped, sometimes stepping in at short notice and/or personal inconvenience, on these occasions.

New feature: 'Research Development and clinical practice': I very much hope that by generating thought-provoking contributions from anyone keen to ensure our patients and clients consistently continue to benefit from the latest clinically relevant research findings, this page will become a regular Newsletter item going forward. It has been germinating in my mind for considerable time, so I am delighted that it is finally appearing in print.

Ian Pollard, who attended the recent 5th International Fascia Congress in Berlin (14th-15th November 2018), has been given the honour of authoring the inaugural article for this section, followed by 'Part 1' of a long overdue paper from me summarising the evidence as to why, contrary to what virtually every textbook would have you believe, *psoas major is NOT a hip flexor...*

Expand your knowledge, enhance your skills (CPD): Details of various 2019 CPD (Continued professional development) opportunities can be found in this section. These include a range of workshops mostly in London, Dorset, and north Hampshire, and as previously, readers will be notified of further courses and workshops in subsequent Newsletters and/or by group email as and when appropriate. A short reflection from Mel Cash on how 'A good career needs a good investment' completes this section.



Those considering Soft Tissue Therapy 'Tools' or 'Instruments' – whether to spare their hands of for other reasons – may be interested to read Chartered Physiotherapist Chris Gordon's introduction to Instrument-Assisted Soft Tissue Mobilisation (IASTM) for STTs.

Reminder – Good news for all ISRM Members!

May I draw everyone's attention to the various special offers/discounts to both students and full members, displayed on the inside or outside of the back cover of this Issue:

- Health Education Seminars (HES) postgraduate courses/workshops: £20 off one-day and £40 off twoday courses
- ✓ *Marshcouch*: 10% off all couch orders
- Physique Management Company: 10% off sports injury treatment and massage products

Obituary

Au-revoir to a 'Gentle Giant'...

I am sure that those of you who knew him personally or through his prolific publications will share my deep sadness at the news that Leon Chaitow passed away last September. I thought that no tribute to him could equal or surpass that of his dear daughter Sasha, which is reproduced below.

Besides hearing him present at a various clinical / research conferences and other events over the years, I was most privileged to attend an entire Module entitled 'Advanced Soft tissue Techniques' led by him in person as part of my MSc in Complementary Therapy – Bodywork Pathway (back in 1998-99!), and he was my intermittent editorial 'boss' in relation to reviews and/or publications in the JBMT (Journal of Bodywork and Movement therapies).

To me (and no doubt many), Leon will always be fondly remembered

 ✓ Journal of Bodywork and Movement Therapies (JBMT): 15% off annual subscriptions.

*** Newsletter contributions – please get writing *now*! ***

My most grateful thanks to all contributors to this Issue, some of whom I know dug very deep into their limited 'spare' time to enable the rest of us to benefit from their insights. Going forward, I am appealing to each of you not to leave it to 'somebody else' to make the effort. Consider how much you have gained from others' tips, knowledge, and experience, and make sure you return the compliment by sharing yours in the next Newsletter. *Please get writing now! Thank you!*

<u>Please note that the submission</u> <u>deadline for the spring 2019 Issue is:</u> <u>Friday 17th May 2019</u>, thank you.

as a 'Gentle Giant' in personality, wit, disposition, and stature, as well as a phenomenal mentor and inspirer as a clinician, tutor, speaker, adviser. For all his exceptional knowledge and skills, he would display warm, reassuring open-mindedness to other views, interpretations, suggestions, one of his staple replies having been, "Try it and see!" His presence and inspiration shall live on through his abundant publications.

Tanya Ball



Leon Chaitow (7 December 1937 – 20 September 2018)

It is with great sadness that I must announce that after a long and uneven battle fought with courage, strength, and the humour that those who knew him were privileged to enjoy, as of September 20th 2018, Dr Leon Chaitow is no longer with us. Since early 2018 he found himself in failing health. Nevertheless, in that Please keep sending your newsletter contributions to me at: editor@theisrm.com

ISRM Newsletter format – reminder

For the benefit of our new Members, please note that our 'mid-year' newsletter editions are published online only, followed by an extended hard copy as well as e-format for the December Issue. Any nonobsolete material from earlier electronic editions of a given year is reproduced in its end-of-year printed issue.

Members can access previous newsletters online dating back to the spring 2009 edition. A very grateful 'thank you' to ISRM website manager Martin Docherty for his continued efforts in making our website ever more user-friendly and informative, and to Glyn Rees of QP Printing for his high quality and creative design.

time, he was able to complete his last book, Fascial Dysfunction 2e, soon to be released by Handspring Publishers, and made arrangements for editorial succession of JBMT. For those who knew him well, in the words of Dylan Thomas, Leon raged like few against the dying of the light and did not 'go gentle into that good night.' He died at home, in the arms of his beloved wife Alkmini and daughter Sasha, and now lies in the British cemetery in Corfu. In truth Leon is not gone. His legacy lives on in his many books and articles, in the students he taught, in the patients he treated, and in the family to whom he was a most beloved husband and father whose loss will never fade. The greatest way to honour him is to continue to carry that torch and pass on the spirit and essence of his work. It is with great honour and pride that I, for one, shall do so. Arrangements are being made for a memorial service in London in coming months.

Sasha Chaitow PhD, 21 September 2018



Southampton's LSSM course moves to enviable contemporary premises!

From Tanya Ball



Fifteen years ago...

The inaugural Southampton-based LSSM Diploma Course in Soft Tissue Therapy (STT) was launched in autumn 2003, under the coleadership of my exceptionally wonderful, multitalented friend and colleague Sarah Tidey and me. Since those early days of expansion of the London School, demand for high quality training in STT along the South Coast has steadily risen, resulting in over fifteen successful years of us virtually consistently running two Diploma courses per annum, plus associated Introductory Module, First-Aid, and a range of CPD including Taping workshops.

Among the critical factors which, from the onset, enabled this project to thrive, was the University of Southampton's agreement to lease us their Health Sciences Department's facilities housed in 'Building 45' and used on weekdays by the School of Physiotherapy, Occupational Therapy, and Podiatry. This provided spacious rooms readily equipped with some 14-16 hydraulic couches, chairs, low tables (ideal for towels, lotion, anatomy manuals, and course notes), not to mention an abundance of 3-D models, from individual bones to complete skeletons, via flexible spines, peripheral joints, dismantlable body structures and organs, and so on - a perfect tutors', students', and occasionally tutor's kids' (supervised) playground!

You win some, you lose some ...

As a (sadly nowadays mostly former) London tutor, I have remained aware of and grateful in equal measures, for the privilege of <u>not</u> having to negotiate wheeling carts piled high with portable couches or bags of bolsters and towels through double fire doors and round sharp corridor corners, before more often than not humping equipment upstairs on Saturday mornings, and reversing the process on Sunday evenings! Yet I am delighted to stress that our lovely fellow London tutors and students have been 'getting their own back' in other important ways including:

- ✓ Regent's College's boasts an incomparable setting with the glorious surroundings of Regent's Park with its beautiful river, stunning and impeccably maintained 'Queen Mary's Gardens', vast acreage of mature trees and green spaces, Botanical and Zoological Gardens, and largest outdoor sports facilities within the Capital. In contrast, our 'Building 45' is surrounded by... an unattractive, bland car park devoid of any seating facilities, with a busy and noisy trunk road immediately in front of the site.
- ✓ Regent's college offers a well-appointed cafeteria with ample seating both indoors and out for socialising, while to date we in Southampton have merely been

able to offer students (complimentary) hot drinks from our own hot water urn inside the classroom (supplemented with biscuits from the corner shop – aaah – we are so kind...).

✓ Lastly, instead of Regent's College's efficiently manned turnstile entrance system, security regulations have meant that to date, we have invariably needed to call Security to open/disalarm the building for us each morning and secure it each evening. We have also been responsible for keeping the revolving access door in the lobby bolted throughout the day when unmonitored − causing disruption and logistical inconvenience when students arrive late or find themselves inadvertently locked out at the end of a lunch break!

All change!

Earlier this year, we were advised by the University that the Health Sciences would be relocating to another near-by building from September 2018 offering improved facilities after considerable refurbishment. The question was whether LSSM wished to continue the leasing arrangement under a new contract, which I privately interpreted to mean 'at a higher rental fee'. After consultation with Mel Cash, we confirmed our keen desire to pursue the proposal, and various logistical discussions, financial negotiations, and planning took place over the summer. A mutually satisfactory leasing rate was agreed, and the move scheduled for the third week of September 2018 – subject to building work keeping on schedule.

Fast-forward to Wednesday 19th September, when I met our faithful University administrative contact William and ever-helpful and resourceful caretaker Allan, who showed me around the freshly completed and decorated new venue (permeated by a strong smell of emulsion!). With great excitement, Sarah and I then welcomed our first group of students –



30SA, Weekend 2 – to Nightingale House (Building 67) on Saturday 22nd September. If the previous facilities had already been excellent, our new home, which we knew very little about beforehand, surpassed our expectations in numerous ways, offering:

- ✓ Two large rectangular 'practical skills' rooms, wide enough to accommodate two rows of couches perpendicular to the long walls, plus a generous corridor between them – ideal for placing a bed for demonstrations.
- ✓ One long wall comprised a continuous row of windows, maximising natural light.
- ✓ A heavy-duty shelving unit against the short wall nearest the door enables tutors and students to store clothing and bags, leaving the working space refreshingly uncluttered (well, *in theory* at least...).
- ✓ To our delight, a well-equipped kitchenette with 'hot water drinking tap'

(making the need for our urn redundant), microwave, fridge, a few tables and chairs, all of which help keep food and drink within the classroom to a minimum (though we often save teaching time by continuing theory or demo sessions while people finish sipping their drinks – draconian tutors that we are!).

- ✓ A further refectory room with ample seating is available adjacent to the kitchenette, ideal for private tutor mini meetings, one-to-one talks with students, phone calls, etc.
- ✓ As previously, all onsite parking is free of charge at weekends, there is a selection of small grocery shops and cafés within under five minutes' walk.

We still depend on Security to open up the building for us in the morning, but have established an excellent rapport with them over the years, and their office is now literally just across the road from us, which minimises response time. Once dis-alarmed, the building is accessed and exited by simply pressing a pad controlling the automatic door. No more stranded students, and no more text messages to tutors followed by disruptive trips down to the door and back again!

