

Newsletter

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Breaking news! By Mel Cash

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LSSM – A 30-Year 'History'... and 'Evolution'



X₁, S, R, M

comprised just 6 weekend workshops run over 6 months.

At the end of the third weekend of this inaugural course, Mark announced that he was going off to America and we never saw him again - wow! But somehow Sarah and I rose to the challenge, the course went remarkably well, and the verifier from OCR gave us a good report. So we scheduled more courses and our reputation rapidly grew. A few years on, Sarah left us because she had moved further away from London, got married, and had two children! This was not a problem because by then we had a number of other good therapists with teaching potential, and we were starting to build our great team of tutors, some of whom also went on to become Osteopaths. We also left OCR, turning to BTEC for our external accreditation, which has worked out very well for us. We soon moved to bigger premises at Regent's College (now a University), in the beautiful setting of Regent's Park, where we could run several concurrent classes at weekends.

In those early days, Sports Massage was a good job because there were not many of us around and we could all make a good living. Oh happy days! But this wouldn't last long as other schools soon entered the market. VTCT and ITEC were the two main awarding bodies who specialised in training for the Spa and Beauty industry, and their courses included relaxation massage. Without a definition of what 'Sports Massage' was, they were able to run basically the same massage training but with heavier pressure, and called it Sports Massage. And so it started to turn into an industry. These days the market is saturated with too many sports-based therapies and sports massage is no longer the fun, easy-going job it once was.

In the mid 1990's I was approached by a Physiotherapist, Joan Watt, who wanted to set up the 'Sports Massage Association' (SMA), and as LSSM was the biggest training school she needed to have us on board. I made it absolutely clear at our first meeting that their curriculum had to include more than just basic massage, and needed to include some advanced techniques which could only be achieved through a Level 4 qualification. Joan promised me that this would be the case and on this basis the SMA was formed. But I was politically naïve in those days and believed what I was told.

It turned out that she wanted to control sports massage for the benefit of her own Physiotherapy profession, and so would not allow any advanced techniques into the SMA curriculum. Then they took on a business manager who opened up SMA membership to Level 3 therapists to gain more members and make more money. I had warned them many times that if these things happened I would leave and set up my own association, which is exactly what I did, and so the Institute of Sport and Remedial massage (ISRM) was formed in 2005.

The ISRM is more than just a membership association though - it was also set up as a way to expand our qualification benchmark more widely across the country. I did not want my own school (LSSM) to run courses all over the land because it would have been impossible for me to maintain the direct contact with all my students and tutors which I feel is so important. Making ISRM a BTEC centre meant that it could license other training providers to run courses offering the same qualification as well. Several universities wanted to include it within their broader degree courses but were unable to meet our criteria. We demanded that they use experienced therapists rather than university lecturers to teach practical subjects, with a 12/1 student to tutor ratio, which was also beyond their budget. Nevertheless, we now have a number of private, independent schools in London, Southampton, Exmouth, Bristol, Oxford



LSSM's first training course started in September 1989 and so 2019 has been our 30th anniversary year, which is something worth reflecting on. ISRM certainly has a history now, but I see the actual training we provide rather as an evolution.

So first, the 'history'

My first book on Sports Massage came out in 1988 and became a rallying point for a few other massage therapists doing the same thing. As a result of some chance meetings and phone-calls, a group of four of us met up in London and decided to try running the first-ever Sports Massage course in the UK. There was myself and another massage

therapist called Mark Zambarda, who had become well-known for working with a group of high-profile Olympic sprinters. He and I were to be the main tutors leading alternate weekends, and were to be assisted by Sarah Parker (now Ashmore) who was another great massage therapist with a very strong sporting background. The fourth, Wrio Russell, was also a massage therapist but was mainly to be involved in the administration aspects.

None of us had been happy with the massage schools we had attended, and we were determined to offer something much better. From the start we wanted our course to include External Accreditation, which was a fairly new idea at the time. We wanted the involvement of an independent body that would check to make sure we were achieving a high standard, and would grant us accreditation for doing so. We identified the awarding body OCR and wrote up a curriculum leading to a qualification that they accepted.

We found a room to rent at the Seymour Leisure Centre in central London, we advertised the course in a sports magazine and managed to get (or persuade) 8 people to enrol. One of those was Alex Fugallo, who is still one of our tutors today. This first London School of Sports Massage course

and Cambridge, which are run by highly competent and experienced therapists who all share my passion for Soft Tissue Therapy. I work closely with them to ensure good quality and consistency across all our training centres.

Whilst all this had been going on, our training program had grown in scope and depth and the course was increased from 6 months (Sports Massage) to 9 months (Sports & Remedial Massage) in the mid-1990ies, and eventually to 12 months (Soft Tissue Therapy) in 2008, when the qualification rose from BTEC Level 4 to Level 5. Voluntary Regulation was introduced concurrently, which you can read about in another article in the 'Our profession and its future' section of this newsletter.

As we expanded, so did our administration requirements - hence we moved into an office, took on 3 staff, and today the admin team have lots of business matters to deal with that have nothing directly to do with therapy and teaching. By that time, my only remaining LSSM co-founder Wrio had moved out of London and retired after many years of dedicated support, so I was the only one left in charge of it all.

And now, for the 'evolution'

The reason I see the development of our training program as an evolution is because it did not really involve much forethought or planning: instead, it all just seemed to develop naturally in response to changes in our working environment.





We had the best start possible because BTEC support *customised* the qualification, which gave us the freedom to devise the course we wanted without any outside organisation telling us what they thought we should do. As pioneering therapists, my tutors and I really understood (and continue to do so!) the clinical needs of our clients and how to make a successful career out of this. It was just a matter of tracking back from this desired outcome, and designing the training program that would achieve it. As the years have passed, being hands-on therapists as well as tutors we have continued to improve our skills and knowledge and have naturally incorporated these developments into our training as we have gone along.



With an integral link between clinical practice and training we have also been able to respond well to changes in the marketplace. Over the years, the NHS could increasingly ill-afford to treat minor and chronic musculoskeletal injuries, so as the sports massage market became saturated with too many therapists, demand from the general, non-sporting population grew significantly and remains an ongoing trend. Over the last 10-15 years we have increasingly focused on developing this area of work so we could be ever-better equipped to meet many of those needs with the wider population. We now place a greater emphasis on client assessment, to ensure that we only treat those minor and chronic injuries that lie safely within our scope of practice. These also represent by far the highest incidence of all injuries, coinciding with the largest commercial market as well. We are also teaching and carrying out more detailed postural assessment as this is so often a key factor in the root cause of chronic injury. The advanced neuromuscular techniques we so deeply value have also been developed further to enhance our effectiveness with

This combined 'evolution' over decades explains why we now use the title 'Soft Tissue Therapy' for our Level 5 qualification: the time is long overdue for us to publicise that what we offer is so much more than 'just' Sports Massage. We are no longer defined or limited by the word 'massage', because we have the training and skills

more complex problems.

to deliver a highly effective treatment using advanced soft tissue techniques, without applying any 'traditional', lotiondependent massage strokes if there is a more appropriate option at the time. The 'sport' element applies to just one of the categories of clients we see, so this term no longer defines us either. Of course, 'Sports Massage' remains a significant part of our training, and many of our therapists promote themselves as 'Sports Massage and Soft Tissue therapists' and capitalise on both markets.

When I compare this against all the other massage-based courses in the UK, I am in absolutely no doubt that the ISRMaccredited qualification stands head and shoulders above all the rest. The training we provide truly meets our clients' needs better than any other, and offers the therapist the greatest career potential and sense of fulfilment

When I look back over the last 30 years, I can feel very proud of what we have achieved. We have successfully trained several thousand therapists who have gone on to treat hundreds of thousands of people. This implies not just having given our therapists a stimulating and rewarding career, but also having improved the quality of life of all their clients. We have also created a whole new and vital service within modern healthcare – a niche destined to continue to meet an otherwise neglected need. To finish on a personal note. I have thoroughly enjoyed the experience of this 'evolution', and intend to continue doing so for many more years to come. I also must thank all the great people who have supported and helped me along the way.



Editorial By Tanya Ball

Welcome...

A very warm welcome to our December 2019 ISRM Newsletter. A special welcome to any new students or full members for whom this is their first Issue. It is always my intention and goal that this publication should prove sufficiently informative, beneficial, and motivating to inspire readers to contribute a story or article in the next edition! Please forward this to me at: editor@theisrm.com.

Please note that the closing date for submissions for the next Issue is: Friday 15th May 2020, thank you. Please send all contributions to me at: editor@theisrm.com

Newsletter 'facelift'

Unless this is your first issue, you won't have failed to notice (and hopefully appreciate!) the newsletter's slicker, more contemporary look, aimed at reflecting more accurately the nature of what ISRM has come to represent and the values it upholds. This 'facelift' perfectly coincides with the end of 2019 marking the London School of Sports Massage's (LSSM) 30th Anniversary.

Besides the fresh front and back page design, this edition introduces a number of exciting novel features aimed at serving and inspiring our readers even better going forward. I wish you all many hours' enjoyable and informative reading, and of course inspiration for the future.

In this Issue...

Breaking News - LSSM's aforementioned 30th Anniversary this year is a remarkable accomplishment in the history of our profession, worthy of recognition and celebration by all of us! Accordingly, fresh from his autumn newsletter minisabbatical, Mel Cash has chosen to write an engaging first-hand account of the School's journey from its inception to the present, aptly likening this to an 'evolution' rather than a 'history'. Make sure therefore you turn to Mel's Breaking **News** section on page 2 for an inspiring

read of what a spirit of enterprise with a can-do attitude can achieve!

Our profession and its future – As LSSM completes its third decade, Mel has taken a long hard look at 'the Good, the Bad, and the Ugly' with regard to how the professional and regulatory standards of Sports Massage & Soft Tissue Therapy have - you have guessed - evolved over the years. Unafraid to speak his mind, Mel offers an uncompromising appraisal that includes criticism of past failures and optimism for the present and future - see section 'Our profession and its future' below.

Adding strings to our bows - The enthusiastic reception of Sue Wells' inaugural article in December 2018 about how, as an experienced STT therapist, she trained, gualified, and has successfully been incorporating Manual Lymphatic Drainage (MLD) alongside STT in her clinic ever since, has prompted me to create a new feature entitled 'Adding strings to our bows'. The aim is to enhance readers' awareness of other professional options 'out there' that they may wish to consider combining with their existing and growing clinical skills. For each edition, a seasoned practitioner from a different but 'compatible' field shall be invited to present his/her therapy, explaining and supporting its efficacy claims with relevant evidence. In the present issue, Mary Flicking introduces us to the nature and benefits of Deep Oscillation Electrostatic Massage.

Feature articles – I am delighted that the autumn 2019 'drought' within this section has given way to two contrasting, equally inspiring 'monsoon' contributions, from Sue Ainley and Derek Marks respectively. Long-standing members will know that Sue and husband Rob were founders, then primary pillars to this day, of the growth and expansion of the tiny but thriving and life-changing Charity 'Seeing Hands Nepal' (SHN). The idea was to train destitute blind Nepalese (no health or social 'safety net' in Nepal!) in STT so they could earn a living, become self-sufficient and even support a family. Just as LSSM has turned 30 this year, so SHN has reached its 10th birthday, and Sue's story looks back at



just how much has been achieved, how many lives have been transformed, thanks to the generosity, dedication, courage, determination, enthusiasm, and faith of a few UK and Nepalese 'strangers' united by the same goal.

In contrast, **Derek** shares his lifelong passion for music both as a listener and professional performer, discovered and nurtured in his native South Africa, and explores the therapeutic impact and 'power for good' he believes music can have on patient and therapist alike - the focus always remaining on the patient's best interests. On the basis of the profound effect of music in his clinical work, Derek concludes the story by calling on those who may never yet have considered it, to 'give music a go' in their practice.

