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ENHANCING HEALTH THROUGH REHABILITATION & REGISTERED MASSAGE THERAPY

FALL/WINTER ISSUE 2021

INSIDE

THE RMTBC REVIEW | FALL/WINTER 2021

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RMT Magazine is published twice a year for Registered Massage Therapists (RMTs). It provides a voice for RMTs and acts as a source for the latest research. It is a vehicle for the general population to understand and respect the valuable work of RMTs. Funding is provided by the RMTBC and through advertising revenue.

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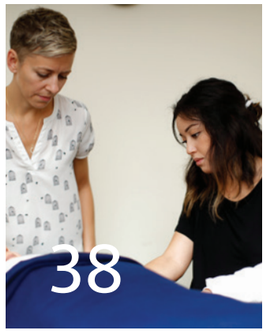

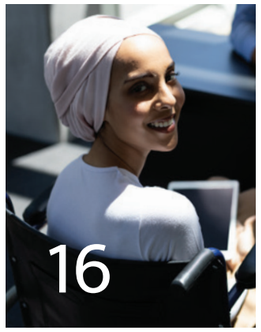

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Adding Manual Osteopathic Therapy to Your Practice

MANUAL OSTEOPATHIC COLLEGE OF CANADA
HEALTH & WELLNESS COLLEGES OF CANADA

What happens when massage isn't enough? What can you do when client results and improvement are at a standstill? What are your options as a practitioner when you hit that wall?

The Manual Osteopathic College of Canada (MOCC) has an answer with the Manual Osteopathic Therapist Program. This modality allows practitioners to care for their clients with new methods that break down those treatment walls and provide enhanced client care.

What is Manual Osteopathic Therapy?

Manual Osteopathic Therapy is a modality between chiropractic and massage that examines the body as a whole unit. It supports the body's natural capability to heal, self-regulate, and maintain overall health. This is done through examining the entire body and treating mechanical disruptions at the root of the issue rather than just at their symptoms. Manual Osteopathic Therapists (MOTs) are able to assess and correct issues beyond the scope of massage therapy, adding an additional layer of treatment to your practice.

A Closer Look into Manual Osteopathic Therapy

Manual Osteopathic Therapy uses hands-on skills for both investigation and treatment of body dysfunctions. The whole body is examined, and mechanical disruptions are treated whether symptoms exist or not. Simply put, if a client has right shoulder pain, the Manual Osteopathic Therapist would be expected to examine the joint and soft tissue around the shoulder, but they will also:

- Assess the pelvis because if it is imbalanced it will drop the shoulder and create a strain;
- Check the spinal column because inflamed nerves can send pain to the shoulder;
- Palpate the liver and gall bladder because dysfunction in those organs radiate pain to the right shoulder and lastly;
- Assess the fluid dynamics in and out of the shoulder because fluid congestion is linked with pain.

The therapist then gently treats imbalances found with techniques that engage the dysfunctional tissue until function is normalized. Techniques include:

- Mobilizing joints by muscle-resisted techniques.
- Manipulating connective tissue to healthier states.
- Flushing fluids in the direction of drainage.

The treatments are gentle with a light amount of pressure applied to the client's body. This minimizes the physical exertion and 'wear' for the practitioner. Manual Osteopathic Therapy techniques have been known to completely resolve chronic symptoms in patients who have sought help from a variety of practitioners in other fields.

Contact Manual Osteopathic College of Canada to learn more:

Phone: 877.902.8636
Email: info@moccanada.ca

Benefits of adding Manual Osteopathic Therapy to your practice:

- Gain an additional billing number
- Add treatment options to your client care plan
- Learn a whole-body philosophy
- Practice techniques that are gentle on the client and the practitioner

INTERVIEWS

MEET YOUR NEW BOARD MEMBERS

REGISTERED MASSAGE THERAPISTS ASSOCIATION OF BC
Safe, Effective Healthcare

MEET YOUR NEW BOARD MEMBER

ROXANNE PETRUK

Please tell us a bit about your background and where you went to school for your massage therapy training

I had a career in forestry prior to becoming an RMT. I went to Okanagan Valley College of Massage Therapy

What motivated you to get into this profession?

I really like people and have long had an interest in healthcare. I was looking for a career that enabled me to make a positive difference in the lives of people, but also allowed me flexibility in my working life. I had personally experienced the benefits of massage therapy and I felt it was the right fit.

"I wanted to use my knowledge and management experience to support and inform RMTs in BC, and to bring a fresh perspective to the great work of the RMTBC."

What are your areas of expertise or particular interest?

I have a general practise with a focus on women's health. I have a strong interest in quality evidence informed education for RMT's, and have worked at OVCMT as a Supervisor, Teaching assistant, Instructor, and now as the Executive Director of the RMT program.

Where do you live and practice?

I live and work in Vernon, BC

What type of involvement do you have with the community? i.e. volunteering, etc.

Through my work as a massage therapy educator, I have had volunteer involvement with numerous community events, including sporting events, arts and theatre, fundraising for charities and humanitarian events. I also volunteer on the board of the Canadian Council of Massage Therapy Schools.

What changes would you like to see in the profession?