All in all, students and tutors alike are delighted with this positive new chapter in the life of 'LSSM-Southampton' and I am sure that each of our invaluable team of tutors – Vicky, Jo, Gisela, Garry, Steve, and Peter, as well as Sarah and I, look forward to providing ever-higher quality training in STT at our superb venue. *So here's to the next even more successful fifteen years!*

Feature Articles

Four years as a Soft Tissue Therapist

From Tanya Boardman

"You can't connect the dots looking forward; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future." – Steve Jobs

Four years on...

I qualified as a Soft Tissue Therapist on the LSSM Diploma course in 2014, having studied at Southampton, and I have found it useful to reflect on what has happened since.

Firstly, a look back at what I was doing and why I joined the course: I had a full-time job in university administration and wasn't particularly looking for a new career. I had experienced sports massage as an athlete (mainly running) but hadn't thought seriously about whether I could deliver it myself. I had booked myself on the Introductory Module weekend and found out that most people I met there were already signed up for the full Diploma course. Hmmmm! They seemed like a nice bunch, I'd enjoyed the weekend – what was there to lose? And what am I doing now? I'm fully selfemployed, and delivering soft tissue therapy for about 10 hours a week (amongst other things*). How did this happen? Well – there were a series of small steps that got me here.

Growing my business step by step...

Baby step 1: At around week 5 into the Diploma course, I realised that I needed to up my practice hours. I signed up to help at an event. It happened to be a 24-hour running event, but I met some great therapists that still help and inspire me to this day. And I earned some money!

Baby step 2: Around week 9 into the Diploma course, I was becoming aware of all the opportunities that being a Soft Tissue Therapist (STT) could offer, and in a lightbulb moment I realised that the only thing stopping me from making a good go of this was my job. I pretty much decided there and then to see if I could reduce my hours to part-time to find more time to explore massage therapy as a career. It took some negotiation,

but I agreed to work 3 days, giving me 2 days (plus weekends) to develop STT or explore other things.

Baby step 3: I continued with event work and began spreading the word amongst friends and family. Shortly afterwards, I saw an advert for a newly qualified therapist to join a clinic. Perfect! I called up and we arranged a time for me to give a demo treatment (when I think I was more nervous than for my practical exam!) and I got the job.

It was a slow start due to my time availability, as I was still sorting out my part-time hours, but it was a start, and we had a plan to increase my hours during the week with the option of some weekend work as well.

Over the first few months, bookings were a bit sporadic, but after my first appointment (a 30 minute session for neck and shoulder tension), they slowly built up. My confidence increased ("this may take longer than a single session to improve"; "would you like to book another appointment?") and soon I had my first repeat booking. Having said that, I still



think it took me about eighteen months to be confident of a regular client base, which I'm pleased to say, has continued to grow. I still do event work at running, cycling and triathlon events and my clients include stressed office workers, elite runners, trainee dancers and a stunt man! Not knowing quite who's going to walk through the clinic door is one thing that keeps it interesting and keeps me learning.

I'm particularly reflecting on my journey now, because it feels a little like I'm starting all over again, as I recently started working in another clinic. I'm back to regular checking of the team calendar, and trying not to sound surprised when clients book again. And gradually, like the first time, it's growing.

My top eight lessons for success:

Asked to capture my top eight lessons learned, this is what they are:

 Can you make money from it? I was asked this countless times during my training and in transitioning to make Soft Tissue Therapy more of an income generator for me. It may not be an immediate source of riches, but there's an ever-expanding client base that you can tap into with application and effort. It is also flexible, enabling you can to expand or restrict your working hours to suit your needs.

- Don't take it personally if people don't re-book or if they cancel an appointment (especially if they haven't even met you yet). There will be other clients and it isn't personal – people are simply busy and have changing priorities.
- Tell people what you do, when you do it and where you work. The most surprising of contacts can become champions for you and a word of mouth recommendation is priceless.
- 4. Consider partners/collaborations/ joining an existing clinic. It is good to have the reassurance of a team around you, even if you don't actually see them very often because you're all working out of the same room, but at different times. Working at events, or for sports teams, all help in remembering that you're working for yourself, you're not alone.
- Keep up with CPD this keeps things fresh, gets you meeting other therapists and helps you to treat your clients better.
- 6. Look after yourself. Remember the ideal posture, get a treatment yourself, or book in some down time between clients to eat and drink. There's a strong tendency, especially initially, to "people-please", which leads you to work anti-social hours, travel long distances and exhaust yourself. Try to stop doing this as soon as you realise you are doing it!

- 7. Learning the techniques of soft tissue therapy is just the start. You can learn about starting a business, efficient administration, excellent time management, social media management, marketing, public speaking and the logistics of setting up and running your own clinic. You may already have these skills, and you may not want to use them or learn them and that's just fine – you can do things your way.
- Keep up membership of ISRM you can get various discounts, keep up with the latest industry news, and it can be a way to gain clients as some health insurers insist on using a registered therapist.

"All you need to do is..."

If you join the dots looking backwards, it all seems obvious and pre-determined, but looking forward, it most often feels like you need to make giant leaps to get anywhere. Finding a little bit of courage to try the smallest "something new" is all you need to do. That's how we all got started.

*In my "amongst other things", I run a small consultancy company and I coach people wanting to start or grow their business. I would be delighted to offer some mentoring slots to ISRM members who are feeling a bit stuck or who have lost their way in developing their therapy business.

Finding calm in the chaos

From Jon Tilt - Soft Tissue Therapist (in training!)



I've been back home from my trip to Nepal for nearly a month now, and I'm still trying to find words to describe it. Chaos, hustle, bustle, dust, rain, humid, and loud all spring to mind, and at the same time, calm, gentle, and beautiful. How can that be?

A country where cows wander unbothered across busy streets, where scooters whiz through crowded pavements tooting at anyone in their way. Where pedestrian crossings appear to be advisory, traffic signals non-existent, and police risk life and limb in the middle of the road dispensing arbitrary hand signals to passing motorists.

Then you stumble across a World Heritage site, the most ornate temple or palace, or a vibrant market full of colour and wonderful smells. You watch for a moment the locals, carrying huge loads on their backs, getting on with life, and realise that it just is what it is and for some reason it works.

It was a late decision to travel to Kathmandu to see my sister Sophie and her family, and





picking the monsoon season probably wasn't the smartest idea. A chance discussion with my daughters over Father's day brunch ended with us booking to meet for a week. My sister, who has worked for various NGOs around the world and currently works for Marie Stopes, was surprised at the speed we arranged everything, especially as she had been encouraging us for the past few years to come out.

For me personally it was more than just a trip abroad. Having lost two very special people in the past two years, my wife Liz to breast cancer, and my new partner Judy to the effects of an auto-immune illness, this was my first chance to look to the future and start thinking about what the rest of my life might hold. Pretty heavy stuff really!

Arriving after a fourteen-hour trip in the pouring rain didn't appear to be a good omen, but luck was with us and despite it being in monsoon season, the weather was good for most of the time.

We spent the first few days exploring Kathmandu, temples, palaces, markets, cycling and running in the local hills and getting a feel for this wonderful city.

At the weekend we set off on a six-hour epic cycle ride to a retreat in the mountains called Nanobuhda, close to a monastery. The ride consisted of two brutal climbs up muddy and rutted paths, with the most beautiful valley of paddy fields in-between. Our climbing efforts were rewarded with stunning views, and over breakfast the next morning we had our first glimpse of the Himalayas as the clouds parted for a few minutes. Before setting off, I had been discussing the trip with one of my LSSM class teachers, Tanya Ball, and she told me about the 'Seeing Hands Nepal' project and how I <u>had</u> to visit them.

Checking out previous articles in earlier ISRM newsletters and their website I found:

"Seeing Hands Nepal (SHN) is a social enterprise to provide training and employment for blind and partially sighted people in Nepal as Massage Therapists."

With three centres in Kathmandu, I discovered the nearest was in the district of Thamel, fairly close to my sister's house. After some help from Mr Google we managed to track down the clinic in a back street, and I went in and introduced myself.

The clinic had a reception area where the therapists and clients were waiting. I was given a menu and decided an hour long sports massage at \$18 was too good an opportunity to miss. Ramji was to be my therapist, and I was taken upstairs to one of several treatment rooms. Mine had two tables, I assume for couples to be treated together.

Ramji left the room while I changed, then got me to read a list of contraindications (which of course I recognised and had memorised from Mel's book during my studies!).

I like to talk during my treatments, and Ramji obliged in excellent English.

Ramji is a completely blind therapist who originally trained as a teacher, but massage gives him the freedom to work on his own with no dependencies on others for doing things like marking homework.

He explained how his training had had to have been done in very small classes and had taken a year – no point in using a book to learn anatomy, training had to be totally hands on!

I have to commend Ramji on his techniques

and skills. He worked on my legs and back, easily finding all my usual niggles and a few more that I didn't know I had! One of the best massages I've had.

I learned that their clientele is mainly westerners as the locals still associate massage with somewhat dubious practices.

Once you see what *Seeing Hands* has achieved here and how superbly trained the staff are, it seems so obvious that having a blind therapist is a brilliant idea. A beautiful quote from their website seemed to capture it for me and help me articulate why I enjoy massage so much:

"When you touch a body, you touch the whole person, the intellect, the spirit and the emotions"

I'm back home now, ready to resume my soft tissue therapy training that had been on hold for six months, and I'm still pondering how to describe Nepal.

"Beautiful, gentle, chaotic, with a temple or palace around every corner."

"It's all about finding the calm in the chaos."

I certainly left calmed, motivated, and inspired by my experience.





From pioneering Ballet Choreographer to Soft Tissue and Manual Lymphatic Drainage Therapist

By Sue Wells

"From starting out not believing that such a gentle massage could possibly achieve anything, to seeing the results I can gain, has been a truly amazing period in my life."

Human movement – Fascination and preservation

I never had myself down as becoming a therapist when I was young. As a teenager I had decided to become a <u>world famous</u> choreographer and radically change the way Ballet was taught but as you won't have heard of me you can safely assume that dream never materialised. I did, however, train at the Royal Ballet School in London and taught for 37 years becoming ever more fascinated with the human body and how it moves.