Event Work – Looking ahead: an exciting new feature is being launched in this issue, which you can read all about in the relevant newsletter section.

Looking back: as in past years, a number of ISRM-organised onsite soft tissue therapy (STT) opportunities took place this year, and readers can catch up on and draw inspiration from first-hand stories and action photos. These include engaging first-hand accounts of the 2019 London Marathon thanks to Chloe Cyrus-Kent and Janice Barrett. Enjoy the selection of pictures from various participants (thank you again to all of these) reflecting the buzzing atmosphere and deep emotions of these events! A very grateful 'thank you' once again to all who helped, sometimes stepping in at short notice and/or personal inconvenience.

Research Developments and Clinical Practice - Timed to perfection to complement and illustrate Mel's contributions in the 'Breaking News' and 'Our profession and its future' sections respectively, Matt Scarsbrook's insightful, probing article 'So what makes it a sports massage?' raises legitimate, relevant questions about commonly claimed therapeutic benefits of, differences between, and rationale for, massage versus sports massage versus soft tissue therapy,

and calls for scientific, evidence-based grounds to support - or indeed refute such claims.

My long-overdue (adapted) article Why Psoas Major is NOT a 'hip flexor' – Parts 1 and 2. As explained in a previous Issue, after having over many years engaged in good-humoured – but no less 'serious' – controversial discussions with colleagues and students about the contrasting classifications reported roles of the psoas major muscle, I decided in autumn 2018 that it was more than high time for me to share, in *two* parts, the essential findings of a 4,000 word research paper I had completed as a Motor Control module essay as part of qualifying as a Kinetic Control Movement Therapist (KCMT) in 2013.

Far from seeking to 'generate controversy for controversy's sake', my intention was and remains to encourage and urge members to question and reflect on perceived contradictions or conflict between longestablished, universally accepted knowledge or beliefs, and their personal self-directed learning and/or clinical experience. If something doesn't 'fit', 'gel', or 'make sense'... then question it! Challenge it! And do so without implicitly clinging to the premise that all established, collectively accepted 'science' is necessarily infallible and accurate. I would stress that this is *not* the same as arrogantly assuming that 'we know better' than the countless highly accomplished researchers and scholars whom we owe most of the body of scientific knowledge available. It is in my view a matter of simply but boldly acknowledging that medical and healthcare research is perpetually evolving, and is often generated or motivated by anecdotal clinical experience ('why does such-and-such a treatment "work", how, and in what circumstances?'). In turn, ensuing new scientific findings lead to enhanced understanding and innovative developments which can fantastically inform, enrich, and further promote optimal, pioneering clinical practice.

I therefore wish you 'enjoyment' in reading why, contrary to what virtually every textbook would have you believe, I contend that psoas major is NOT a hip flexor ...

Expand your knowledge, enhance your skills (CPD)

Confirmed 2020 CPD (Continued

professional development) courses can be found in this section, which we are endeavouring to offer over an expanding geographical catchment area. I would particularly draw your attention to the forthcoming Born to Move (formerly Active Fascial Release) and Born to Walk three-

day workshops in Winchester in March and May 2020 respectively, to be tutored by eminent writer, lecturer and bodyworker specialising in Myofascial Release and Structural Integration James Earls. At the time of writing, there are only 3-5 places remaining on each workshop, so you are advised not to delay in securing your place... As previously, members will be notified of any further courses and workshops in subsequent Newsletters, via the ISRM website, and/or by group email as they become confirmed.

More good news for all ISRM Members!

Make sure you CAREFULLY check the newlook inside and outside newsletter back cover for a range of preferential offers to members: in addition to the existing discounts:

- ✓ Health Education Seminars (HES) postgraduate courses/workshops: £20 off one-day and £40 off two-day courses
- ✓ *Marshcouch*: 10% off all couch orders
- ✓ Physique Management Company: 10% off sports injury treatment and massage products
- ✓ Journal of Bodywork and Movement Therapies (JBMT): 15% off annual subscriptions.

You will find an assortment of new/recent deals, including free access to the excellent Kenhub online 3-D anatomy learning tool and to the Sports Injury FIX listing. This is complemented by a fully updated list of useful websites, links, online videos, and other educational resources, which will continue to be reviewed at regular intervals.

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

My grateful thanks as always to the many contributors to this Issue. Please would everyone (i.e. not just 'other people'...) make an effort to ensure your newsletter remains a stimulating, thought-provoking, and motivating forum by writing your piece for the next Newsletter.

Thank you!

Please note that the submission deadline for the Spring/Summer 2020 Issue is: Friday 15th May 2020, thank you.

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 non-obsolete 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.

****** It remains for me to wish you all a most enjoyable and informative read, a peaceful, stress-free festive period, and abounding good health, inspiration, and fulfilment in 2020 and beyond.



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OUR PROFESSION AND ITS FUTURE

The Good, the Bad, and the Ugly - Update on Regulation By Mel Cash



Historical fast-track

There has always been talk about Regulation for the Complementary Healthcare professions such as ours to ensure the public can be safe and confident of getting a high standard of treatment. The Government has made it clear that we will never gain Statutory Regulation because this is a very expensive process which has to be approved through an Act of Parliament. They will only do this if a therapy has the potential to cause serious harm, but what we do is inherently very safe, so Voluntary, rather than Statutory, regulation is the only path we can take.

The Complementary and Natural Healthcare Council (CNHC) was set up with Government support to protect the public by providing a UK-wide voluntary register. This register was approved as an Accredited Register by the Professional Standards Authority (PSA) for Health and Social Care, a body accountable to Parliament.

I strongly supported the creation of CNHC more than 10 years ago because its primary role was to protect the public from poor treatment. To do this they would have to put procedures in place which would guarantee that only well trained therapists could be registered with them. It was hoped that the medical profession would then be more willing to refer patients to registered therapists because of this quality guarantee, as would employers and the general public.

The Bad...

ISRM was approved by CNHC so our members could apply to CNHC for registration, and about 10% of the membership have done this. But we have found that they tend only to stay on the Register for one or two years and then

stop. This is because Accredited Registers have not really taken off in the way we had hoped. Doctors are supposed to know that if they want to refer patients to a Complementary Therapist, they should only use those on an Accredited Register, but many that I have spoken to still have not heard about this. Most of our work comes from the general public, few of whom know about the CNHC register either, and nor do the very rare employers we have. But recognised accreditation is something that a small number of our therapists will benefit from and it is something that may grow in the future, so ISRM must continue to facilitate Registration for our members. However, I have become increasingly disillusioned with CNHC over the years because I do not believe they are doing a satisfactory job. They are registering some therapists with qualifications I know to be very poorly accredited. Without good and robust accreditation, there can be no guarantee that the registered therapist has genuinely achieved the necessary level of training.

The Ugly...

For example, CNHC accept VTCT/ITEC gualifications which use Multiple Choice (MCQ) exams that have long been discredited as a poor assessment method, and something our external validator BTEC would never allow us to use. Their students' written assignments are marked by personnel from the local schools themselves, and the VTCT/ITEC external examiners' input is limited to merely briefly looking through assignments whilst observing the practical exam. This is nowhere near good enough and does not compare at all with the very thorough audit that BTEC put us through every year. Worst still, CNHC register therapists through the Complementary Healthcare Professionals association, who accredit courses by visiting the school just once - NOT once a year - and observing only one hour



of teaching, and that's all! How can this be a reliable way of ensuring good quality?

I am not suggesting that the training schools and therapists with these qualifications are necessarily bad, but CNHC are not enforcing procedures to guarantee they are of adequate standard. This is what their main role is supposed to be and they are undeniably not living up to expectations.

So now for the Good!

CNHC are not the only Accredited Register in the Complementary Health sector. The Federation of Holistic Therapists (FHT) is the largest complementary therapy professional association in the UK with about 20 times more members that ISRM. Despite the big difference in size, we have worked well together on projects in the past and have built up a great mutual respect for each other. FHT are also approved by PSA to operate Accreditation Registers, and will be happy to support any of our members who wish to be registered. What pleases me most about FHT is that they really understand what it is to be a Complementary Therapist because their management team all come from that background. They also understand the importance of good, effective accreditation and make sure that is at the heart of their Register. I believe that we can trust the FHT register with much greater confidence than the CNHC register, and that this is now the right place for us to be.

Our members will from now on be able to enjoy dual ISRM/FHT membership if they so wish, and for significantly less than it would cost to register with CNHC. Not only can we be listed on the FHT Accredited Register, but also access a whole range of their membership benefits on top. I think this is an excellent deal for us all, and being more closely linked with such a large and well-respected professional association could lead to even more benefits in the future.



ADDING STRINGS TO OUR BOWS

DEEP OSCILLATION® Electrostatic Massage – An Overview for ISRM

DEEP OSCILLATION® is an internationally patented, electrostatic massage therapy, which, as opposed to externally applied mechanical forms of vibration massage (only acting on the surface of the skin), works through the entire tissue layers, including the connective tissue, to a depth of 8 cm (Hernandez Tapanes et al, 2010).

effective, Biologically intermittent. electrostatic impulses are delivered via the therapist's vinyl gloved hands (the vinyl acts as the medium for the therapy to flow). Because little to no pressure is required to apply the therapy, the therapist's hands are protected from the usual demands placed upon them when providing deep tissue massage, yet the effect is still able to permeate an eight-centimetre depth.



Application



The client hand-holds a small titanium bar, the therapist slips on thin vinyl gloves and fits an electrode to their arm: the electrode and the bar are connected to the machine. There are no new massage techniques to learn; the biologically effective oscillations work within the targeted tissue area, and the tissues are attracted to the hand and then released between 5 and 250 times a second.

Trapped excess residual metabolic matter following injury or surgery, is broken down and pumped to the lymphatic system for removal, enhancing the speed of natural physiological healing processes. Deep Oscillation® is thus believed to promote a more effective lymphatic drainage, quickly improving tissue quality.

Non-invasive and non-traumatic

The resonant vibrations emitted by DEEP OSCILLATION® are non-invasive and nontraumatic, most patients love the subtle tingling sensation, and it is also enjoyed by therapists, who benefit from their own hands receiving treatment whilst delivering it. Because of its gentle application, it is a unique and 'unrivalled' treatment for acute injury, where deeper therapeutic massage would normally be contraindicated. This

By Mary Fickling

means that Deep Oscillation® can help boost the rehabilitation process, which accounts for its growing popularity in the world of elite sport.

It can be very effective in early post-operative care in reducing resultant scar tissue volume and rugged texture, swelling and bruising, and even in some cases lessening pain medication requirements. With some chronic conditions, including for example Secondary Lymphoedema of Head and Neck, where other therapies have perhaps struggled to make an impact, Deep Oscillation® has been found to make a really positive difference. One illustration is the case study below:

"The Leeds Lymphoedema team has been using HIVAMAT[®] 200 (DEEP OSCILLATION[®]) in conjunction with Manual Lymphatic Drainage for over 2 years. Manual Lymphatic Drainage as a stand-alone treatment gives good results over time. Since introducing HIVAMAT® 200 we have found the results happen more quickly, especially when softening fibrosis or scar tissue. The advantage for the Practitioner is that they are still delivering a hands-on treatment, just with the addition of gloves. This enables them to feel the tissues as they work, adjusting their movements and depth of working alongside the frequency of the oscillations to obtain optimum results for the patient. It also still enables good control of their hands in delicate and small areas. The treatment is pleasant to receive and we have only ever had positive feedback. The treatment of Head and Neck Oedema can be challenging for both therapist and patient, so to be able to achieve effective results more quickly is hugely positive for both, as it also frees up clinic slots to enable more patients to be treated. The use of HIVAMAT® 200 has definitely improved the overall treatment



ADDING STRINGS TO OUR BOWS

opportunities we can give our patients." Catherine Groom, Leeds Lymphoedema Service, BLS, MLD UK, PHIA Vodder and Casley Smith, MLD DLT Practitioner and Lymphoedema Therapist , extracted from article "Eight Years On – An MLD DLT Practitioners & Lymphoedema Therapist Review of DEEP OSCILLATION® (HIVAMAT[®] 200) Therapy" in: Journal of Manual Lymphatic Drainage UK, Autumn 2015.