Over the years I realised that childhood injuries had a nasty habit of catching up with me and, after having been hospitalised with a prolapsed disc in my early thirties, learned that I had Spina Bifida Occulta, which in my case presented as a malformation of the L1 vertebra. Medical advice was "don't flex, extend or rotate more than a few degrees or you could end up in a wheelchair." This was seriously daunting news but I ignored the advice... and am still walking!

My efforts to keep mobile led me to various therapies including osteopathy, reflexology, massage, acupuncture, shiatsu and many more. As the years passed I realised that massage-based techniques and cranial osteopathy were among the most logical and effective treatments for me (I know, I'm a slow learner!).

From "seeing" to "feeling" and "changing" tissue/movement

To help me understand better the functioning of the musculoskeletal system I signed up for an introductory weekend course of massage with the LSSM. The idea was to put myself in a position to improve my self-help strategy but learning palpation and various massage strokes opened up a whole new world for me. I could feel and understand soft tissue.

I promptly signed up with LSSM to do the full Sport and Remedial Massage course (now the Diploma in Soft Tissue Therapy), qualifying in 2008. I was in seventh heaven until I realised that deep tissue work could be a little hard-going on a fifty-something with bilateral hip replacements plus arthritic hands and elbows (yes, I'm *still* a slow learner and with little foresight!).

Undeterred, I revelled in the way I was able to rid people of pain, give them freer movement and, in one lady, help the return of sensation after paralysis.

MLD: a light bulb moment?

Finally, the voice of reason penetrated my brain when Tanya Ball suggested I look at Manual Lymphatic Drainage (MLD) as it was gentle on the hands and could be an excellent foil to the deep tissue work. "Daft" I thought. Then I researched it a little. "Not so daft" I thought. Luckily, there was a course quite near me in Lymington so I signed up not knowing much about the lymphatic system or the techniques involved. I studied the Dr Emil Vodder method which is widely recognised and keeps to the original form as devised by Dr Vodder and his wife, Dr Estrid Vodder, in the 1930s.

What an eye-opener! The massage consists of disciplined routines of gentle, pumping actions which stimulate the lymphatic system to speed up removal of waste products, toxins and excess fluid from the tissues. You work *at skin depth* most of the time and, when you tune into it, a whole new world opens up. You become sensitive to feeling where fluid is collecting, when it starts moving, and where there are blockages.



The initial lymph vessels are found in the dermis. Their job is to absorb fluid and proteins from the interstitium¹ passing it to the Pre-Collectors² which have valves that open and close using diffusion, osmosis and filtration. This is why massage and compression are so



effective in stimulating the process by their "pumping" action.

Training in MLD

There are four qualification levels in the Dr Vodder technique.

Basic and Level One teach you how to massage people with healthy lymphatic systems so it is an excellent detox, promotes the healing of fractures, torn ligaments, and sprains, plus it is remarkably effective when used pre- and post-surgery (including cosmetic surgery) accelerating the healing process. The entire body can be treated including the head. I picked up the style of massage quite quickly, finding it as deeply relaxing for me as for my clients.

Levels Two and Three add the skills necessary to help people who have had lymph nodes removed or have otherwise damaged or inefficient lymphatic systems. These clients are often post-cancer surgery patients and usually suffer from lymphoedema³, so they have swelling of some part or parts of the body. With these cases the therapist will give daily sessions using MLD massage, very specific bandaging, and help select compression garments. This is called Complex (or Combined) Decongestive Therapy (CDT).

As well as lymphoedema, people often develop complications resulting from scarring which blocks the flow of lymph as well as distorts connective tissue. Even physical trauma such as a broken bone, any surgery or having a tattoo may disrupt the lymphatic system.

MLD can divert lymph flow around damaged tissue and blockages to find new pathways enabling it to exit the body in the usual way via the kidneys.





I must say that these conditions are sometimes not easy to look at but people have to live with them for the rest of their lives and need treatment. "Not for me" I thought. Wrong again!

Challenging, sometimes – rewarding, definitely!

It is so rewarding when you manage to find a way around a specific problem which results in reducing the size of a leg, for example. These clients are often dealing with life-threatening conditions and suffer from the heaviness, tightness and poor guality skin, reduced movement and pain that come with excess fluid, not to mention the trouble getting clothes and shoes to fit. I expected people with long-term, incurable conditions to be depressing to work with but I was wrong (again)! We laugh at the sheer absurdity of what we are doing and the situations we find ourselves in, so I finish sessions feeling uplifted and privileged to be doing this work.

Incredible though it may seem, both lymphoedema and lipoedema⁴ remain largely undiagnosed until they become a major problem. Most of my current clients have had these conditions for eight or more years before being referred to a specialist. This means that they can far too easily develop secondary conditions such as leg ulcers or lymphorrhea⁵.

NHS vascular clinics appear to be struggling to cope and patients are usually offered only one half-hour appointment every six weeks or so with rather basic compression garments. Add to this the relatively small number of qualified MLD practitioners "out there", and you can understand the problem. We have some excellent and talented experts in this country but there is so much more we could do.

A broad spectrum of skills literally at my fingertips!

From starting out not believing that such a gentle massage could possibly achieve anything to seeing the results I can gain, has been a truly amazing period in my life. When doing an intensive course of treatment (usually referrals from the NHS and funded by them), you treat the same person every day for three weeks which gives you the opportunity to build a unique relationship with them and attain a deeper understanding of their body.

Seeing the joy and relief they express when we remove a litre or more of fluid from a leg so they can wear certain clothes again, move more easily or see their ankles for the first time in months is fantastic.

I'm now using MLD, deep tissue techniques, kinesiology taping and Deep Oscillation[®] on my patients and loving the results. I have a broad spectrum of skills literally at my fingertips and I truly believe my clients benefit greatly from the mix. I know that my back, hips and hands benefit from the variety and I have only one negative – why on earth didn't I do all this sooner?

For further information, visit: www.mlduk.org.uk www.lipoedema.co.uk www.thebls.com

- ¹ Interstitium: a fluid-filled space within a tissue or organ
- ² Pre-collectors: collect and channel lymph fluid into the larger collectors
- ³ Lymphoedema: a condition of localised fluid retention and tissue swelling caused by a compromised lymphatic system
- ⁴ Lipoedema: a long-term condition where there is an abnormal build-up of fat cells in the legs, thighs, buttocks, and sometimes in the arms
- ⁵ Lymphorrhea: the flow of lymph from disrupted lymphatic channels that drains externally through the skin



Event Work

2018 London Marathon — Children with Cancer

From Sarah Dunkley



A glorious day to be running the marathon, said no one on the 22nd April 2018, there were very hot conditions for all who were running. We were fortunate at the Children with Cancer venue, an air conditioned room with over 50 couches set up, and a delicious spread of lasagne, jacket potatoes and a range of sandwiches along with plenty of fruit, water and sweets to get us ready before the runners finished their race.

We had our team briefing, were given free t-shirts, and informed of the expected number of finishers and the funds raised to date (can't recall), and then we waited for the first of the runners... A huge round of applause erupted as each of them came through, creating a great atmosphere, with all the volunteers and runners in high spirits.

We worked in pairs, sharing a couch, so there was the option to take it in turns or to treat one leg each! The massages focused on effleurage and petrissage with some stretching movements to help relax our clients' aching bodies. My therapy partner and I settled into a pleasant routine, asking each runner if they had picked up any injuries during the race or had any specific pain, as well as enquiring how they felt now they had stopped; with the heat in particular, we wanted to make sure they were taking in enough water. Most runners wanted their legs treated and had sore quads and calves in particular. We saw a fair few pairs of blistered feet and lots of hobbling and shuffling. Some runners had achy upper backs and shoulders, but it is safe to say they were all grateful for any and all remedial work. We had one runner who

was on their phone for the whole massage, retelling their run to a loved one, another who looked like he was asleep, one lady told us this was her first and last marathon, and another said she had completed five marathons and loved them!

The Children with Cancer organisers on the day were brilliant, lots of photos were taken and they chaperoned each runner to a free couch, ensuring that the queue never exceeded one runner! The ISRM team were very sociable, sharing experiences and hints and tips in-between treatments. Some of the team were about to graduate, while others had years of experience to share, and we were able to observe one another's techniques.

Our team supervisor Roberto was wonderfully supportive, very positive, full of energy and most importantly he prioritised keeping us fuelled up with sweets and drinks – a big 'thank you' to him for his encouragement and guidance, and the shoulder massages he gave us all!

The charity and ISRM teams were excellent company, we were well looked after and enjoyed a good laugh as we worked hard to support those amazing runners.





Event Work

Event work update

From Tanya Ball



For those readers new to the ISRM and anyone unfamiliar with 'Event work', this is an optional scheme offered by our Institute for the benefit of both

student and full members, aiming to provide hands-on work experience in delivering pre- and/or post-event soft tissue therapy (STT) at various sports and other, mostly 'mass' events. Most Event work opportunities are nonremunerated, but provide valuable and enjoyable occasions for participants to boost their confidence (and treatment log sessions if still students), learn to 'think on their feet', gain new knowledge and ideas by watching others at work, meet and network with colleagues, promote their practice, and enjoy enormous fun all at the same time. It also most often proves a deeply rewarding experience in that STT teams are frequently allocated to a charitable organisation keen to reward their fundraising (sports) competitors with a complimentary postevent treatment.

As Event work coordinator, I am responsible for administering the scheme overall, including recruiting volunteers (see heading 'How to apply for Event work' below) and allocating these to different teams (where several, or even numerous charities are involved, such as the London Marathon), promoting our service to new potential event organisers, liaising with existing ones, volunteers, and any other stakeholders, answering a million and one enquiries from all sides (especially when people insist on asking questions already answered in what I have sent them... but which they haven't read... no - of course this never happens!).

As in numerous past years, an enthusiastic contingent of ISRM students/therapists generously volunteered their time, energy, and skills in supporting the scheme in 2018, and providing the high standards of pre/post-event STT which event organisers, charities, and the recipient general public have come to expect of ISRM. My very grateful thanks to all concerned for their kindness. We could not have delivered onsite support to any of the events listed below without your much appreciated inputs.

2018 events which benefited from ISRMprovided STT include:

- Fleet ½ Marathon originally Sunday 18th March, rescheduled to Sunday 29th April due to adverse weather
- Inaugural London Landmarks Half Marathon, Sunday 25th March
- London Marathon Sun 22nd April
- SWRC MayFlyer Cyclosportive (in aid of Full Circle Fund Therapies [Charity]) Cycling Event, Oxshott, Surrey – Sunday 6th May
- Bournemouth 7's Festival, Bournemouth – Fri-Mon 25th-28th May
- Ride London Surrey 100/London Sunday 30th July

This year's London Marathon saw some 80 ISRM volunteers, distributed into thirteen STT teams, deliver first class post-race treatment to well-deserving fundraising runners at their respective charities' 'thank you' reception venues.

In addition to the above list of events, ISRM volunteers have been recruited on an *ad hoc* basis for 'smaller' ones as and when required and possible. Regrettably some requests from event organisers for onsite STT support reached me at too short notice for us to be able to respond favourably. Readers can taste the vibrant atmosphere of the London Marathon and London Landmarks Half Marathon events through first-hand accounts, and a range of photos from these and other events are also featured in this section of the present newsletter. May these inspire many to sign up for event work in 2019!

<u>2019 events</u>

Details of these will be posted on the ISRM Event Work page as and when they become confirmed; registration to volunteer for the 2019 London Marathon will open in December 2018.

<u>Finally: How to register for ISRM-organised event work</u> (this reminder features in each Issue)

Would all members, and specially new student members for whom this is their first ISRM Newsletter, please kindly note the <u>one and only Event Work</u> registration process below, thank you.

Registration for any/all ISRM event work is available exclusively online. For logistical reasons, there can be no exception, and because the Event Work web page is understandably accessible to members only (as the ISRM fund the associated administrative costs), it follows that applicants/participants must be ISRM members. Unfortunately I regularly receive e-mails from people unable for some technical reason to access the page, or... because they are not/no longer ISRM members. In the former case, I can only advise people to ask to borrow someone else's PC; in the latter case... I can only suggest that they (re-)join the ISRM and reap its many benefits!

In addition, to qualify for ISRM event work, <u>Professional Indemnity and Public</u> <u>Liability insurance at the appropriate</u> <u>level (student/graduate) and valid at the</u>



Event Work

time of the event is mandatory. We regret that no exceptions can be considered.

<u>Students must have successfully passed</u> <u>their Weekend 5 General Massage</u> <u>assessment in order to be considered for</u> <u>ISRM event work</u>. Very rare exceptions may be considered at ISRM's discretion.

How to apply for Event Work:

- ✓ From the ISRM home page
- (<u>www.theisrm.com</u>), login ✓ Click on 'Your ISRM' and select 'event work' from the drop-down menu
- ✓ Follow any (very easy) instructions to view the current list of events
- ✓ Click on whichever you are interested in
- ✓ READ CAREFULLY the information in red below the event, and ENSURE that you are available on the date of the event(s)
- ✓ Please, please, PLEASE ensure that you enter ALL details requested including your 'status' e.g. 'student', 'recent graduate', etc.,
- ✓ Please, please, PLEASE only apply (click) once for a given event! Some

people have managed to click as many as seven times for the same event...

Duplicate entries are difficult for me to spot due to the automated system.

If you cannot 'view' the event you are looking for but know it was previously on display on the web page, the most likely reason is that I have 'closed' the event because applications have reached full capacity. Please therefore do not e-mail me individually to ask if you may be included – events fill on a first come, first served basis and it is therefore up to members to 'jump in early' if they want to secure a place. Please note however that sometimes a 'closed' event may re-appear 'on view' nearer the date if withdrawals mean that new places have become available, so it is a good idea to keep checking.

Should you encounter problems that you suspect to be *website-related*, *please contact the ISRM/LSSM office* and not me, as this is completely outside of my

remit, let alone my skills 🙂! Thank you.

Once again, a very grateful thank you on behalf of ISRM to all who have supported/are supporting ISRM events over the years. In contrast, if you have never attended an event and/or are currently studying on the Diploma course... *what are you waiting for?* Here are selective examples of the numerous benefits that could be yours in return for 'giving it a go':

- ✓ Skills enhancement, consolidation, new techniques – from watching others
- ✓ Significant gain in self-confidence – from achieving a successful 'day' involving 'thinking on your feet' and receiving genuine, positive feedback from recipients
- ✓ New ideas, tips, lasting friendships, networking, etc. – from meeting and mingling with like-minded fellow therapists
- ✓ A tremendous sense of achievement coupled with an urge to find out: 'When is the next event?'!

ISRM Team support Tommy's at inaugural London Landmarks Half Marathon, 25/03/2018

From Libby Palmer – Clinical Sports and Remedial Massage Therapist



The first London Landmarks Half Marathon took place on Sunday 25th March 2018. It was a pleasure to act as the Team Leader for the ISRM Soft Tissue Therapy team, offering post-race massage to fundraising participants running for the Charity Tommy's. ISRM students and graduates offered the high standard of treatment expected of us, and coped with the high demand with exemplary professionalism, dealing with the usual range of tight calves, hamstrings, blisters, and cramps. I also witnessed some lucky runners receiving a shoulder massage. We had the privilege of treating the first female athlete to finish, British runner Joanne McCandless, who completed the course in a time 01 hr 22' 42".

Our team comprised Jenny Holmes, Seon Rice-Lupin, Julie Davidson, Rachel Gower, Charles Kinsey, Vitalijs Gubskis, and me – Libby Palmer.

The Tommy's team were fantastic, ensuring that our clients were well looked after, that everything ran smoothly, and that we were kept fed and watered. Thank you all for a great day!



5th International Fascia Research Congress — Berlin, 14-15 November 2018

By Ian Pollard, Soft Tissue Therapist, LSSM ISRM

'We were encouraged not to think of some six hundred plus different muscles, but of one connective muscle of some six hundred plus different pockets.'



I recently attended the Fifth International Fascia Research Congress, held at the historic Urania Centre in Berlin on 14th and 15th November 2018. Having been highly recommended through the ISRM newsletter and CPD emails – many thanks Tanya Ball, I decided to go to further my knowledge in this integral subject for my personal development as a soft tissue therapist, whilst at the same time having a look around this captivating and greatly acclaimed city. I was not disappointed on either front.

Billed as 'connecting key issues on how fascia research can impact on health

outcomes', the Congress brought together the latest scientific findings in fascia research and their implications for conventional and complementary health care. It was very much an international event with the 'superstars' of the fascial world mixing freely with a wide range of practitioners and therapists from all levels within their respective professions.

The keynote presentations covered a range of specific topics, commencing on fairly familiar ground with the evolution of human walking and running with regard to the ITB (iliotibial band) and plantar fascia. They soon delved deep into

the matrix biology of fascia, interstitium, lymphatic system, biophysics of the human spine, neuromuscular motor function, neurology of spinal pain and pain and movement control.

As a first-timer at this level of proceedings, I quickly became aware of how significant the keynote speakers were as the stars and celebrities of the fascial world, with some being greeted with an almost cult-like status! Notably, Daniel Lieberman, Melody Swartz, Carla and Antonio Stecco, Paul Hodges, Robert Schleip, and Jean-Claude Guimberteau were for me the most outstanding speakers. The Late Leon Chaitow was honoured with a fitting tribute, and his daughter Sasha gave a moving address on how his work and legacy will be continued through the Fascial Research Congress and the Journal of Bodywork and Movement Therapies.



What the Congress demonstrated was how biology and biomechanics are





inherently linked. How advances in fascial research have heightened our understanding of how fascia facilitates the whole body to function, and its significance for physiological and psychological interaction. How the role of fascial research has been instrumental in bringing together fields previously isolated and working independently.

The daily format saw four keynote plenary lectures in the main auditorium in the morning, with two sessions of multiple scientific abstract presentations in the afternoon, spread throughout various lecture halls of the congress venue. Coffee and lunch breaks afforded ample time to explore the other activities and exhibits, visit the associated sponsors' stands, and of course network with some of the several hundred other delegates from countries and continents around the world. I teamed up with a Romanian physiotherapist form Bucharest, а Californian body worker from San Diego, and chatted with an osteopath from 20 minutes down the road from where I live in Dorset!

Of the exhibitions, the abstract poster displays detailed a wide range of current fascia research projects, findings and conclusions, which added visual detail and context to the lecture room presentations. Photographic displays dedicated to art in the context of fascia research were equally intriguing and beautiful, whilst images of fascial dissections were definitely not for the squeamish. There was a palpation lab where you could test your palpation skills, a yoga room and a treatment room, although the latter seemed more in use by a few weary delegates having an afternoon nap.

The standout exhibit for me was the Plastination exhibit, with a room full of 'plastinated' human specimens from the Human Fascial Net Plastination Project, some of which were on display for the first time. Using a revolutionary method of cadaver tissue preservation, the Plastination Project was created to preserve actual anatomical specimens in life-size form for study and education. A truly impressive and graphic study of myofascial anatomy, with body parts galore just an arm's length (pardon the pun) away - sadly no photos were allowed.

The Congress concluded with a summary and awards session, followed by a spectacular 'Fascial Illuminated' presentation of photographic images and videos on the main auditorium screen. The 90-minute presentation aired some of the latest microscopic imagery into the fascial world of connective tissue and proved magnificent both as an artistic masterpiece and an exploration of human facial form.

I decided not to join the Congress evening river cruise dinner and disco party, but instead headed for the Berlin Philharmonic for a brilliant Classical Jazz concert. Whilst enjoying the musical masterclass, I was equally captivated by a highly energised violinist whose balletic movements seemed to epitomise perfect fascial harmony – fascia was obviously getting to me...!

My trip also presented the opportunity to attend a pre-congress full day Anatomy Trains workshop, entitled 'Myofascial Continuities in Assessment & Practice', presented by Thomas Myers himself. Mixing the latest theory with practical demonstration and hands on work, the workshop combined myofascial anatomy with how the body incorporates the 'Anatomy Trains' lines in structure, posture, and function. It explored the meaning of the twelve myofascial meridians in stability and movement, and the value of global over local treatment for chronic injury and compensation. We were encouraged not to think of some six hundred plus different muscles, but of one connective muscle of some six hundred plus different pockets.