Where there is hardened scar tissue and/or fibrosis, the treatment works quickly to break down problem areas – softening of fibrotic breast tissue in as few as 20 minutes has anecdotally been reported (see physiopod. co.uk references). Deep Oscillation has been proven to be effective for "Prevention of fibrotic remodelling processes, reduction of fibrosis" (Schönfelder, G and Berg, D 1991; Jahr, S and Schoppe, B Reisshauer, A 2008; Gasbarro, V et al. 2006; Gao Y C et al. 2015).

Clinical Effects

Clinically proven benefits below (see physiopod.co.uk references) include: significant pain reduction, anti-inflammatory, anti-fibrotic, detoxing, oedema- and haematoma-reducing effects, and promoting of the wound healing process.

Unlike other treatments, Deep Oscillation® can be safely applied over metal pins and plates, prosthetics and breast implants. It can be used safely over the eyes and is frequently employed in anti-aging and address dark circles under the eyes, swollen eyelids, as well as cellulite in the lower limbs (proven improvement in 80% of grade I and II cellulite cases [Korkina et al. 2007]).

THE SCIENCE behind Deep Oscillation®



For a detailed scientific review, please read Dr Jens Reinhold's Mechanisms of Deep Oscillation (2017) who presented the therapy in 2018 at the MLD UK Annual Conference.

Products

DEEP OSCILLATION[®] equipment is available in four products: The Personal Basic, Personal Pro, Evident (Sports/Aesthetic/ Clinical versions), and the lonoson-DO-Evident - a combination unit which includes Therapy, and Deep Oscillation® in the fourth channel. PhysioPod are happy to discuss with therapists which unit would best suit their needs.

Training

Training can be completed over the phone and/or therapists can train in Nottingham, one-to-one with Managing Director of PhysioPod UK Julie Soroczyn. Julie is the person responsible for having brought Deep Oscillation® to the UK from Germany in 2006. Most therapists initially train over the phone (it is very easy to use), as the skills required have already been acquired by the therapists' hands. It is a simple case of slipping on the gloves, connecting the device, and starting the massage. Pre-programmed conditions allow for ease of use and a sound indicates the end of the session. PhysioPod are always on hand for any questions and queries, no matter how small, via email or phone.

Therapist Map

All therapists investing in Deep Oscillation® are included free of charge on the PhysioPod UK's Therapist Map on completion of a website questionnaire. Mary Fickling, Julie's sister and Co-Director, is deeply committed to creating high quality web representation, which she shares through the powerful tools of social media. Mary also helps with providing the correct wording and images to support marketing efforts of therapists who have invested in a device.

Insurance

Deep Oscillation[®] is covered by the majority of Professional Indemnity and Public Liability insurance providers, including Balens, and PhysioPod provide a certificate of training suitable for adding Deep Oscillation® to existing policies.

For more information, please email info@physiopod or call 01159 167 685, or Julie on 0788 692 5715.

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DEEP OSCILLATION® Clinically Proven, Patented Electrostatic Massage Therapy Applied via special gloves or applications

- Permeating an 8cm depth without pressure
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FEATURE ARTICLES

Developing massage as a career for blind people in Nepal: the Seeing Hands legacy continues By Sue Ainley



When Rob and I first travelled to Nepal twenty years ago, we had no idea how big an impact the country and its people would have on our lives – or how we would impact on theirs. It's been an incredible journey.

We began teaching massage to four blind students in a spare room in a guest house in Pokhara – with a portable couch and a roughly designed curriculum. One of those first students was Chiran Poudel, who won us over instantly with a cheeky grin and an old-school, 'BBC World Service-style' English accent. Over the following months and years we found sponsors and volunteers (many from the ISRM), raised funds, established a clinic for Chiran and his co-students to work in, and started building a reputation. The clinic grew fast in popularity, thanks to writeups in guidebooks such as the Lonely Planet, and our focus on providing quality. From the start, we wanted to be different from the

existing 'spa-style' massage outlets in Nepal, offering a <u>remedial</u> sports form of treatment, which we knew would appeal to visiting trekkers and tourists. It was that aim that first prompted us to reach out to the LSSM and sparked our long-standing friendship with Mel, whose involvement in Seeing Hands, along with countless visiting tutors and therapists, has been so key that looking back, it feels like it was firmly meant to be.

More blind students were trained, qualified as therapists, and began working in the clinic, and soon we needed to expand. In 2009 we opened a second clinic in Thamel, a popular tourist area in the capital, Kathmandu, and Chiran and a couple of other therapists moved there to work in it. Word quickly spread, with more glowing reviews. At one stage the Seeing Hands clinic was even listed as the top activity on Tripadvisor's Things to do in Kathmandu'! Training activities were also moved to Kathmandu, and Chiran who



was already taking on most of the work involved with managing the Kathmandu clinic, became a tutor. Operating in Kathmandu came with a lot of challenges for our blind teams, who had to navigate their way to the clinic in a much noisier and hectic environment, but they coped admirably and enjoyed the excitement of being in the capital city. We had trips to the cinema, concerts, and their new favourite eateries - Pizza Hut and KFC!

Over the next couple of years, we built a strong local network with our immediate neighbours and a number of hotels and social organisations in the region. One of those social organisations was Change Fusion, and in 2011 they awarded Chiran a





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REVERSE HELCOW REVERSE HELCOW

prestigious prize for social entrepreneurship. It was covered on national TV, and Chiran walked on stage to receive his award to great applause from the entire Seeing Hands crew and a large contingent from the blind community.

Change Fusion then helped Chiran to open our third clinic in Patan, a suburb of Kathmandu popular with expats and international NGO [*non-governmental organisations – ed.*] workers, and that clinic now welcomes a healthy number of regular clients.

In 2015, Nepal suffered one of the worst earthquakes in its history, centred on the Gorkha region, just 80 km from Kathmandu. Over 9,000 people died and 3.5 million people were rendered homeless. Fortunately, all the clinic buildings stood firm and our teams were unaffected. We raised funds to help earthquake victims but it took a long time for things to return to normal.

A year later we took on a fifth group of students, and as they neared the end of their training, a fourth clinic was opened in Boudha, near the iconic Swayambunath temple, popular with visiting Buddhists and Tibetans. Chiran now manages not just one but three clinics in the Kathmandu area, looking after day-to-day operations, training students, and managing over a dozen staff. Last year, he also relocated our main and busiest clinic in Thamel to a new site when our lease came to an end. In a new location with better footfall, the clinic is now booming and welcoming almost 1,000 clients a month in high season.

The impact the entire Seeing Hands project has had on the lives of those involved has been huge. We've provided a vital source of employment and income for over 30 blind individuals and their families, developed a new and exciting career path for blind people in Nepal and established a professional standard of massage therapy in the cities we operate in. All of this is thanks to the dedicated efforts of a few humble heroes, therapists who wanted to do something different and give something back. It's an amazing legacy and one we're very proud to see evolve.







Call for volunteers

The team in Kathmandu are now planning for the future, readying to train more therapists to meet ongoing demand. After weeks of intensive interviews, a new group of blind students (officially the sixth) have now been selected and have just started their training. As a result, we're back on the hunt for willing volunteers and would love to hear from therapists interested in dedicating some of their time to help guide four young blind individuals, learning massage and embarking on a life-changing career. It's a once in a lifetime opportunity to visit an amazing country, take on the challenge of teaching massage to blind people (no visual demonstrations), and help us carry on the incredible legacy of the Seeing Hands charity and its partnership with the ISRM.

Therapists interested in volunteering their time will need to commit to spend at least 3 weeks in Nepal and fund their own travel, accommodation, and expenses.

For more information, please email sue@ seeinghandsnepal.org



FEATURE ARTICLES

Music Makes Massage Mean More By Derek Marks



'2 years later my sister said, "why don't you become a massage therapist? You are good with your hands and love medicine". My response was, "are you mad?" to which she said, "go and find the best course in Cape Town and I will pay for it". I did and the rest is history.'



It started when I was eight years old in junior school, having passed a music exam with 98/100. My elation at the result stayed with me and continued to give me a particular confidence into my early teens (age 13). Not being too academically inclined, I took woodwork as a school subject. I suppose being good with my hands had started at an early age. A school friend and I had started playing acoustic guitar some years earlier. The band *The Shadows* were all the rage and our favourite band as they played electric guitars. In our ignorance, by only looking at pictures of the band, we made five electric guitars out of scrap wood, but had been able to purchase genuine hardware

(strings, bridges, tuning knobs) etc. from a general dealer near where we lived.

I was earning great pocket money from performing at fetes, church do's and 'bops' as they were called in those days - these being social dancing get-togethers where bands would be present playing the latest songs. We too formed a band called The Saxons, whose name we subsequently changed to The Marksmen. After many years and bands, at the age of 17, I left school to join my first professional band called The *Square Set*, and by the time I got to 19 I was riding the airwaves with number one hits in South Africa, Brazil, Portugal, and North

Africa. I went on to become a semi-pro musician from the late 1960's to this day. I still perform at weddings, corporate dinner dances, parties, stage shows etc. I regard my musical talent and ability to play an instrument as a gift.

The reason I am mentioning the above is because my life as a musician permeates and plays an integral part in my entire life, which includes massage therapy. My career as a Sports and Remedial Massage therapist has been very successful almost from the very start.

The sound of music in my practice is vital not only to my patient but to me - I say 'me' never selfishly but always with the patient in mind. 50 decades of listening to and performing music have given me countless examples of music to play for my patients. I take time and trouble looking for and experiencing various music genres to find music that I think suitable. This is done always keeping the individual patients in mind during their visit. I will always consider who I have lying on my plinth before choosing what to play. Young or old, most people enjoy music so one's chances of making a mistake are slim. Music tends to relax the atmosphere in a medical establishment or even a treatment room.

It is a well-known fact that some people are nervous about getting into a lift as this makes them claustrophobic. Lift manufacturers play music in the lift to relax its users. The same applies to my massage practice.

I find choosing music for my patients a twoway street, as I too need to enjoy what is being played at the time.



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In the early years of building my practice, I had a tape player, which meant having to turn the tape over – this felt like 50 times a day – a difficult task when keeping one hand on the patient while handling the tape with oily fingers! I never did progress to CDs, but ended up with the 'love of my life', namely an 80 gig iPod. Joy at last.

I would recommend acquiring an iPod if funds allow, or using your smart phone. This could make your music-massage life a pleasure. Today one can purchase or download music from many different sources such as Apple music, Spotify, Amazon, and thus create a playlist of the countless suitable tracks. These should be melodies/songs you enjoy and which you consider your patients will also like and have pleasure listening to. You could create a suitable playlist that would run for the entire day. An iPod can hold thousands of CDs and instantly obeys your instructions. A note of caution: in the UK, if you are playing music in a commercial setting, you may be required to obtain (and pay for) an appropriate licence. I would recommend that you check whether you should apply for a licence for your practice by visiting https://www.gov.uk/licence-to-play-live-orrecorded-music

What sort of music should you choose? 'Now hear in lies the rub' – excuse the pun. Allow me to give you some suggestions:

Be brave, and by that I mean be adventurous. We all have different tastes. It can be good sometimes to go out of your usual comfort zone and listen to artists you possibly would not consider. I have been told that we should avoid having a heavy beat playing as it reportedly can affect the heart rhythm. Well! I can only imagine that listening might stimulate the listener, generating greater enjoyment and thus possibly raising his/her heart rate through pleasure. I have had a Rabbi client singing the words to a Rolling Stones album throughout his treatment, and the end-result was exhilarating in that he found himself transported away from his usual pastoral existence. The music, I trust, had enabled him to relive some of his youth, surely bringing back many happy memories, thus further relaxing my patient while I proceeded with his full treatment. The fun element created some

laughter, which I know was an expression of happiness, very, very therapeutic for him and me. I had performed a good job and the music further contributed to the beneficial outcome.