Much of the Congress was highly specific and technical, but overall my general awareness and deeper understanding of the complex structure and importance of fascia, and most importantly how I will approach my work as a result, has been immediate and will no doubt be far-reaching over the years ahead. As an investment in knowledge I'm sure it will prove extremely beneficial and an experience I will refer back to for many years to come.

The sixth International Fascial Research Congress will take place in 2021 in Montreal, Canada. Ian Pollard

The London Road Clinic www.56londonroad.co.uk/ sportsmassage/ Elevate Physiotherapy & Sports Injury Clinic - www.elevateyeovil.co.uk





Event work - London Landmarks Half Marathon













Why Psoas Major is <u>not</u> a 'hip flexor'

From Tanya Ball

Why the question? Historical context

My lifelong fascination for all things medical, and specific longing, as a (20th Century/first Millennium!) élite marathon runner / County basketball player, for in-depth understanding of 'how muscles worked' in posture and movement, turned me into an irrepressible 'sponge for knowledge' as a LSSM student back in 1996. With hindsight, I must have been by far the most *an-noy-ing* person ever to have completed the Diploma course – forever asking *yet another* question!

My utter absorption in learning soon led me to the notion of 'muscle classification', which immediately made huge sense to me. The first model I had come across was the dualistic 'postural' versus 'phasic' one proposed by the Late Leon Chaitow, my deeply appreciated and fondly remembered mentor, in the 1990ies. However, my eyes were soon opened to others equally meriting critical evaluation. The challenge was that, not only did these appear to contradict one another in part at least, but more importantly I was increasingly convinced that a number of muscles failed to 'fit the model' when it came to my experience both as a therapist and a runner!

The convenience of man-made compartmentalisation versus elusive reality...

In the year 2000, I was thrown in under most fortunate circumstances at the deep end of a virtually vertical learning curve opportunity, courtesy of a series of modular courses delivered by the world-renowned Company Kinetic Control (www.kineticcontrol.com), which focused on 'motor control-based clinical assessment, treatment and rehabilitation skills for movement dysfunction'. Central to this systematic approach was an innovative, firmly evidence-based three-way muscle classification distinguishing:

- ✓ Global mobilisers
- ✓ Global stabilisers
- ✓ Local stabilisers.



While this has firmly remained my muscle classification cornerstone to date, albeit with further refinements over the years, it shares and overlaps a space within my clinical thinking and application with the equally compelling but contrasting biotensegrity-based Anatomy Trains® model pioneered by Thomas Myers. As I trained and gualified as a KMI Structural Integrator in 2009-10 under the superlative tutoring of both Myers and James Earls - both highly revered mentors to me - I found it as stimulating as challenging to be confronted with such radically divergent anatomical and functional interpretations of just about every muscle I had learned about since Weekend 1 of the LSSM course... perhaps most exciting of all, one message that was emerging from this exposure to multiple models was that the time was well overdue to take 'what the textbooks tell you' with a generous tablespoonful of salt!! Among the various muscles I had consistently found to transcend researchers' best and most learned attempts to fit into a single category, psoas major easily trumped the rest as the source of greatest controversy. A fairly basic 'Dr Google' search suffices to reveal a wealth of variably reliable literature on the subject, from well-designed, compelling scientific research papers to (in my view) utterly speculative, 'woolly' wishful claims, via interesting and thought-provoking qualitative studies. In summary, my conclusion was that psoas major was an exceptionally disputed and therefore uniquely fascinating muscle to explore in greater depth because of:

- Its contrasting 'classifications' among different therapeutic models
- The mutually exclusive roles sometimes dogmatically ascribed to it
- Disagreements even within therapeutic models
- Potentially unsubstantiated 'claims' about its significance
- In particular, my increasing grievance that what I knew to have been obsolete, incorrect information about the role(s) of psoas major was continuing to be perpetuated in textbooks and taught in classrooms across the nation if not the world
- My perceived conflicts between 'classification' and 'clinical experience': no classification system in my view adequately accounted for some of my (and others') clinical findings, hence...
- I needed to investigate for myself and gain solid 'scientific ammunition' to support my research conclusions!

At last! An unmissable chance

The golden opportunity to engage in this project arose in 2012 when, as part of my third and final Module of Kinetic Control's hallmark The Movement Solution course, I was required to write a 4,000-word Motor Control research paper as one of a four-section clinical portfolio, to gain a much-coveted qualification as a Kinetic Control Movement Therapist (KCMT) via an 'APEL' (Accreditation of Prior Experiential Learning) Pathway in partnership with the University of Keele. While the essay quite rightly had to focus on Motor Control, I regarded this as an unmissable opportunity critically to appraise the evidence supporting the prime contrasting interpretations of psoas major within the literature. A further private aspiration was if possible to demonstrate that what may at first glance appear to be



irreconcilable 'man-made classifications' are almost invariably transcended by the sobering, humbling brilliance and infinite wisdom of 'real life', whether human or otherwise.

I am reproducing below an edited version of the first part of my Motor Control essay referred to above. Please note that this does assume a degree of prior knowledge of/familiarity with relevant clinical research and therapeutic models.

'Scientific evidence and clinical practice: A critical evaluation of contrasting interpretations of the roles of psoas major' – Part 1

Introduction

Psoas major (PM) (please refer to Appendix B) has elicited controversy with regard to its structure and functional role over recent decades (Gibbons et al. 2002; Morling 2009; Myers 2009) (please refer to Appendix A). Textbooks traditionally classify PM as a prime hip flexor (Adams et al. 2002; Biel 2005; Earls & Myers 2010; Jarmey 2003; Schuenke et al. 2006; Tortora & Grabowski 1996). Whether PM is also a lateral (Schuenke et al. 2006; Morling 2009; Tortora & Grabowski 1996) or medial (Rolf 1977) hip rotator, or neither (Myers 2001; 2009); a lumbar flexor (Biel 2005; Schuenke et al. 2006: Tortora & Grabowski 1996). extensor (Morling 2009), both (Earls & Myers 2010, Myers 2001; 2009), or neither (Adams et al. 2002), is disputed.

A motor control (MC) research and expert opinion sector has stimulated further debate: developing the notion termed '*segmental spinal stabilisation*' (Comerford & Mottram 2001 a&b; 2012; Gibbons et al. 2002; Lee 2011; Vleeming et al. 2007) since the 1960s, **it proposed PM's** *prime role as 'spinal stabilisation via axial compression of the lumbar spine'*, alongside lumbar flexion relative to the *pelvis*, and innominate *posterior* rotation, whilst refuting PM's hip flexion potential on anatomical, biomechanical, and neuro-physiological grounds.

Concurrently, research findings on the fascial system, including the lumbo-pelvic fasciae (Findley & Schleip 2007; Huijing et al. 2009; Schleip et al. 2012) contribute scientific and empirical clinical evidence relevant to PM's potential roles. Alongside consensus between

these authors' findings, and those of Comerford & Mottram (2001 a&b; 2012), contrasting evidence arises from fascial/myofascial embryology, morphology, neuro-physiology, force transmission (Findley & Schleip 2007; Huijing et al. 2009; Schleip et al. 2012), and clinical practice (Myers 2001; 2009; Morling 2009). Considerable literature suggests PM involvement in thoraco-lumbo-pelvic-hip postural and functional asymmetry, breathing and somatic dysfunction, and emotional 'holding' patterns (Chaitow 2006; Chaitow and DeLany 2000; el Rif 2005; Huijing et al. 2009; Jacobson 2011; Myers 2009; Morling 2009; Schleip et al. 2012; Schultz & Feitis 1996).

Regarding PM's role(s), differentiation is required between **available scientific evidence**, and contrasting **interpretations among clinical models**. For example, although both regard PM as a spinal stabiliser, Comerford & Mottram's (2012) classify PM as a 'local' and 'global' stabiliser, while Myers (2009) classes PM as a multi-articular 'express' working alongside 'locals' iliacus and quadratus lumborum (QL). PM can thus contribute to complex patterns of thoraco-lumbo-pelvic imbalance involving localised/asymmetrical shortening/ hypertonicity, which conflicts with local stabiliser consistent patterns of dysfunction (See Table hereafter).

This Paper critically evaluates the evidence underpinning expert opinion on PM's various functions. Clinical model assumptions are discussed, and their scientific basis appraised.

Evidence for PM's roles proposed by different neuromusculoskeletal models

For an overview of the respective MC, biotensegrity, and 'traditional' models considered, the reader is referred to the relevant literature (Comerford & Mottram 2012; Schleip et al. 2012; Herbert et al. 2008). The reader's acquaintance with Comerford & Mottram's (2001a&b) muscle classification system of global mobilisers (GMs), global stabilisers (GSs), and local stabilisers (LSs) is assumed.

Ascribing muscle functions strictly in relation to their attachments is nowadays widely acknowledged as an over-simplification (Comerford & Mottram 2012; Findley & Schleip 2007; Gibbons 2005; Gibbons et al 2002; Huijing 2009; Lee 2011; Myers 2009; Sahrman 2011; Schleip et al. 2012; Schultz & Feitis 1996; Vleeming 2007). Comerford & Mottram (2012), Vleeming (2007), and Gibbons (2005) instead advocate determining muscle classification on four criteria:

- Anatomical structure and location
- Biomechanical capability
- Neuro-physiology
- Consistent and distinctive pattern of change with pain/dysfunction/pathology.

The notion of 'fascial continuity' between neuromusculoskeletal (NMS) structures is essential to fully grasping the roles of muscles in bio-tensegrity-modelled research (Findley & Schleip 2007; Huijing 2009; Schleip et al. 2012). Growing recognition of the relevance of this notion in NMS MC research (Vleeming 2007; Lee 2011; Sahrman 2011), justifies its inclusion as a fifth muscle classification criterion.

The Table below summarises PM's main classifications according to these five criteria.

Discussion

PM's diverse features in the above Table can be summarised as: 'prime hip flexor'; 'segmental spinal stabiliser'; and 'integrative role'. Their scientific underpinning is evaluated below. **Evidence for/against PM as a 'prime hip flexor'**

lexor'

Scientific evidence supporting PM's continued 'text-book' classification as a hip flexor/lateral rotator (Table 1.a-1.e) is sparse. Yoshio et al. (2002) used morphology and passive kinetics to correlate PM's actions with hip flexion angle on 35 cadavers. Effective hip flexion was only achieved between joint angles of 45°-60°, as endorsed by Vleeming et al. (2007), but refuted by Gibbons (2005). Sajko and Stuber's (2009) scientific review on PM's spinal action(s) states that 'It is well established that the psoas functions as a primary flexor of the hip joint ...' (p.313). This rests on a single, outdated (1958) electromyography (EMG) study and subsequent expert opinion. Hides et al. (2010) soundly investigated PM and QL cross section area (CSA) asymmetry among 54 professional Australian footballers. Three MRI measurements at different training phases over two years consistently revealed significantly larger PM CSAs ipsilateral to players' preferred kicking leg. The author considers that this supports PM's involvement/participation in high-velocity hip flexion, but does not imply 'hip flexion' action.



The notion of **extramuscular myofascial force transmission (EMFT) evolved from recent research** (Huijing 2003a;b; 2009; 2012; Schleip et al. 2012; Yucesoy et al. 2003; 2008) refutes PM's classification as a hip flexor. Traditional biomechanical models regard muscles as *'mechanically independent force generators'*, with the 'torque generated at a joint [being] the sum of torques produced by individual muscles crossing the joint.' (Herbert et al. 2008, p.1549). In contrast, EMFT implies in-series intermuscular mechanical dependency, producing non-linear torque forces at associated joints (Patel and Lieber 1997). Credible finite-element modelling (Yucesoy et al. 2003) and fasciotomy (Huijing et al. 2003; Rijkelijkhuizen et al., 2005; Yucesoy et al. 2008) experiments on rats demonstrated significant EMFT impact on muscle function. Implications for PM's actions are discussed later.

Part 2 to follow in the next Newsletter Issue.

The convenience of man-made compartmentalisation versus elusive reality...

	(1)Anatomical stru	ucture/location;	(2) Biomechanical cap	ability; (3	3) Neuro-physic	ology;
	(4) Consistent/distin	ctive pattern of cha	ge with pain/dysfunction/pathology;		(5) Fascial continuity	
Ref N°	References TxB = Text Book EO = Expert Opinion SP = Scientific Paper	Anatomical structure and location (including attachments)	Biomechanical capability	Neuro- physiology	Consistent pattern of change with pain/dysfunction/ pathology	Fascial Continuity/ies
1.a	Drake et al. (2010) (TxB)	Lateral aspect of T12-L5 vertebrae and discs except L5/S1; transverse processes (TPs) of lumbar vertebrae Lesser trochanter of femur	Major hip flexor	Innervation: anterior rami of L1-L3	No NMS-related reference – only refers to PM changes in relation to non-NMS pathologies.	With QL, PM forms the posterior abdominal wall. 'Structurally' continuous with lateral (EO, IO, TrA) and anterior (RA) abdominal walls via fascia/aponeuroses
1.b	Tortora & Grabowski (1996) (TxB) Cunningham (1981) (TxB) Schuenke et al. (2006) (TxB)	Transverse processes (TPs) and bodies of lumbar vertebrae Lesser trochanter	Hip flexion & lateral rotation Trunk flexor from supine position	L2-L3 lumbar nerves	No reference	No reference
1.c	Biel (2005) (TxB/EO)	As 1.b-c above	As 2-3. Above PLUS Spinal stabilisation	L2-L4 lumbar nerves	No reference	No reference
1.d	Adams et al. (2002) (TxB/EO)	As 1.a above	Prime action = hip flexion No intrinsic <i>directional</i> action on lumbar spine, but can highly compress Lx discs with hip flexion or 'sit-up' type activity.	Deep branches of ventral rami of Lumbar spinal nerves supply PM	No reference	No reference
2.	General consensus of the authors below: Comerford & Mottram (2001a & b; 2011) (EO) Lee (2011) (EO) Vleeming et al. (2007) (EO) Gibbons (2007) (EO) Gibbons (2005) (EO) Gibbons et al (2002) (EO) Regev et al. (2011) (EO/SP) Note: distinct statements/	General consensus: PM comprises anterior and posterior fascicles: Anterior attachments arise from antero-medial aspect of all lumbar vertebral bodies and inter-vertebral discs except the L5/S1 disc; Posterior fascicles attach to the antero-medial portion of all lumbar	Vleeming (2007): many biomechanical studies of PM unreliable due to unsupported assumptions/ inadequate anatomy. Consensus among reliable studies: Fibres too close to lumbar (Lx) axis of rotation to produce significant movement, hence dominant force = axial compression on Lx spine,	Vleeming et al. (2007): limited evidence from EMG studies due to deep PM location. Based on available neuro- physiological studies: Evidence that PM <i>participates</i> in hip	General consensus: PM is consistent with local stabiliser (LSs) characteristics with dysfunction as defined in Comerford & Mottram (2001a & b; 2011), namely: Loss of segmental	General consensus: Significant fascial connections: Proximally, with diaphragm via medial arcuate ligament; Postero-medially, with (i) left (L) and right (R) diaphragm crura at L1-L3



	observations from specific authors are referenced individually within the text of Columns 3-7.	transverse processes (TPs); All fascicles are unipennate, descend infero-laterally into central tendon continuing antero- inferiorly to firm attachment on <i>pelvic</i> <i>brim</i> – possibly an 'innominate ligament'; Anterior fibre length (3-8 cm) slightly exceeds posterior (3-5 cm), but essentially consistent fibre length. Lee (2011) states that: 'Short segmental and long multi-segmental [PM] fibres do NOT exist.' (p.43).	providing segmental stiffness that overcomes shear forces. This suggests PM role in helping maintain neutral Lx lordosis. Posterior innominate rotation action at SIJ via pelvic brim attachment. Fibre length, orientation, and ↓ ability to shorten suggest minimal hip flexion capability. Instead, PM deemed to stabilise had into acetabulum. Comerford & Mottram (2011) agree with the above but contend that PM displays <i>both</i> local (LS) and global (GS) stabiliser characteristics and functions: Anterior PM fascicles – LS Posterior fibres – GS. Some sources suggest PM can produce minor extension at L1- L3, and minor flexion at L4-L5 (see Table Section 3. and 'Discussion' Section below).	flexion but NOT as a 'prime hip flexor'. Greater iliacus than PM EMG activity in hip flexion. Research suggests that PM's functions relative to hip flexion angle are as follows: $0^{\circ}-45^{\circ}$: hip & <i>lumbar stability</i> ; $45^{\circ}-60^{\circ}$: hip & <i>lumbar stability</i> + hip flexion; 60° +: <i>lumbar</i> <i>stability</i> – no action on femoral head.	 translation control due to: Delayed activation; Altered low load motor control recruitment pattern; Local atrophy/ reduced cross- sectional area (CSA) at relevant segment(s). Comerford & Mottram (2011) Posterior fascicles are consistent with GS typical response to dysfunction, including: Lengthening Loss of through- (inner range and/ 	vertebral bodies and discs, and (lii) anterior longitudinal ligament (ALL); Infero-medially, with pelvic floor (PF), transversus abdominis (TrA) and obliquus internus (OI).
					or eccentric).	
3.	General consensus of the	General consensus:	Earls & Myers (2010); Myers (2001: 2009):	Sensori-motor	or eccentric). General	General
÷.	<u>General consensus</u> of the authors below: Earls & Myers (2010) (EQ)	General consensus: Largely agrees with anatomical description of	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a bip flexor but	Sensori-motor centre (Jacobson 2011b: Morling	or eccentric). General consensus: Together with other	General consensus:
÷-	<u>General consensus</u> of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above.	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator.	Sensori-motor centre (Jacobson 2011b; Morling 2009: Rolf 1990).	or eccentric). General consensus: Together with other structures within	General consensus: Concurs with (2.) above + highlights
s.	<u>General consensus</u> of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle –	or eccentric). General consensus: Together with other structures within relevant fascial	General consensus: Concurs with (2.) above + highlights PM's key role as a
5.	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy-
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine:	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys,	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting:
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i>	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in /	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine.	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) –
5.	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero-	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular	or eccentric). General Consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following:	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support
÷.	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i)	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, GI tract, diaphragm via common neuro-vascular supply/ies	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function;
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i>	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero-	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009;	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ±	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg;
5.	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990).	or eccentric). General Consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO)	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis in quadruped mammals,	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep layer of 'Superficial Back Line'	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990). Closely	or eccentric). General Consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral rotation;	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip – breath and
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO) Note: distinct statements/ observations from specific	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis in quadruped mammals, except with hind-leg	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep layer of 'Superficial Back Line' [SBL]).	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990). Closely associated with	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral rotation; - Lower lumbar	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip – breath and locomotion;
	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (T×B/EO) Rolf (1977; 1990) (T×B/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO) Note: distinct statements/ observations from specific authors are referenced	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis in quadruped mammals, except with hind-leg hyper-extension.	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep layer of 'Superficial Back Line' [SBL]). Classifies PM as an 'Express' (=	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990). Closely associated with 'defensive' (fight	or eccentric). General consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral rotation; - Lower lumbar hyper-extension +	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip – breath and locomotion; - Stability/mobility.
÷	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO) Note: distinct statements/ observations from specific authors are referenced individually within the text of	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis in quadruped mammals, except with hind-leg hyper-extension.	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep layer of 'Superficial Back Line' [SBL]). Classifies PM as an 'Express' (= multi-articular) muscle supported	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990). Closely associated with 'defensive' (fight or flight')	or eccentric). General Consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral rotation; - Lower lumbar hyper-extension + upper lumbar	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip – breath and locomotion; - Stability/mobility.
÷	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 a&b) (EO) Maitland (2002) (EO) Morling 2009) (EO) Myers (2009) (TxB/EO) Rolf (1977; 1990) (TxB/EO) Schleip (1998) (EO) Schultz & Feitis (1996) (EO) Schultz & Feitis (1996) (EO) Smith (2005) (EO) Note: distinct statements/ observations from specific authors are referenced individually within the text of Columns 3-7.	General consensus: Largely agrees with anatomical description of Section (2.) above. Several sources emphasise the uniqueness of human psoas, arising <i>anteriorly</i> from lesser trochanter to ilio-pectineal ridge attachment, thence continuing <i>posteriorly</i> to Lx spine – <i>there is NO</i> psoas contact with pelvis in quadruped mammals, except with hind-leg hyper-extension.	Earls & Myers (2010); Myers (2001; 2009): Regards PM as a hip flexor but not rotator. Proposes PM as a triangular muscle with contrasting actions on upper versus lower Lx spine: Upper fascicles flex, lower fascicles extend spine. PM balances/counter-balances Lx spine by providing antero- lateral support, against (i) contra-lateral PM; (ii) postero- lateral local erector spinae (deep layer of 'Superficial Back Line' [SBL]). Classifies PM as an 'Express' (= multi-articular) muscle supported by 'locals' iliacus and QL.	Sensori-motor centre (Jacobson 2011b; Morling 2009; Rolf 1990). Visceral muscle – interfaces with bladder, kidneys, pelvic floor, Gl tract, diaphragm via common neuro-vascular supply/ies (Morling 2009; Rolf 1990). Closely associated with 'defensive' (fight or flight') response reflex	or eccentric). General Consensus: Together with other structures within relevant fascial continuities, PM is deemed commonly to be involved in / perpetuating any or a combination of the following: - Unilateral Lx side- flexion ± contra-lateral rotation; - Lower lumbar hyper-extension + upper lumbar flexion ('sway-	General consensus: Concurs with (2.) above + highlights PM's key role as a supporting 'guy- rope' connecting: - Upper and lower body at T12/L1 junction (TLJ) – critical for support and function; - Spine and leg; - Diaphragm and hip – breath and locomotion; - Stability/mobility. Earls & Myers (2010); Myers
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Appendix B – List of abbreviations