It is reported that massage can raise dopamine and serotonin levels in the brain - the 'happy hormones' that help you relax and stay focused. It is believed that music can achieve the same effect and also keep you energised. Combining these together just great!

and massage are that when relaxed, the patient is able to settle down more easily into what can sometimes be a painful experience. My treatment has always been firm/deep tissue. The experience of handson treatment and the sensations that go with it are all-important in themselves. Music can lighten the 'negative' side of this experience with a little distraction if need be.

Allow me to give you some examples of what I may choose to listen to. I usually choose soft relaxing melodies, mostly instrumental tracks from artists like Anthony Miles, Michael Hedges, Patick O Hearn, Pat Metheny, Hennie Becker, Terry Oldfield, Eric Breton, Jazz compilations etc. My choice of jazz music would not include the saxophone as I find its sound disruptive and repetitive. Male vocals include Michael Bublé, Steve Tyrell, Michael Franks, Andrea Bocelli, etc. My personal preference - at the risk of unintentionally ruffling a few feathers - is that I find male voices generally more relaxing... Ooooops! This is only my opinion, but there are plenty of exceptions, as we listen to Barbara Streisand, Annie Lennox, Enya, Basia, etc. to name but a few female artists. The excellent thing is that I have so much music available: from Anastacia, Bee Gees, Beatles, to Van Halen, Van Morrison, and ZZ Top etc. totalling over 2,500 artists! The collection includes more than 10,000 tracks, and I've only just scratched the surface! I have taken the trouble to acquire music from all sources, put them on my iPod, and all this because of the massive difference music can make to my patients' health, my practice, and me. After the treatment, my clients seem exhilarated, relaxed, flushed,

Some of my observations regarding music

floating, happy, often pain-free, usually in a different state of mind and certainly better off than when they had walked in. The person on my plinth has often been known to break out in song, singing along with what they are listening to. I have been known to massage a body area in time to the music being played. I overheard one of my patients saying 'a therapist who plays Michael Franks during my treatment must know what he is doing'. He had enjoyed a good treatment and a great time listening the music had played its part.

To elaborate a bit further, when meeting a patient for the first time, we are both strangers. While taking their detailed history and completing their assessment form, I have very, very quiet music on in the back ground. I find this is a beneficial contrast to the somewhat 'stark' white background of a medical practice. The music assists in relaxing my patient from the onset. When treating at the medical centre I work from, my impression is that many patients walking into our building are a little stressed. They may be feeling be sore, irritated, and in hope of relief to their symptoms. Some soft tissue therapists go to the trouble of painting beautiful colours on the practice room walls, hanging relaxing pictures up with a view to enhancing the feel-good factor, so why not have quiet music playing to the same end?

Volume plays an all-important part in the process, as the volume of the music should never in my view interfere with the session. I have my volume control close at hand, and make sure I am ever-aware of the volume. Too low could more than likely be irritating, too loud may sometimes be rewarding by 'bringing my patient into the moment', however, I would not recommend 'loud' for too long – maybe just for a single track or brief moment. Setting the volume 'just right' is therefore uppermost in my mind. My iPod virtually always plays at the right volume, thus needing no further attention or intervention unless I deem so, on rare occasions.

Working with a different person each hour of the day requires individually tailored treatments, using a range of techniques and strokes - skilled therapists don't treat like robots! A good therapist will feel and

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have purpose for each and every stroke or move delivered every second of the day, and I count myself among them. Music enables my mind to stay focused on the here and now.

My instrument of choice and always has been the Bass Guitar. For those who don't know it's a four stringed guitar with a very long neck used to create the low notes as the strings are very thick. I started in the early years playing the piano, progressed to learning to play 6 stringed guitars and then fell in love with the Bass guitar. It plays a support role in the band, allowing the lead instruments freedom of expression. My job in a band is to keep the platform other instruments can rely on by playing the lower bass notes of a chord and at the same time add to the groove by supporting the drummer and the beat. As members of a team, all instrumentalists are constantly aware of each other's volume, so being aware of this playing in my massage practice is second nature to me. I am mentioning volume guite a lot because I play with it when needed. In this respect, I personally consider some classical compilations as an unnecessary hindrance, since loud and soft volumes are deliberately included in the

composition, and change according to the mood in the musical piece and/or of the composer. One could argue that all music is created in this way, but in certain genres it is much less so.

Piano music is pleasant, but must in my view have some substance to avoid tedium, and my choice here would be popular songs patients may possibly recognise. I believe the need to explain myself here is evident: I was once receiving an early morning massage listening to a piece of piano music I did not recognise. It actually began to frustrate me as I lay there. Trying to be diplomatic, I asked the therapist who the pianist was, and I said it in a way to show my displeasure... only to be told, 'Oh! This is my favourite pianist of all time'. My therapist remained unaware of my frustration. I would have preferred to listen to heavy Rock at 9:00 am in the morning! These are my thoughts and feelings. What I am trying to say is, if you are going to play music, then make the effort to know your stuff. Listen, be aware of, and interpret what is going on with your patient. Ask yourself, 'is this music suitable? Volume OK'?

It saddens me to think of therapists who do

not enjoy music, and therefore use it only for the patient's sake, or not at all. Such people do exist in this world, and my sense is that they have no idea what happiness music can bring to the body, mind and soul without trying. As an active performer, I have witnessed for most of my life what the art of music can do for us humans. To those who do use music to the max, I salute you and say 'well done'. I would invite and encourage any therapist reluctant to play music, or who may never have considered this, to 'give it a try'.

Musical taste can change at different times of day: I prefer livelier tunes in the morning. In my experience, many patients regardless of pain might book a morning session for the feel-good state of mind the treatment brings them as well as the relief from pain. Most humans are more active in the morning, so although I am always concerned about what to play for an individual patient, no too much effort goes into choosing the right music at that time of day.

For me, it could be modern pop or any genre, but in the afternoon, I think it advisable to slow it down to a quieter mood, as patients may be a little tired after a busy morning.

I have been known to play a same artist relentlessly over consecutive days without my patients knowing – or perhaps some did. Music suits my practice so well; hence it is my first choice. A musician like Hennie Becker – a South African living and recording in Canada – is such an artist. He has produced 10 albums, all different. Letting them run for the day is fantastic. This is just one among many other examples.

I am known to ask, 'what would you like to listen to today'? Sometimes the answer is 'what about that compilation of UK hits from 1953 to 2008? You only played up to 1957 at the last visit, can I hear more?' or 'just something quiet' (I have a lot of quiet) or 'whatever you want'. 'Whatever I want', is of course with both of us in mind, and it can change mid-way through the treatment if it isn't 'working'. My choice can sometimes be wrong, and the client doesn't have to tell me – I know this instinctively. The music must suit and be appropriate for the patient. You can gauge a client's mood as they walk



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through the door, even just by reading their face. On reflection, I don't recall ever having been asked not to play any music during a treatment.

I understand some therapists use a radio as musical background, but you have no control over what is being played, and I personally regard this as a 'lazy way out'. As mentioned above, it takes effort to make the music in your practice mean something to both you and your client. The playlists on the radio are generally not scheduled with massage therapists in mind.

It has always been clearly obvious to me that the music I play brings me clients, and hopefully keeps them coming back. I know this because they tell me so. The music I play puts me in a good mood and makes me happy day after day. Obviously however, after years of study and 27 years as a day-in, day-out hands-on therapist, I am well aware that music isn't the only criterion for patients returning. My skills, knowledge and love of the job at hand are beyond doubt the main factors, but I do also know that the music helps.

In summary... have fun, be confident, and enjoy what you do. Bring happiness, joy, relief and healing to your patients. Isn't that what being a massage therapist is all about? And if you have not yet tried enhancing your sessions with music, then I urge you to give it a go. Music Makes Massage Mean More.

Derek Marks – a brief Bio

My early childhood was unfortunately plagued with a disease called poliomyelitis. I did not escape the epidemic. Both my legs were affected but one came right and the other improved after 17 years of physiotherapy three times a week. This left me with a disability. Following a successful professional music career I decided to settle down and married at age 24. We had two wonderful children.

Supermarkets were a new phenomenon at the time, so it was decided that I should get

a job to become a Supermarket manager. After 10 years I moved to the Fashion industry, selling clothes; 5 years later I migrated to the Insurance industry, and 3 years after that, I was very fortunate to own a fast-food restaurant. There were a few other jobs in between.

At age 42 I was completely disillusioned with and in fact very depressed about my life so far. I 'had it all', most of it successfully, but in my mind I had nothing. I decided to go for an aptitude test to find out what I was good at. The test took 3 hours and the consequent test results and visit to the Psychologist proved that I was a born musician. I was good at a few other things on the list, but had scored 100% in the music category. I know for a fact that throughout the years of trying to be a business man, and despite always playing in a band and earning good money, I had concealed the fact that this was my vocation. On hearing this very good, news I came to terms with myself and adopted a completely different outlook on life. I was a proud musician and didn't care what anybody thought of me. I was once again able to dream.

My childhood dreams had always been to become a doctor, but due to losing my mum and dad by the age of 19, this ambition had to be shelved. Now at age 42 I visited the University of Cape Town Medical Faculty, but after careful consideration it was decided that it could have taken me 10 years to become a doctor, a bad idea.

2 years later my sister said, "why don't you become a massage therapist? You are good with your hands and love medicine". My response was "are you mad?" to which she said, "go and find the best course in Cape Town and I will pay for it". I did and the rest is history.

I trained at the Cape Massage Academy, at the same time holding down a daily job and performing as a bass player in my own band in the evenings when possible. This was 1993.

I worked from home and did house calls for the first two years, but it soon became evident that I needed to settle and have a place to work. I found rooms at the Sea Point Medical Centre and never looked back. It was evident within 4 months from opening that my business was taking off, and for the next 22 years I ran a very, very busy Massage clinic. I had patients from all over the world. I joined the South African Massage Therapy Association, became an executive committee member, and after many years became an honorary member.

Massage Therapy became a registered profession in South Africa in 2001. My involvement had been instrumental in this development, having gone to Parliament to lobby for this to happen in 1998. The Government decided to create a body they named the Allied Health Professions Council (which incorporated doctors) to accommodate the various allied professions (Massage, Chiropractic, Aromatherapy, Phytotherapy, Chinese Medicine, Ayurvedic Medicine, etc.). After 4 years of extra study at the Cape Town University Medical Faculty, plus grandfathering courses over 2 years, 30 of us sent in our gualifications and became registered members of the profession under Government control, in order to protect the public. There are now approximately 170 registered therapists in SA – a rare breed of passionate people! The terminology changed from 'client' to 'patient'.

Working in a medical centre with referrals from doctors and radiologists, I was dealing with people presenting with a wide range of pathologies, usually with great success.

Meanwhile, our children had moved away from SA in the late 1990's, one to London and one to Cardiff. Both my wife and I are British citizens, and it was decided that we were missing out on our grandchildren. So we too left SA in September 2018. We now live in Caerphilly, Wales, and are loving it.

Having completed courses with the LSSM over the years, I visited Mel Cash on arrival in UK and became a member of the ISRM. I had written my own massage course 9 years ago and have taught many students in SA over time. It is my intention to teach here in Wales. I had the good fortune to provide post-race massage at the London marathon last April as part of an ISRM team, and have a number of patients in London that I visit from time to time.



EVENT WORK

The London Marathon – from a different perspective By Janice Barrett

"So, 38 years later, Andrew ran the London Marathon, and just being a part of that journey has been amazing, which is why I'll be signing on again to be a massage therapist next year."



For at least the past 7 years, I have worked as a massage therapist at the end of the London Marathon, but my engagement with the event has been much longer.

The first London Marathon took place on 29th March 1981 – and I was there watching it from the London pavements with my family. I was only fourteen years old, but it obviously had a lasting effect on me and my younger brother Andrew who was only nine at the time. We went every year to watch it after that.

Fast-forward to 1986, and I was then training to be a nurse right next to the finish line. That year, I was working in the Accident and Emergency Department at St Thomas' Hospital. I remember it being a bit busy, but not as bad as we had anticipated! 1988 saw me volunteering with St John's Ambulance as part of my Duke of Edinburgh's award scheme (I successfully got my Gold Award in part thanks to this). I remember lots of runners getting cramps and massaging and stretching their legs – a sign of things to come.

In 2011, I finally got around, first to studying on a holistic massage course, followed by training with LSSM to become a sports massage therapist. During this time, I volunteered as one of many students supporting charities with massaging their fundraising runners at the London marathon finish. Once qualified, I became a team leader, and that is what I have been doing ever since. Having both my nursing background (I still work as a nurse too) and massage experience definitely makes this role easier. I also really enjoy supporting new massage therapists into their first foray of event work.

My hopes of ever running a marathon myself went with my knees back in my 20's, but that has not stopped me doing marathons in other ways. I used to be a guide for charity treks on such events as the Great Wall of China, the Sahara Desert, Machu Picchu, etc. and then discovered sports involving sitting down – so I have completed kayak marathons on the sea and the Thames as well as the Ride London 100 cycling event.

Now, fast-forward to 2019. My brother Andrew had not given up on his dream of running the marathon and he gained a place with PhabKids for this year's event. I duly signed up to volunteer for them and avidly watched his progress throughout the gruelling training. Anyone who runs a marathon will know that it is the hours and hours of training that count – and he put every one of them in.

In early April, the ISRM teams were announced

and my usual role of supporting new massage therapists began. Whilst Dan was the PhabKids Team Leader, I'd offered to help the new ISRM trainees. A flurry of WhatsApp messages soon followed and concerns allayed. I think it's easy to forget how daunting your first event is, yet it is so rewarding.

On the day itself I had an earlier start than usual. I have the bonus of living in London but I had to drop off my couch and kit at the finish venue extra early this year. Then I abandoned my post (as kindly agreed with Janine from the charity!) and headed to mile 7.5 at Deptford Creek. As I saw Andrew running towards me I realised that he was achieving his life-long dream. After a quick hug, he was back on his way for the rest of the journey.

It took an excruciating 2.5 hours to get back to St James' Park (it had only taken 40 minutes to get there!). However, I made it back in time to meet the rest of the team and before any of the runners (but not in time for the team photo - sorry!).

Various members of my family were on the route and sent me updates throughout the afternoon and Andrew made it across the finish line and onto my couch. Like most runners this year, he found it a hard run on the day despite the reasonable conditions (anyone know why?). He said "never again" and then signed up for the 2020 ballot the next day!

So, 38 years later, Andrew ran the London Marathon, and just being a part of that journey has been amazing, which is why I'll be signing on again to be a massage therapist next year.



EVENT WORK

LSSM Team Tommy's at the London Marathon 2019 By Chloe Cyrus-Kent



This year's London Marathon was met with perfect conditions for runners and much excited anticipation throughout the City. Londoners, beset by Brexit blues in recent months, needed a reason to cheer and they certainly found it on Marathon day. Hundreds of charities, from Save the Children to Save the Bees were all lining the route, cheering on courageous runners raising money for extraordinary life-changing causes. As ever, people from all countries were there, participating or supporting loved ones on their epic feat of running 26.2 miles in one go (wow!).

The LSSM provided teams of soft tissue therapists for 14 charities: Shelter, Scope, Spinal Injuries Association, National Autistic Society, Meningitis Now, Meningitis Research Foundation, Tommy's, National Deaf Children's Society, Together 4 Short Lives, FabKids, Children with Cancer, Teenage Cancer Trust, Prostate Cancer Research Centre, and Pancreatic Cancer UK.

Our LSSM team was privileged to offer postevent soft tissue therapy for Team Tommy's runners. Tommy's is a baby charity funding research into miscarriage, stillbirth and premature birth. Their brave and brilliant runners were treated to a reception at Mabel's cocktail bar in Covent Garden, only a short walk from the finish line (easier to say if you haven't run 26 miles, perhaps). Our team was made up of LSSM students, one massage therapist and our team leader, myofascial release expert Phil Young. We set ourselves up in a bar area beside the main hubbub of Tommy's staff and families celebrating with their runners. Before the first runners arrived our team leader gave us tips on myofascial release for sore legs and prepared us for the new experience of working with post-marathon runners in great need of rest and recovery. We saw lots of very tired and tense quads, hamstrings and calf muscles for which myofascial release, as well as other soft tissue techniques, worked wonders. One of the runners said she felt she'd got "a new pair of legs" after her treatment and it was touching to hear the stories of the runners. In many cases we could see and hear their precious little ones nearby; families very proud they're raising money for a cause that means the world to them. In a small lull between runners, one of the Tommy's staff came to us with a hip flexor complaint and it was brilliant to see our team leader skillfully use myofascial and positional

release techniques with her, including the often-mentioned positional release of the psoas!

Before our post-event therapy work started we were fortunate to watch the first runners going past Cleopatra's Needle, just after mile 25. It was exciting to be in the Marathon atmosphere and see extraordinary elite athletes, seemingly taking it in their stride, followed later by those who were fighting with all their heart, body and soul against wrecked hamstrings and pure exhaustion in the last mile. It was interesting to watch St John's Ambulance staff help one man who had come to a standstill right in front of me, with intense pain in his hamstrings. Ambulance staff helped him focus, relax and release his hamstrings with a few simple exercises, and then get cautiously back on his way to the finish line. I was fortunate to spot a Team Tommy's frontrunner go past at one point and one runner for Pancreatic Cancer UK also caught my eye as he ran by. The back of his top read, "Pancreatic Cancer is tough. So am I". The toughness and determination of all the charity runners we worked with at the London Marathon was both moving and humbling and we hope that after their post-event soft tissue treatments, a few shattered legs felt a lot better. As therapists we certainly learned a lot from the experience ourselves, and even after giving treatments for more than 4 hours solid we could well imagine coming back for more another year!







EVENT WORK - LONDON MARATHON













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EVENT WORK

Event work update By Tanya Ball

Our vision for the future...

*** Not to be missed: NEW for 2020 and beyond ***

Starting in 2020, and gradually adding details as they become verified as accurate, we will be building a list of appropriate contacts within major sports governing bodies, federations, associations, and possibly clubs, for enquiries relating to delivering STT at high profile national and/or international events. The objective is to facilitate opportunities for members aspiring to a professional involvement in high level sport to take their own initiative in pursuing their goal. So - if this is YOU, watch out for the 'Top STT for Peak Performance' box in future Issues!

Confirmed 2020 events to date

(These will be posted on the ISRM website Event work page from January 2020)

- Brighton ½ Marathon, Sunday 23rd February 2020
- Third London Landmarks Half Marathon, Sunday 29th March 2020
- · London Marathon Sun 26th April 2020...
- And many more as they become confirmed!

Our pride in and thanks for ISRM's 2019 achievements

ISRM's reputation for delivering high quality, value-for-money pre-/post-event soft tissue therapy (STT) was further enhanced throughout 2019, with both 'returning' requests for our services, and novel opportunities. The included a couple of mid-week, intensive indoor competitions ideal for, if limited to, 'local' London students and newly gualified therapists.

The invariably grateful and enthusiastic feedback received from charities and other organisations we have worked with, their virtually infallible requests for our support from year to year, and the wordof-mouth recommendations that direct further partners our way, in my view bear testament to the uncompromising professional standards upheld by ISRM. Not for the first time, I cannot overstress that none of this could happen without the immensely appreciated time, energy, enthusiasm, and skills donated by our countless generous students and therapist volunteers! May I therefore yet again express a deeply grateful 'thank you' to all concerned on behalf of our Institute.



2019 events which benefited from ISRMprovided STT include:

- Second London Landmarks Half Marathon, Sunday 24th March
- London Marathon Sun 28th April
- · SWRC MayFlyer Cyclosportive (in aid of the Charity Full Circle Fund Therapies) Cycling Event, Oxshott, Surrey – Sunday 19th May
- · Sweat in the City The Soca Fitness Fete, London – Wednesday 2nd May
- Bournemouth 7′s Festival Bournemouth - Fri-Mon 25th-28th May
- Ride London Surrey 100/London -Sunday 4th August
- Sweat in the City The Soca Fitness Fete, London – Wednesday 21st August
- Royal Parks 1/2 Marathon, London, Sunday 13th October.

Selective events roundup London Landmarks Half Marathon

After having stepped in at the 11th hour to support the inaugural 2018 event following the demise of the originally appointed event massage provider, we were delighted to be approached again this year, this time as a first choice and in good time (and as indicated above, we have been asked to support the 2020 event).

A sixteen-strong ISRM team attended the event under Sue Burnett's experienced leadership, and the numerous feedback messages from team members, organisers, and runners alike are a testament to both the therapists' performance and enjoyment. So here's to even surpassing this success next year!

London Marathon

This year's London Marathon saw some 90 ISRM volunteers + team leaders distributed into fourteen STT teams, each



EVENT WORK

allocated to a different charity, travel to various venues within a short distance of the race Finish, where the charities' respective 'thank you' receptions were being held for their fundraising runners. As in the past 20+ years since LSSM started offering students and graduates event work experience, the role of our enthusiastic and eager teams was to provide restorative, pain-easing gentle post-race treatment to these highlydeserving aching but elated finishers.

New 'Sweat in the City' events

These are City fitness centre-based 'aerobathons' where a number of 'top' fitness instructors teach participants a range of workouts with live DIs throughout an evening. The organisers have been hosting these events since 2017, which have rapidly expanded. I understand that some 150 fitness enthusiasts participated in both (May and August) events supported by an energetic handful of students, under the fine leadership of Julie Davidson on both occasions.

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 some of the above events through firsthand accounts and a range of photos (unfortunately of variable quality due to lighting etc.), also featured in this Section of the present newsletter. It is my hope that these will inspire many to sign up for future event work!

*** To register for all future event work, please keep an eye on the relevant page of the ISRM website (www.theisrm. com) and follow the instructions below, published in every single newsletter issue, thank you. ***

How to register for ISRMorganised event work

Would all members, and specially new student members for whom this is their

first ISRM Newsletter, please kindly note the one and only Event Work 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, Professional Indemnity and Public Liability insurance at the appropriate level (student/ graduate) and valid at the time of the event is mandatory. We regret that no exceptions can be considered.

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

How to apply for Event Work:

- ✓ From the ISRM home page (www.theisrm.com), login.
- ✓ Click on 'Your ISRM' and select 'event work' from the drop-down menu.
- view the current list of events. ✓ Click on whichever you are
- interested in. ✓ FIRST, READ CAREFULLY the
- information in red below the event, and ENSURE that you are available on the date of the event(s).
- 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

✓ Follow any (very easy) instructions to

✓ Please, please, PLEASE ensure that you

Duplicate entries are difficult for me to spot!