AT	Anatomy Trains®
BFL	Back Functional Line
CoG	Centre of Gravity
CT	Computed Tommography
CTJ	Cervico-Thoracic Junction
CSA	Cross-Section Area
Cx	Cervical (spine)
C4/C5	Denotes segmental Cervical vertebral level, in this instance 4th/5th segment
DBAL	Deep Back Arm Line
DFAL	Deep Front Arm Line
DFL	Deep Front Line
EMFT	Extramuscular Myofascial Force Transmission
EMG	Electromyography
ES	Erector Spinae
FFL	Front Functional Line
GHJ	Gleno-Humeral Joint
GM(s)	Global Mobiliser(s)
GS(s)	Global Stabiliser(s)
(- /	

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IMFT	Inter-Muscular Force Transmission
IMS	Inter-Muscular Septum/Septa
KCI	Kinetic Control International
L	Left
LBP	Low Back Pain
L4/L5	Denotes segmental Lumbar vertebral level, in this
	instance 4th/5th segment
L-P	Lumbo-Pelvic
L-S	Lumbo-Sacral
LS(s)	Local Stabiliser(s)
LTL	Lateral Line
Lx	Lumbar (spine)
MC	Motor Control
MF	Multifidus
MRI	Magnetic Resonance Imaging
NMS	Neuro-Musculo-Skeletal
NSAIDS	Non-Steroid Anti-Inflammatory Drugs
NWB	Non-Weight-Bearing
OA	Osteo-Arthritis
OP	Osteoporosis
PM	Psoas Major

Quadratus Lumborum QL R Right

- RoM Range of Movement
- SBAL Superficial Back Arm Line Superficial Back Line SBL
- SFAI Superficial Front Arm Line
- SFL Superficial Front Line
- SII Sacro-Iliac Joint
- Spiral Line SPL
- TIJ Thoraco-Lumbar Junction
- Thoracic (spine) Τх T4/T5
- Denotes segmental Thoracic vertebral level, in this instance 4th/5th segment UCM Uncontrolled Movement
- Weight-Bearing

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Research development and clinical practice: are we keeping up to date? From Tanya Ball

Welcome to this new feature, which I very much hope will become a regular Newsletter item going forward, by eliciting thoughtprovoking contributions from anyone keen to ensure our patients and clients consistently continue to benefit from the latest clinically relevant research findings. This (in my view long overdue) section has been germinating in my mind for considerable time, so I am delighted that it is finally appearing in print.

As soft tissue therapists, and hence as part of the broader healthcare profession, how do we establish and subsequently maintain our working methods, and why? Beyond the countless variables of where and whom we initially learn our trade from, our personal strengths, frailties, interests, scope of opportunities, and preferences, I believe it is fair to say that we initially acquire much of our knowledge and skills from our chosen training school, which in the case of the present readership means an ISRM-accredited Soft Tissue Therapy school. Nothing wrong with that, presumably? We then tend, over time, to develop our own 'style' based on individual preferences, such as techniques we feel greater affinity with, therapeutic models that make sense and capture our imagination, inspiration from specific tutors, mentors, colleagues, and so on. Nothing wrong with that either, it would seem.

With time, experience, and a growing clientele, we rightfully gain confidence in our methods and gradually settle into what has become 'our way of practising', which in turn subtly also becomes our 'comfort zone'. The question I am asking, and inviting each reader to ask him/herself is: 'is this a good thing, a bad thing, or perhaps a bit of both?' On one hand, I think it would be hard to argue against the multiple benefits of increased confidence,

session structure, treatment 'flow', for us therapists at any stage of our journey, resulting in enhanced professionalism and therapeutic relationships. But here in my view also comes the 'but': like most living beings, we humans tend to be creatures of habit who seek comfort and security in the familiar – the routine, the habit. My contention is that within a professional context, this characteristic may be detrimental to personal and professional development, and ultimately in our case to the optimal care we could deliver to our (paying!) patients/clients. How so?

Firstly, and speaking from personal experience, I have learned how very easy it is, when a treatment approach is yielding successful results and clients are progressing well, to 'stick to the recipe' as a default, thereby inadvertently overlooking the possibility that while our familiar strategy appears to be working well, this does not exclude the possibility that a different tactic may prove even more effective. In other words, in the professional context at least, I am challenging the commonly held reasoning that 'if it ain't broke, don't fix it'. Reflecting back on my own development, I would be the first to acknowledge that my patients did indeed get better even in my very early days and years of practice. But I am also in no doubt that, had I been in a position at that time to treat them with the further knowledge and skills acquired in latter years, they would have improved and recovered faster and with fewer, if any, symptom recurrences.

Secondly, I regard it particularly incumbent upon the tutors among us, with our individual and collective responsibility for the accuracy of content delivered, our potential ability and arguably *duty* to influence curriculum content constructively, to ensure we diligently and critically review the 'what – why – how – and when' of our work in light of relevant emerging research findings.

Hence my message to us all, whether students finding their way around the body with their fledgling skills, graduates of few or many years, or most importantly perhaps, tutors, is to remain diligent in revisiting and questioning our long-held therapeutic preferences, in challenging our sometimes distant past learning, and in opening ourselves to embrace relevant innovative trends and incorporate their implications in our clinical practice. In the case of the tutors among us, I believe our privilege in the opportunity to pass on what we are passionate about goes hand in hand with our special responsibility to ensure that the content of our delivery is consistent with contemporary findings, avoiding at all costs the convenience of perpetuating demonstrably obsolete or even discredited material.

The inaugural article launching this feature has kindly and very aptly been provided by lan Pollard, who attended the recent 5th International Fascia Congress in Berlin (14th-15th November 2018), and whose conclusion reproduced here perfectly exemplifies the above message: 'My general awareness and deeper understanding of the complex structure and importance of fascia, and most importantly how I will approach my work as a result, has been immediate and will no doubt be far-reaching over the years ahead. As an investment in knowledge I'm sure it will prove extremely beneficial and an experience I will refer back to for many years to come.'

lan's entertaining report is followed by 'Part 1' of an also long overdue paper from me summarising the evidence as to why, contrary to what virtually every textbook would have you believe, *psoas major is NOT a hip flexor...*





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A Good Career Needs a Good Investment

From Mel Cash

There are now many short intensive massage courses which I suppose fit in with modern-day life expectations. People want fast-food or instant results and they don't want to wait for anything anymore. But you only get what you pay for!

Massage is a skill and it takes real time to develop a real skill. It also takes time to properly study all the underpinning knowledge you need to become a good and effective therapists. You just cannot get this from a short intensive course. Too many people have done these courses but where are they now? Very few actually succeed and become professional therapists with a lifetime career. But it is worse than that because these inadequately trained therapists do try and for as long as they last they do poor quality treatments which can ruin the reputation of the whole profession.

It may look good when you see that you can do a short massage course and immediately get work through an online booking agency but it's nowhere near as good as it looks. These agencies charge the client on average £49 for a massage at their own home. I used to charge £50 for this service when I started my career over 30 years ago! These agencies are badly devaluing the massage profession and they can only do it with cheap poorly trained therapists. And it's not a very dignified way for a professional to work, dragging a massage couch around on the London Underground for only £37 a treatment. If you devote yourself to them full-time, if you are good and lucky you might just about make a living wage. But the agency makes over £10 to automatically process each booking and they are laughing all the way to the bank.

Short intensive course may look good at first but they usually turn out to be a complete waste of money. If you want a stimulating and rewarding lifetime career you have to make a good investment which means at least a year of quality training and nothing less will do.



2019 Born to Walk and Active Fascial Release Workshops

With James Earls





For all information and to book a place, please visit: www.borntowalk.com/workshops or email info@borntowalk.com

Born to Walk 112-114 Gloucester Ave London, NW1 8HX 07774 183458 info@borntowalk.com

2019 UK Born to Walk workshop dates / locations

- ✓ 11th-13th March 2019 Liverpool
- ✓ 10th 12th June Newcastle Upon Tyne

Walking is one of the most common daily functions, but one of the least understood biomechanically. To understand anatomy the therapist must first understand function.

In this workshop, we analyse the mechanics of efficient gait, looking at the chain of movement events from the feet to the spine and into the shoulders. Upon completing this course you will have the tools to understand true, real-life movement and how to correct faulty patterns.