If you cannot view the event you are looking for but know it was previously on display, the most likely reason is that I would 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 been/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 vours 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
- ✓ Depending on the event and location gaining new clients
- ✓ A tremendous sense of achievement and a longing the next event!

I look forward to seeing many familiar and new names applying for events in 2020 and beyond.



So what makes it a 'Sports' Massage? By Matt Scarsbrook



Well...sitting down to write this piece has opened up a rabbit's hole, nay an entire warren, of topics surrounding massage therapy, its history and potentially its future (of which I am very lucky to be a part). But I shall save those details for another day, because I intend to keep this fairly brief for the time-pressed readers among you.

Where massage, or a form of therapeutic touch, originated from is difficult to pin down and is likely to be as old as humanity itself. Our instinct to rub a sore spot could conceivably have led to offering to treat others' hard-to-reach places (such as the back – a favourite treatment area for many clients!) and there are references aplenty demonstrating the practice of massage in the ancient cultures of China, Egypt, India, Greece, and so on.

Indeed it seems that massage has waxed and waned as an orthodox, mainstream treatment for peoples' aches and pains over the centuries, but it was the introduction of Swedish Massage in a gymnastics setting (accredited in the 1800's to Per Henrik Ling and developed further by Johan Georg Mezger) that appears to have set the foundation for remedial massage in the West. After scandals caused by the sex industry, the Society of Trained Masseuses was formed in

1894 in the UK, developing over time and in 1944 becoming The Chartered Society of Physiotherapy, as it stands to this day.

However, as the new profession of Physiotherapy looked to broaden its scope of practice (developing some great new approaches along the way) the focus on massage was reduced until it disappeared almost entirely from undergraduate physiotherapy training. My wife is a physiotherapist and was taught massage skills for only a few days within a 3-year degree course! (In contrast, my qualification followed a full year focussed purely on massage techniques and their role in injury rehab).

It was then in the 1980's, during the first running boom, that industry leaders such as Mel Cash (Founder and Director of the London School of Sports Massage (LSSM) and the Institute of Sports and Remedial Massage (ISRM), of which I am a member) started to explore the application of massage to a sporting context, with the benefits quickly becoming obvious to therapists and athletes alike. The blending of 'traditional' massage techniques with advanced methods used by Osteopaths led to the development of the highest level of massage qualification - 'Soft Tissue Therapy', whose practitioners are experts in assessing, treating and rehabilitating a range of minor and chronic injuries and painful conditions.

So how does this circle back to Sports Massage? Well, fundamentally 'Massage' is... massage, and 'Sports Massage' is massage given in a sporting context - be that pre- or post-competition or training, or performed on an athlete/sports person. However, it is commonly misconstrued as 'like massage but harder', and almost by inference, 'painful'! Yet - It doesn't have to hurt, and thanks to advances in research we can extrapolate with some confidence as to why ...

Scientific research into the efficacy of massage is, frankly, pretty poor. When comparing the quality of the research available to us, if massage were a pill sold by a pharmaceutical company then you'd seriously question any doctor willing to prescribe it! However, we can make cautious assumptions about what is occurring in the body when it is receiving massage based on our understanding of the neural responses to touch (1) (2) helping us to dispel myths and/or question unsupported claims about 'energy flows', 'releasing' sticky layers of tissue, 'affecting blood circulation' (3) and so on. We are now far more comfortable with the notion that the majority of the effects of massage impact on the recipients' nervous system, notably the autonomic system, which may explain the marked improvements clients can experience in their mood (specifically depression and anxiety)⁽⁴⁾, range of movement, pain perception, and overall well-being. We know that in and of itself, massage is seldom a cure for someone's ills, but based on the evidence available, we understand that it can form an important part of a client's journey to enhanced movement, reduced pain ⁽⁵⁾, and ultimately greater fulfilment in life. When properly paired with informed assessment and evidencebased rehabilitation advice, massage can provide a window of opportunity for clients to take responsibility for their own health improvements - be they an elite athlete, or 'just' someone wanting to better enjoy playing with their grandchildren...

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SCIENTIFIC RESEARCH AND CLINICAL PRACTICE

Scientific evidence and clinical practice: Why Psoas major is **NOT** a 'hip flexor'... By Tanya Ball

Introduction

Psoas major (PM)¹ has elicited controversy with regard to its structure and functional role over recent decades (Gibbons et al. 2002; Morling 2009; Myers 2009)². 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.



Psoas major overview showing 'anterior' and 'posterior' fibres. Please note that the long muscle fibres do not reflect their true length or orientation!

A motor control (MC) research and expert opinion sector has stimulated further debate: developing the notion termed 'segmental spinal stabilisation' (Comerford & Mottram 2001a&b; 2012; Gibbons et al. 2002; Lee 2011; Vleeming et al. 2007) since the 1960ies, 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.





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 (2001a&b; 2012), contrasting evidence arises from fascial/ myofascial embryology, morphology, neurophysiology, 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 thoracolumbo-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,



Concurrently, research findings on the fascial

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 guadratus lumborum (QL). PM can thus contribute to complex patterns of thoracolumbo-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 neuro-musculoskeletal models

For an overview of the respective MC, bio-tensegrity, 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 neuro-musculo-skeletal (NMS) structures is essential to fully grasping muscles' roles in bio-tensegrity-modelled research (Findley & Schleip 2007; Huijing 2009; Schleip et al. 2012). Growing recognition of this notion's relevance in NMS MC research (Vleeming 2007; Lee 2011; Sahrman 2011), justifies its inclusion as a fifth muscle classification criterion. The Table on page 25 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'

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.



Epimuscular force transmission: The fascial continuity between two 'independent' muscles is clearly illustrated here, demonstrating mutual influence on activation

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 finiteelement 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.

Evidence for/against PM as a 'segmental spinal stabiliser'

Scientific literature investigating PM's local segmental spinal stabilisation role via axial compression is abundant. Much evidence rests on radiological (MRI/CT) cross-section area (CSA) measurements to identify and correlate muscle atrophy with segmental MC loss. Consensus supports PM's lumbar flexion relative to the *pelvis*, innominate posterior rotation, but refutes meaningful hip flexion potential (Hides et al. 2011). Comparing bilateral MRI CSAs of multifidus (MF) and PM, Barker et al. (2004) consistently identified atrophy ipsilateral to symptoms in 50 unilateral LBP patients. Ploumis et al. (2011) likewise found significant segmental PM, MF, QL, and ES atrophy on 40 military subjects' pain side. Inclusion criteria were ≥three months' LBP, mono-segmental, non-prolapsed disc compression, with \sqrt{MRI} signal intensity. Intriguingly, extent of muscle atrophy did not correlate with pain duration/scale.



Cross-sectional MRI evidence of psoas major asymmetry (circled).

In contrast to these findings, in Kamaz et al.'s (2007) comprehensive CT study, the chronic LBP patient group's consistently reduced PM, MF, and QL CSAs were not always found on the symptomatic side. The results nonetheless support LS response to pain/dysfunction/ pathology consensus (Table Section 2). The author regards this study design and methodology as particularly sound. Lee et al. (2011) compared 'chronic'³ and 'improving' LBP patients' paraspinal and PM MRI CSAs at L3 and L5. Similar segmental PM CSAs were recorded in both groups, with considerably greater L5 PM/ES CSA ratio in the 'chronic' group's, against consistent MF proportions. This finding was attributed to reduced ES CSA proportion at L5, where most weight-bearing/ lumbar movements occur. The absence of symptomatic segmental PM atrophy corroborates Hides et al.'s (2008) earlier study: mid-lumbar MRI CSAs showed neither PM asymmetry nor atrophy among LBP/ asymptomatic elite cricketer groups, despite marked asymmetry and/or MC deficits in other relevant muscles. The author contends that these findings challenge PM's consistent LS response to pain/dysfunction/pathology and involvement in LBP scenarii, as do the following studies, suggesting further potential PM roles. Kader (2008) measured MRI signal intensity changes in MF, ES, and PM at L4/L5 pre/post lumbo-pelvic flexion/extension gymball exercises in 24 asymptomatic subjects. Unchanged PM readings, against significantly increased MF and ES post-exercise data, were recorded. Kader (2008) inferred stability functions for both mono- and multi-articular paraspinals, refuting 'any significant role in lumbar stabilisation' for PM, 'used as control' (p.82) thus concurring with Bogduk (1992; Adams et al. 2002).

Hides et al. (2011) insightfully compared 'general and trunk flexor strengthening' (TFS) versus 'specific motor control' (SMC) rehabilitation modalities following prolonged bed-rest. L1-L5 PM, MF, ES, and QL MRI CSAs were measured immediately before/after bed-rest, at fourteen, and at 90 days into the rehabilitation phase. While both groups' MFs recovered their original size, PMs exceeded pre-study sizes within fourteen days' TFS retraining.⁴ In the author's view, this suggests that medium/high load TFS generates combined isotonic/phasic, isometric/tonic PM activation. Asymmetrical hypertrophy/atrophy implications are discussed later.

Santaguida & McGill (1995) segmentally



SCIENTIFIC RESEARCH AND CLINICAL PRACTICE

TABLE: Summary of PM main classifications on the basis of the five criteria:									
	(1) Anatomical structure/location; (2) Biomechanical capability; (3) Neuro-physiology; (4) Consistent/distinctive pattern of change with pain/dysfunction/pathology; (5) Fascial continuity								
Ref No	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: Cornerford & Mottram (2001a & b; 2011) (EO) Lee (2011) (EO) Vieeming et al. (2007) (EO) Gibbons (2005) (EO) Gibbons (2005) (EO) Gibbons et al (2022) (EO) Regev et al. (2011) (EO/SP) Note: distinct statements/ observations from specific authors are referenced individually within the text of Columns 3-7.	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 transverse processes (TPs); All fascicles are unipennate, descend infero-laterally into central tendon continuing antero-inferiorly to firm attachment on pelvic brim - 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).	Vieeming (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, 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 hip joint by drawing femoral head into acetabulum. Comerford & Mottram (2011) agree with the above but contend that PM displays both local (LS) and global (CS) stabiliser characteristics and functions: Anterior PM fascides – 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).	Vleeming et al. (2007): limited evidence from EMG studies due to deep PM location. Based on available neuro- physiological studies: Evidence that PM participates in hip 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: 0o-450: hip & lumbar stability; 450-600: hip & lumbar stability; hip flexion; 600+: lumbar stability – no action on femoral head.	General consensus: PM is consistent with local stabiliser (LSs) characteristics with dysfunction as defined in Comerford & Mottram (2001a & b; 2011), namely: Loss of segmental 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 - Inhibition - Loss of through-range control (inner range and/ or eccentric).	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 vertebral bodies and discs, and (iii) anterior longitudinal ligament (ALL); Infero-medially, with pelvic floor (PF), transversus abdominis (TrA) and obliquus internus (OI).			
3	General consensus of the authors below: Earls & Myers (2010) (EO) el-Rif (2005) (EO) Jacobson E (2011 &&b) (EO) Maitland (2002) (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 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 anteriorly from lesser trochanter to ilio-pectineal ridge attachment, thence continuing posteriorly to Lx spine - there is NO 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' illiacus and QL. General consensus: tensegrity model and fascial research inter alia in force transmission challenge ultimate relevance of question Which muscle(s) produce X or Y movement? (Schleip et al. 2012 pp. 132 ff. [SP]).	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 and/or emotional 'holding' (Morling 2009; Kock L. 2005; Schleip et al. 2012).	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-back'); - Scoliosis; - Loss of integrated, whole-body participation in movement, specially walking. Earls & Myers (2010); Myers (2001; 2009) reinforce the above consensus by incorporating PM as a key structure within the Deep Front Line (DFL) Anatomy Train.	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 (2001; 2009) furthermore regard PM as a key 'express' within the DFL, connecting upper & lowed DFL. The DFL connects the under- foot to the deep structures of the throat, mouth, and face (Myers 2009 pp. 188 ff.).			



Diagrammatic illustration of PM (and QL) segmental and bi-segmental fibres.

investigated PM's line of torque as a function of lordosis in a combined cadaveric/MRI/ biomechanical study, concluding that: spinalto-femoral attachment straight lines of torque neither represented PM biomechanics, nor were affected by lordotic angle(s); while PM can side-bend, compress, and stabilise the lumbar spine, it cannot influence spinal lordosis, rotation, nor shear except anteriorly at L5/S1. This author finds the latter conclusion contradictory, as spinal stabilisation involves three-dimensional movement control. In contrast, Penning (2000) concluded that PM's morphology supports its versatile lordosis stabilising capability.

Evidence for/against a tensegritymodelled integrative role for PM

The concepts of *extramuscular myofascial force* transmission (EMFT), human resting myofascial tone (HRMT), and bio-tensegrity (Levin and Martin 2012) provide relevant insights into NMS biomechanics and physiology (Findley & Schleip 2007; Huijing et al. 2009; 2012; Schleip et al. 2012). They contribute insights into PM's roles on cytological, histological, embryological, anatomical, biomechanical, biochemical, and neuro-physiological grounds. Authors contend that: i) HRMT transcends individual muscles/ myofascial units, distributing sufficient lowlevel, *passive* – CNS-*independent* and EMG-*silent* - stabilising tension throughout the fascial network, efficiently supporting postures/ activities requiring static and/or minimal effort; ii) excessive or deficient HRMT may contribute to NMS disorders including LBP, due to unequal compression distribution; and iii) though relevant, HRMT has yet to feature within contemporary spinal MC stabilisation models, alongside active/contractile force transmission (Masi et al. 2008; 2010; Schleip 2003a&b).



Bio-tensegrity modelled literature supports PM's important role for lumbar stability (Langevin 2009). Functional PM hypertrophy/atrophy, shortening/hypertonicity, compensatory lengthening/hypotonicity, adverse resulting local and/or distant fascial thickening/fibrosis, affect muscle activation patterns and spinal alignment (Driscoll and Blyum 2009; Masi et al. 2010; Yucesoy et al. 2003).

The following studies support PM's potential involvement in thoraco-lumbo-pelvic alignment issues: Park et al. (2012) used EMG to determine QL and PM anterior (PManterior) versus posterior (PM-posterior) fascicle activity with different lumbo-pelvic tasks and positions. In standing, PMposterior recruitment was greatest with trunk extension, and PM-anterior, with hip flexion. In sitting, whereas PM-anterior activity remained consistent, PM-posterior activity increased with lumbar lordosis. Hoshikawa et al.'s (2011) large four-way MRI study showed greater PM CSA and hypertrophic differences between male/female athletes/non-athletes, than in quadriceps, hamstrings, or adductors. PM attained the highest male/female hypertrophic ratio in both groups. Peltonen et al. (1998) interpreted significantly greater PM CSA, strength, and endurance among 49 female athletes than in seventeen controls, correlating relevant training, musculature hypertrophy, force, endurance, and CSA parameters. These findings support the author's proposed combined 'phasic' and 'tonic' PM function, and PM's susceptibility to asymmetrical functional/ postural patterns. Irrespective of 'causality', these features reflect GM-type responses to pain/dysfunction/pathology (Table, Section 2.), challenge PM's strict LS/GS classification, and are widely documented in clinical, notably Structural Integration, literature (Jacobson 2001; Morling 2009; Myers 2001; 2009; Rolf 1977; Smith 2005). Myers' (2010) detailed 'Deep Front Line' (DFL) - which includes PM - fresh cadaver dissections compellingly demonstrate DFL muscles' mutual biomechanical relationship, notably between the adductor-PM-iliacus-QL-diaphragm arrangement. This illustrates how altered PM recruitment, length, fascial thickening/fibrosis, disruption, impacts elsewhere within the DFL and thence on global spinal postural and functional alignment. PM's accessory respiratory, and diaphragmatic 'pressure distribution' role on inhalation, is supported by embryological and dissection evidence of the PM-QL-diaphragm connection (Breul 2012; Paoletti 2012; Myers (2010). Chronic obstructive pulmonary disease patient autopsies by Scott et al. (2006) revealed extensive diaphragmatic, more moderate PM injury, collagen deposits, and abnormal myofibres, suggesting a 'regional pattern of iniun/ (p.51).

Ultrasonographic PM length and tendon displacement evidence in stepping up and walking (Matsubayashi et al. 2008), and significant PM CSA decrease among elderlynon-walking, compared to young or elderlywalking females (Ikezoe et al. 2011) support PM's integrative locomotion role, consistent with its diaphragm-hip DFL continuity. Takahashi et al. (2006) found greater, earlier PM MRI CSA loss than quadriceps with each decade among 20-79 year-old women, while Andersson et al. (1997a&b) reported earlier, increased PM and iliacus EMG signal than bi-articular hip flexors in running versus fast walking, and in fast versus slow walking. Though PM's participation in locomotion can be concluded, these findings in the author's view neither prove nor disprove specific actions



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PM's visceral fascial connections (Willard 2012; Myers 2010) suggest interaction with visceral function. PM abscess is reported as a rare inflammatory bowel disease (Agha et al. 1985; Marín et al. 2009; Ogihara et al. 2000) or hemodialysis (Chuang et al. 2002) complication. Post-rectal prolapse laparoscopic sigmoid colonic suturing to the left PM fascia (Wang et al. 2007) imply PM's visceral supporting role. Lastly, fascia's multiple proprioceptive characteristics (Schleip et al. 2012) support proprioceptive PM input within the DFL.

Conclusion

The following methodological validity caveats qualify the author's conclusions: despite MRI (Gatton et al. 1999; Ropponen et al. 2008) and ultrasonography (Takai et al. 2011) being found reliable in measuring paraspinal muscle morphological data, CSA area was found inaccurately to correlate with functional performance.

After due consideration of all above findings individually, collectively, and in relation to her clinical experience, the author concludes that: While PM's activation/participation in hip flexion is confirmed, prime hip flexion/lateral rotation is refuted on compelling biomechanical evidence, including its pelvic brim attachment, absent in textbook literature.

Though credibly established as a segmental spinal stabiliser, PM exceeds this role: LBP can occur *without* relevant segmental PM atrophy; and PM's established hypertrophic response to sufficient training load suggests concurrent phasic/tonic, concentric/eccentric activation. Shortness/hypertonicity, postural change -GM characteristics with pain/dysfunction/ pathology - may reasonably be inferred from functional asymmetrical hypertrophy, reflecting many clinicians' experience (Morling 2009; Myers 2009; Rolf 1977; Smith 2005) including the author's (Ball 2011; 2012). PM's DFL fascial continuity implies integrative input to EMFT, HRMT, breathing, locomotion, and visceral function.

Thus PM transcends the expedient, but reductionist notions of 'muscle' and 'classification'5. Instead, PM synchronises with adjacent and distant muscles to fulfil multiple stabilising and mobilising tasks as required.

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Notes

- 1. For Abbreviations List, please refer to Appendix B, 'List of Abbreviations'.
- Exempt of arthro-discogenic lesions Although no significant differences in LBP were reported
- between groups, the SMC program was deemed safer as it avoided potentially adverse compressive spinal loading. 5. Myers highlights that though expedient, the very concept of 'a muscle' is a reductionist, abstract, anatomical term: 'One may
- ask the question whether the nervous system "thinks" in terms of

Appendix A – References

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For Reference List, please refer to Appendix A, 'List of References'.

individual muscles, or whether the muscle, a convenient division for the dissector, is even a distinct physiological unit.' (Schleip et al. 2012

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Appendix B – List of abbreviations

Apper	
AT	Anatomy Trains®
BFL	Back Functional Line
CoG	Centre of Gravity
CT	Computed Tommography
CIJ	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
EIVIFI	Extramuscular Myotascial Force
FMC	I ransmission
EIVIG	Electromyography
ES ITT	Erector Spinae
FFL	Clean Llumoral Joint
GHJ	Glehal Mabilisar(a)
GIVI(S)	Global Stabilicar(s)
	Gloudi Stabilisei (S)
IMC	Inter-Muscular Force Haristinssion
KCI	Kinetic Control International®
I	Laft
	Low Back Pain
14/15	Denotes segmental Lumbar vertebral
2-1/25	level in this instance 4th/5th segment
I-P	Lumbo-Pelvic
1-5	Lumbo-Sacral
15(5)	Local Stabiliser(s)
I TI	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
QL	Quadratus Lumborum
R	Right
RoM	Range of Movement
SBAL	Superficial Back Arm Line
SBL	Superficial Back Line
SFAL	Superficial Front Arm Line
SFL	Superficial Front Line
SIJ	Sacro-Iliac Joint
SPL	Spiral Line
TLJ	Thoraco-Lumbar Junction
Tx	Thoracic (spine)
T4/T5	Denotes segmental Thoracic vertebral
	level, in this instance 4th/5th segment
UCM	Uncontrolled Movement
WB	Weight-Bearing

K 1 . S . R . M

SCIENTIFIC RESEARCH AND CLINICAL PRACTICE

Is the Psoas a hip flexor or not? By Mel Cash

First we must consider evolution which is the basis of all my understanding of functional anatomy. Our musculoskeletal system has been evolving over millions of years to efficiently meet the needs of our lifestyle. The Psoas could not possibly have evolved into the big powerful muscle that it is today if it did not have a big powerful job to do. So what is its big powerful job?

When standing upright we don't need much strength to flex the hip to move the leg forward but we do need considerable strength to stabilise the lumbar spine and pelvis. In this position the Iliacus and Rectus Femoris have enough power to flex the hip and the psoas can devote its force to stabilise

the lower back and pelvis. So here the answer is no, the psoas does not flex the hip. But gravity makes this a completely different situation when laying on your back in the supine position. Now to flex the hip you have to lift the weight of the leg against the downward force of gravity which is 1 kg per square centimetre or 15 lb per square inch. This is a huge additional loading which can only be achieved by recruiting an extra big strong muscle. In this position the lumbar spine and pelvis are usually resting stably on the floor and do not need much power from the Psoas to maintain stability. So now the muscle can add its strength to meet greater force need to flex the hip.

The 'Psoas major (PM) debate' – Clarification! By Tanya Ball

I am as delighted as honoured that my 'Psoas major' research paper should have elicited Mel's response and, I hope, an invitation to all to a healthy debate. Due to space constraints at the 11th hour of this newsletter production, I must limit myself to a succinct, bullet point style reply. To save repeating myself, my response below reflects my understanding of contemporary clinical science and practice findings.

1. The premise that Psoas is a 'big powerful muscle with a big powerful job' is refuted by both in vivo and in vitro research. With rare exceptions e.g. unilateral hypertrophy, PM's anatomy, physiology, innervation, and fascial context display (a) local stabiliser (LS) (anterior ['short'] fibres), (b) global stabiliser (GS) (posterior ['longer'] fibres), and (c) supporting, connecting fascial 'guy rope' characteristics. These are not

- 2. Uphill running or kicking from a standing position demand comparably forceful hip flexion to supine leg-lifting. The lumbar spine is as unstable if not more in the latter scenario (place one hand under your lower back in supine and feel the intraabdominal effort resisting uncontrolled lumbar extension + rotation to the same side as you lift one leg). The bi-articular (global mobilisers - GM) Rectus femoris, TFL, and Sartorius provide the primary 'forceful' hip flexion, synergised and 'fine-
- 3. Let's be clear: muscle activation does not 'prove' any specific function! No one, least of all me, is disputing that PM activates on hip flexion! Like Mel and most manual therapists no doubt, I too





As a hands-on therapist with almost 35 years' experience, I know how to palpate the Psoas with a client in the supine position and when I get them to raise their leg (to flex their hip) I can absolutely positively feel the muscle contract.