Description

To understand anatomy the therapist must first understand function. In this workshop we analyse the mechanics of efficient gait, looking at the chain of movement events from the feet to the spine and into the shoulders. We explore how gravity works in concert with the joints and thereby the fascial and myofascial tissue to improve proprioceptive communication, muscle firing, and collagenous recoil. You will come away with the tools to investigate, analyse and intervene in non-pathological walking, learn how to build a personalised movement program to improve your clients' gait.

Workshop Format:

The workshop will be split into roughly equal time on

- ✓ Presentation of the underlying principles.
- ✓ Interactive Postural and Functional Movement Analysis, and
- ✓ Learning functional movement interventions and assessments to explore how your client uses their body.

This course helps you:

- ✓ Assess your client's postural and movement patterns with greater accuracy.
- ✓ Analyse the normal motion of the spine
- ✓ Understand the connections and correcting mechanisms between the pelvis and the feet.
- ✓ Assess the feet and their role in shock absorption.
- ✓ Relate textbook anatomy to your client's actual movement patterns.
- ✓ Apply Tom Myers' Anatomy Trains & Robert Schleip's Fascial Fitness in function.
- ✓ Effectively identify and correct your client's faulty movement patterns.

Course Objectives:

- ✓ Present an introduction to the geometry/character of the connective tissue, to understand fascial and anatomical links through the body & the sequence of events through the joints in normal gait.
- ✓ Supply you with an understanding of fascial recoil and the roles of mechanoreceptors in the myofascia.
- ✓ To fully appreciate the significance of tensegrity of fascia and human movement.



- ✓ Let you explore what switches on the 'core', what really corrects pronation, why we flex our elbows to run, and many more functional connections and interactions.
- ✓ Give you the tools to apply various gait assessments and then construct alternative movement strategies to help unwind and resolve compromised patterns.
- ✓ Providing you with a fun, relaxed, informative and empowering experience that you can implement the next day in clinic.

2019 UK Active Fascial Release workshop dates / locations ✓ 12th – 14th April 2019 – London

✓ 23rd – 25th September 2019 – Liverpool

Active Fascial Release (AFR) blends functional movement principles with hands-on manipulation of the soft tissue to give you completely new and exciting assessments and treatment strategies for your clients. AFR allows the practitioner to work with motor control, joint and soft-tissue issues all with the same technique – the client is simultaneously assessed, treated and re-educated with pain-free interventions.

Description

What is Active Fascial Release (AFR)?

Active Fascial Release has been developed by James Earls, blending his understanding of myofascial and functional movement principles with hands-on manipulation of the soft tissue to create a variety of therapeutic effects. James trained with Tom Myers, the originator of the Anatomy Trains model, and studied functional movement principles with Gary Gray and David Tiberio of the Gray Institute. Active Fascial Release aims to bring the best of both these models together to give you an immediate and effective treatment tool. Active Fascial Release combines elements of motor control theory with a neuro-myo-fascial approach to identify, treat and finally re-educate the client's movement patterns. The blending of guided movement with various soft tissue engagement protocols has created a method that addresses the body as a whole and acknowledges the roles of the body's various tissues and their interrelationships.

Workshop Format:

- ✓ Relevant Anatomy: short, intensive and integrated presentations from multiple sources including video of fascial dissections are combined with the palpation of relevant structures. We aim to convey information in an inspiring and understandable fashion.
- ✓ Postural & Functional Assessment: learn how to see and 'read' the intricacy of individual movement patterns.
- ✓ Active Fascial Release Techniques: each technique is fully laid out for intent and 'feel'. Plenty of time is dedicated to practice, ensuring you can apply these methods immediately in your clinic.

Timetable:

- The lower limbs are covered during the first day, along with essential elements of functional movement such as directions and drivers.
- ✓ The second and third days address the pelvis, torso and shoulder girdle.
- ✓ Throughout the course, fascial touch skills are explored in movement, creating powerful effects on the myofascial tissues.
- ✓ We finish by blending the material together to give a full body treatment, learning to feel the connections through the body in many different positions with a variety of movement ideas.
- ✓ Once the principles of AFR are learned they can be easily adapted to almost any client or situation. The application of this work can increase your clients' body awareness and understanding of movement as well as resolving or easing many of their issues.

Learning Objectives:

- ✓ Understanding and applying essential principles touch, layering, movement.
- ✓ Applying different movement drivers to create different effects and knowing when to use them.
- ✓ Knowing how to create tissue length versus separation and when to apply each.
- ✓ Combining structural and functional assessments and making sense of how they interact.
- ✓ Building on the principles listed above to develop global and local movement strategies and knowing when to use each based on the combined structural and functional assessments.

Further Highlights Include:

A full repertoire of interventions for the upper body including quadratus lumborum, obliques, and intercostals, multifidi and shoulder girdle muscles. Bringing the protocols together to assess and understand the full body connections.

Learning Aids:

A fully illustrated manual outlines the principles and techniques. Participants also receive access to video content to review and expand on the techniques demonstrated during the workshop.

Who Should Attend?

The workshop is designed for massage therapists, physical therapists, osteopaths, chiropractors and those wanting to add an extra dimension to their treatments. While anatomy and pathology will be acknowledged during the 3 days of training, time is too short to teach basics, so a reasonable understanding is expected to allow for a rapid progression and focus on techniques.

What to Bring:

Wear loose, comfortable clothing that allows you to move freely.



Instrument-Assisted Soft Tissue Mobilisation (IASTM) for Massage Therapists

From Chris Gordon MCSP SRP



You may have read about using metal tools as part of your treatment. I thought it would be a useful opportunity to provide some details on how the instruments work and how they may fit into your daily practice.

I have been using instruments as part of my treatments for 10 years now. I was introduced to them when I was working at Bisham Abbey as a Physiotherapist with the English Institute of Sport.

I was originally trained to use Graston tools and taught Graston Technique.

It fits quite closely with a Traditional Chinese therapy called Guasha ('moving blood', I think is the translation) and that has given IASTM a bit of bad press as Guasha is a very deep and aggressive treatment, expected to produce bruising by the end of a treatment session. That is not the plan with IASTM!

At the same time as starting to use Graston tools, we were doing some work with a Bowen Technique Therap ist, Nick Baker, who elicited an interest in looking at fascia in much more detail. Fascia features surprisingly little in the skill set of a Physiotherapist, and in my experience of working with and teaching Massage Therapists, I feel you have a better understanding of and ability to feel fascial tissue. And that is important because understanding fascia is essential to using instruments effectively as part of your treatment.

A number of different makes of instruments are available nowadays. They can be made of polycarbonates, which cost much less, or you can find stainless steel tools, which are more expensive. They have different curves to suit different body areas and have different edges of variable sharpness. These edges enable you to adjust your pressure from deep to superficial.

If you are able to afford a good quality stainless steel tool, it is worth the investment. Bearing in mind that these tools will last forever if you look after them, it may be worth splashing out a little more money. Ultimately, the better the tool, the better the feedback you will receive, the better the outcome you will achieve, and especially, the better the patient's experience!



A full set of Graston tools - of which I use three more than the rest:



How do the instruments 'work'?

Initially, I use a tool to 'sweep' along and across a fairly large area around the area targeted for treatment. This also allows me to assess effectively a fair scope of tissue proximal and distal to the target area. This initial 'sweeping' technique enables me to feel for areas of thickening and roughness where I picture fascia as congested or stuck. This is where a good quality tool presents an advantage as it mediates better feedback into your hand. Having assessed the tissue I can use a range of techniques and edges to mobilise the tissue and 'iron out' some of the 'creases'.

Why not just use your hands?

I thought this when I originally worked with tools. 'Isn't this what I do with my hands, surely?' Basically the answer is 'yes', that is true – but I feel I can achieve greater depth and be more targeted using tools. Occasionally a patient will return with some bruising following a relatively gentle treatment, which is not something I ever see following treatment with my hands. So I feel the tools can reach deeper and be more targeted.

Secondly, there is the bonus of saving your hands. I still use my hands to assess and manipulate tissue, but the bulk of the heavy work can be done with tools, which definitely saves my hands by the end of a busy day.

Do clients like it?

Yes – once they have got over the shock of being attacked with metal blades! I explain carefully how the tools work, which helps start a conversation about fascia and movement etc., which in turn

will tie in with their exercise prescription.

More importantly, patients appreciate the immediacy of the treatment. As I work, I keep re-assessing ROM (range of movement) and pain levels etc., and if I am targeting my treatment effectively, I would expect to see improvements during the session. Patients report that they 'like the feeling that something is being done' even though it can be a little uncomfortable.

How do you learn?

If you are already a practising Massage Therapist, learning to use instruments is quite easy. The tricky part is assessing tissue and formulating an effective plan. If you are already experienced at doing that you will find that the introduction of tools complements what you have been doing with your hands.

A one-day course with a recognised trainer should be sufficient to give you the confidence to get started and decide which instrument is appropriate for your needs.

There are more advanced techniques that you can learn as an additional day's course, but you may not feel the need to do this until you have used instruments regularly for six months or so.

Courses

After running one-day courses in 2018, I plan to provide some courses in February and March 2019. For further details, please visit <u>www.chrisgordonsportsphysio.co.uk</u> or email me at <u>chrisgordonsportsphysio@gmail.com</u>.



Refresher/Revision sessions Sarah Tidey BSc, LSSM, ISRM

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Please send an email to sarahtidey@ymail.com if you wish to attend.

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Requests can be made by e-mailing tanya@tmb-src.co.uk

Please note that while specific requests for tutorial or workshop subjects are all welcome, courses can only take place subject to sufficient uptake.*

Thank you in advance for your interest.

Tanya Ball MSc BA KCMT BCSI LSSM MISRM MCNHC MIASI Remedial Soft Tissue Therapist / Board Certified Structural Integrator / Kinetic Control Movement Therapist

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Below are a selection of websites that might be of interest to you. If you have discovered some others that you would like to share, please send them along to admin@theisrm.com Thanks

http://www.movementlectures.com

www.news.bbc.co.uk/1/hi/business

www.getbodysmart.com/ap/muscularsystem/quizzes/ upperextremities/menu/menu.html

shoulderdoc.co.uk

sportsinjuryclinic.net

stopsportsinjuries.org

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leonchaitow.com

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ISRM is on the Sport and Remedial Therapies Council, which is recognised by CNHC as the lead body for Sport and Remedial Therapies.



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