I do respect the great researchers Tanya quotes in her article. Indeed I have met many of them over the years, like them personally and admire them professionally, and I hope we can happily agree to disagree. Although their research results sound convincing, even to me, my hands and my self-developed understanding of functional anatomy convince me that the Psoas is indeed a hip flexor.



consistent with a muscle designed for large amplitude/powerful function.¹

tuned' by the mono-articular GS iliacus.

can readily palpate PM 'firing' as a supine client lifts one leg off the couch. It is the inference that this should equate with hip flexion that is being challenged. Analogy: if you stand 'neutrally' upright and palpate your lumbar multifidus (MF) on one side (place thumb LIGHTLY immediately next to a spinous process), you should feel very little muscle tone, if any. Keep palpating while you flex your opposite arm. You will instantly feel MF contract under your thumb - stabilising that spinal segment in relation to the change in centre of gravity induced by the shoulder flexion. But this does not make MF a GHJ *joint flexor!* The same principle is more generally applicable, so it is important to be wary of drawing fallible inferences...

1. (PM has a predominance of 'low threshold', highly aerobic, endurance-efficient slow motor units (SMUs), as opposed to 'on/off' (phasic), less aerobic, faster-fatiguing fast motor units (FMUs).



EXPAND YOUR KNOWLEDGE, ENHANCE YOUR SKILLS

Refresher/Revision sessions Sarah Tidey BSc, LSSM, ISRM

Practical workshops to revise hands on skills and underline theoretical knowledge. Designed to target your areas of weakness. Come armed with a list of injury scenarios, joint assessment that would like to revise.....Or just a list of things you have forgotten!!

Dates: Fri 17th Jan 2020 Fri 28th Feb 2020 Fri 27th March 2020

Time: 10-2pm Venue: 15 Parkstone Heights, Parkstone, Poole, BH14 0OE Cost: £60 * 4 people max*

Revising all techniques

- Refresh the way you assess injuries and work out treatment plans
- Introducing tips to avoid getting 'stale'
- Review rehab protocols

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

Strapping & Taping workshop

Course objectives:

Part 1

- Basic principles of strapping to include rigid taping, compression, immobilisation and facilitation
- Looking at different types of tape and understanding their functions
- Practical application of compression strapping of an ankle
- Practical application of ankle & thumb rigid strapping
- Functional taping of the knee

Sat 14th March 2020 Date:

9.30am-4.30pm Time:

Venue: BWT Physio. 1 Springfield Road, Poole, BH14 0LG Cost: £100

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

Part 2

- Introduction to the theory of Kinesiotaping.
- Investigating Kinesiotape's uses for:
- Inhibition of trigger points
- Increase/decrease muscle tone
- Offloading Myofascial pathways
- Use of Myofascial taping in a sporting arena

* 4 people max* Course Tutors: Susie Toms MACP, HCPC - Physiotherapist Sarah Tidev BSc Soft Tissue Therapist

Emergency First Aid at Work (EFAW) Colin Iggleden

This is a 6-hour course designed for where an organisation's risk assessment of First Aid needs identifies that there is a requirement for Emergency First Aid at Work practitioners. The national Award for Emergency First Aid at Work issued on successful completion of this course satisfies the requirements of the regulatory body for First Aid. All learners will have the skills and knowledge to provide their organisation with Emergency First Aiders who can provide treatment to their casualties in a prompt, safe and effective manner.

Date: Sat 7th March 2020 10am-5pm Time: Venue: Nightingale House, Building 67, University of Southampton, 12 University Road, Southampton SO17 1BJ (Same as LSSM)

If you wish to attend, please send an email to: sarahtidey@ymail.com

Cost: £70

Tutor: Colin Iggleden



EXPAND YOUR KNOWLEDGE, ENHANCE YOUR SKILLS

(1)

*** CPD Too Good To Miss *** Book and block your diary NOW!



Venue: Winchester Date: Fri-Sun 27-29 March 2020

Born to Move (previously 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. Born to Move 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.

What is Born to Move?

Born to Move 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. Born to Move aims to bring the best of both these models together to give you an immediate and effective treatment tool.

Born to Move 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.



(2) Born To Walk Venue: Winchester

Date: Fri-Sun 01-03 May 2020

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.

Need more incentive to book?

*** Rare opportunity to be tutored by eminent writer, lecturer and bodyworker James Earls *** *** Early Bird discount until 07/02/2020 *** Complimentary welcome pack, fresh fruit and refreshments *** Cost, discounts, and registration information overleaf. For full course details, visit www.borntomove.com For all further enquiries and/or to request a WORD version of this registration form, email Sarah at: sarahtidey@ ymail.com. Please send your completed Registration form with payment if applicable to: BTMove/BTW Courses, c/o 15 Parkstone Heights, Poole, Dorset BH14 0QE.

Time: 9 AM – 5 PM Tutor: James Earls

Time: 9 AM – 5 PM Tutor: James Earls

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

EXPAND YOUR KNOWLEDGE, ENHANCE YOUR SKILLS

A – Dates, venu	e and gene	ral details								
Venue (both cou	both courses) Course dates & times				Accommodation			Parking		
Winchester Rugby Club AFR: 27-29 March 2020 North Walls Park, Hillier Way BTW: 01-03 May 2020 Winchester, Hants SO23 7SU Both 9:00 AM - 5:00 PM			Winc accor budg arran	Winchester offers a wide range of accommodation options to suit all budgets – please make your own arrangements as required.			Plenty of car parking is available behind and to the side of the Club House.			
Directions		1					•			
By car: > M3 Leave at Junction 9. > Head north on A34/A33. > Keep to right hand lane marked A33 Basingstoke & Kingsworthy > Take the first left onto B3047 (Cart & Horses) for 1.2 miles. > Turn Left into Russell Road. > Turn right at end, then first left into Hillier Way. > The WRFC Grounds are 220 m on right at end.					By rail / public transport: Trains: South Western Railway / Cross Country Rails From Winchester Railway Station: On foot: 15 min walk (check map or use preferred app.) The following transport lines have routes that pass <u>near</u> Winchester Rugby Football Club: buses numbers: 1, 66, E1 (please check according to individual requirements). Website:					
B – Personal an	d professio	nal details					······			
Surname		First name(s)		Mobile nun	ber		Email address (please write <u>LEGIBLY</u> , thank you!)			!)
Postal address								Post code		
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	Additiona	l:		FT _ / PT _ Years' experience since qualification Year				Year	s / Months	
C – Your goals: 1) 2) 3) 	what are yo	our goals and/c	r expectations i	n attendin	g this	/thes	e course(s)? (Multiple	e answers w	elcome!)	
D – Course regi		Early Pird	Full course fee					Cancellation	Doligy	
Course	rariv i	closing date	Full course lee	Please tie course(s	Please tick selected course(s) and rates		Cancellation Policy			
Course	Bird fee	closing date			1					Within 14 days (or fewer) of
Course Born to Move (27-29 March 2020)	Bird fee	Friday 07 Feb. 2020	£510	Early Bird	Ful	l fee	Up to 30 days prior to relevant course start	Betwe	een 29 5 days	Within 14 day (or fewer) of
Course Born to Move (27-29 March 2020) BTW (01-03 May 2020)	Bird fee £450.00 £450.00	Friday 07 Feb. 2020 Friday 07 Feb. 2020	£510 £510	Early Bird	Ful	l fee	Up to 30 days prior to relevant course start date(s): <i>Full refund</i>	Betwe and 1 pric relevan start d	een 29 5 days or to t course late(s):	Within 14 day (or fewer) of relevant course start date(s): No refund (*)
Course Born to Move (27-29 March 2020) BTW (01-03 May 2020) BT Move + BTW joint reg.	Bird fee £450.00 £450.00 £750.00	Friday 07 Feb. 2020 Friday 07 Feb. 2020 Friday 07 Feb. 2020	£510 £510 £930	Early Bird	Ful	l fee	Up to 30 days prior to relevant course start date(s): <i>Full refund</i>	Betwe and 1 pric relevan start d 50% rej <u>LESS</u> admi	een 29 5 days or to t course late(s): fund (*) £50 n. fee	Within 14 day (or fewer) of relevant cours start date(s): <i>No refund (*)</i>
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EXPAND YOUR KNOWLEDGE, ENHANCE YOUR SKILLS

Five ways to become an even better therapist - to suit all budgets!

Ongoing post-qualification learning is essential to your growth as a therapist - but it needn't break the bank! Here are five suggestions as to how you CAN further enhance your knowledge and skills to suit all budgets:

Type of learning



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Pre/post event STT offers a unique learning experience combining selfreliance with team work, guick thinking/ treating with efficacy, back-to-back treatment madness with unpredictable waiting... forging of lasting friendships with exchanging of tips, and an unforgettable experience with enhanced self-confidence.

Attending UK and/or overseas Conferences, Symposia, Congresses, etc. (moderate to medium cost)



Choose your event well from the myriad of opportunities on offer: check the host / organiser's and the presenters' credentials, read reviews from previous years, consider the fee versus duration, content, and level, and you should enjoy a first-class experience offering value for money.

Jointly with former classmates/colleagues, request a small group refresher or more advanced workshop on a chosen subject. A number of ISRM tutors are available by mutual arrangement (moderate cost if a group).



Refreshing/consolidating after a career break, needing the cure for 'staleness' of exceeding your comfort zone, exploring something new from sheer interest... Gather your mates and contact a (former?) tutor!

Invest in a CPD course or workshop on a theme you are hungry to know more about - enhancing your assessment skills, a specific technique, understanding patterns of dysfunction and how to address these... costs of CPD courses and workshops may be higher, but nothing can truly compete with group-learning, sharing questions (and perhaps confusion), and being tutored by an experienced, recognised course leader passionate about sharing the knowledge and skills s/he loves.



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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

* Ideally four attendees

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Journal of Bodywork and Movement Therapies

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- Professional and clinical advice (from Mel Cash and others) available within the members' forums

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* Please note that not all items listed are free of charge

Educational websites/links (listed alphabetically)
Best 10 Anatomy Apps - tinyurl.com/w2sjssd
Introduction to Anatomy Trains - tinyurl.com/reqmzhq
Born to Walk - tinyurl.com/wmw632l
Born to Move - tinyurl.com/vnpcum7
Comera Movement Science - tinyurl.com/vzo85ze
Evidence Based Fitness Academy - tinyurl.com/qkgpocr
Evidence Based Fitness Academy [Video] - tinyurl.com/twf6z8a
12 Best Anatomy Apps for Android & IOS - tinyurl.com/sewcst7
Kenhub - tinyurl.com/v8vh4fc
REHAB My Patient - tinyurl.com/vbsxcfl
Sports Injury Fix - tinyurl.com/uynxunb

Introduction to Anatomy Trains® [Video] - tinyurl.com/utuvnu9 Anatomy Trains® talk by Tom Meyers [Video] - tinyurl.com/qs2zztt

E-/hard copy books, Journals, DVDs etc. (listed alphabetically) Anatomy Trains[®] BodyReading 101 - tinyurl.com/uo432xn Journal of Bodywork and Movement Therapies - tinyurl.com/u4gsl2h Fascia by Robert Schleip - tinyurl.com/wj7n5u2

Kinetic Control by Mark Comerford - tinyurl.com/ue5rlun Training & Educational Materials - tinyurl.com/rv5b94v

Clinical equipment suppliers

Marshcouch Pro - tinyurl.com/qn3paeh Physique Management Company Ltd - tinyurl.com/r8ncvvz



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