I think with the 2017 introduction of national accreditation standards for massage therapy education across Canada, through the Canadian Massage Therapy Council for Accreditation (CMTCA), massage programs across the country will be required to meet minimum standards similar to what has been in place in BC and Ontario for many years. This will elevate massage therapy nationally, and garner recognition and respect for massage therapy in line with other nationally accredited healthcare professions. I would love to see RMT's in BC come together as a collective positive voice for quality healthcare, and build excitement and support toward evidence informed practise, with a strong base of research for the efficacy of massage therapy. Internal conflict within a profession does not move it forward. Strong governance, and strong representation, such as the work of the RMTBC, will. We need to amplify our collective voice provincially and across Canada as leaders in standardized RMT care for all Canadians.

What motivated you to join the Board?

I wanted to use my knowledge and management experience to support and inform RMTs in BC, and to bring a fresh perspective to the great work of the RMTBC. I have appreciated the way in which our professional association has represented RMTs, and how they continue to work in the background with government, accrediting bodies, and regulators to elevate RMT's.

Do you work in a clinic or as an individual?

I currently work solo, although I have had the privilege of working in large a multidisciplinary clinic with other healthcare providers in the past.

rmtbc.ca/our-board

MEET YOUR NEW BOARD MEMBER

ROBYN LANCASTER

Background:

I grew up in Calgary, AB and moved to Kimberley B.C. in 2004 to teach skiing and enjoy the mountain lifestyle. I originally went to school at Mount Royal College and studied theatre. I worked in that industry for a few years before deciding that it wasn't the right fit for me and moved to the recreation industry.

What motivated me and where I went to school:

Before coming to BC, I worked for a company that cross trained hockey players and other highly skilled athletes, and as the Schools and Group Program Administrator for a ski area. After moving to BC, I worked in a Drug and Alcohol treatment center for a few years. These experiences really showed me how disconnected people seemed to be from their physical selves. Pain and discomfort were often a regular part of people's everyday lives including a wide spectrum of society from highly paid athletes to those who struggled to feed and clothe themselves. Massage had always been on my radar as my "path untraveled" and I finally decided that I needed to explore my options and enrolled at CCMH (Canadian College of Massage and Hydrotherapy) Foothills, which was a satellite campus of CCMH in Ontario. We studied the Ontario curriculum and I wrote my registration exams in Newfoundland (I also could have written in Toronto). At the time I was the first to write in Newfoundland from out of province, so it was a steep learning curve for everyone! I then transferred my registration to the CMTBC and started working in Kimberley.

Areas or expertise/particular interest:

My focus over the past number of years has been on pediatric care. I have completed as many pediatric focused courses as I can find and now work with quite a few children and teens. There are so many possible benefits for children who are often underserved in our profession.

Where I live and practice:

I live and practice in Kimberley B.C. with my husband and 2 sons who are 4 and 7. I work as a Sole practitioner at a multi-disciplinary clinic (Creekside Physiotherapy) owned by physiotherapists. I have been part of the team since we opened in 2011 when there were the 2 owner physios, myself and 1 receptionist. It has grown to now include 7 physios, 3 RMTs, an acupuncturist, a counsellor, 5 kinesiologists and 6 receptionists. Earlier in my career I worked from my home.

Community Involvement:

Being the mom of young kids my community involvement is largely centered around them and their activities. I am also the Secretary for our Parent Advisory Council (PAC). We are a skiing family, so we spend most of our free time in the winter at the ski hill.

Changes I would like to see in our profession:

I am proud to be a health care professional and professionalism and evidence informed care are things I feel passionately about. They are also things that I think we can do better as a profession. I feel as though the momentum is increasing in these areas and I am hopeful that those changes continue. I also believe in many of the

suggestions from the White Paper regarding specialization in our profession. It would be a complicated road, but I believe that pursuing specialization options could benefit both the public as well as BC RMTs.

What motivated me to join the Board:

I am proud to be an RMT and I have ambitious dreams for us as a profession. I recognize that there are always people working hard behind the scenes to achieve our goals. I wanted to contribute to that effort. I have had occasion to contact RMTBC in the past and every encounter has been respectful and helpful. They seemed like a team that I could happily be a part of. I also wanted to learn more about the background workings of our Association.

rmtbc.ca/our-board

NEW RESEARCH COMING FROM THE CMTA

A NATIONAL STUDY

For more, visit crmta.ca/research

ON CANADIAN RMTs' EXPERIENCES OF SEXUAL HARASSMENT & ASSAULT BY CLIENTS

The Canadian Massage Therapy Alliance membership recognizes that a strong health care system is guided by evidence-informed decision-making. Research evidence is essential to advance the knowledge related to massage therapy as a healthcare service in every community.

CMTA supports and promotes the development of effective and well-resourced research capacity both within and outside the profession. The Alliance works to advance a collaborative research agenda, empower alliance member involvement in research, disseminate research knowledge and conduct research related to professional issues in order to inform the public/private health sector and to advance social policy.

A National Study on Canadian Registered Massage Therapists' Experiences of Sexual Harassment and Assault by Clients

The purpose of this study is to investigate Canadian registered massage therapists' experiences of sexual harassment and assault by clients on a national scale. The intent is to survey 1600 Canadian registered massage therapists about whether they have been subjected to sexual violence by a client and about the nature of those incidents. This sample will represent approximately 10% of all registered massage therapists in Canada.

The primary objectives of this study will be to:

1. Assess rates of sexual harassment and assault by clients during provision of services among Canadian RMTs;

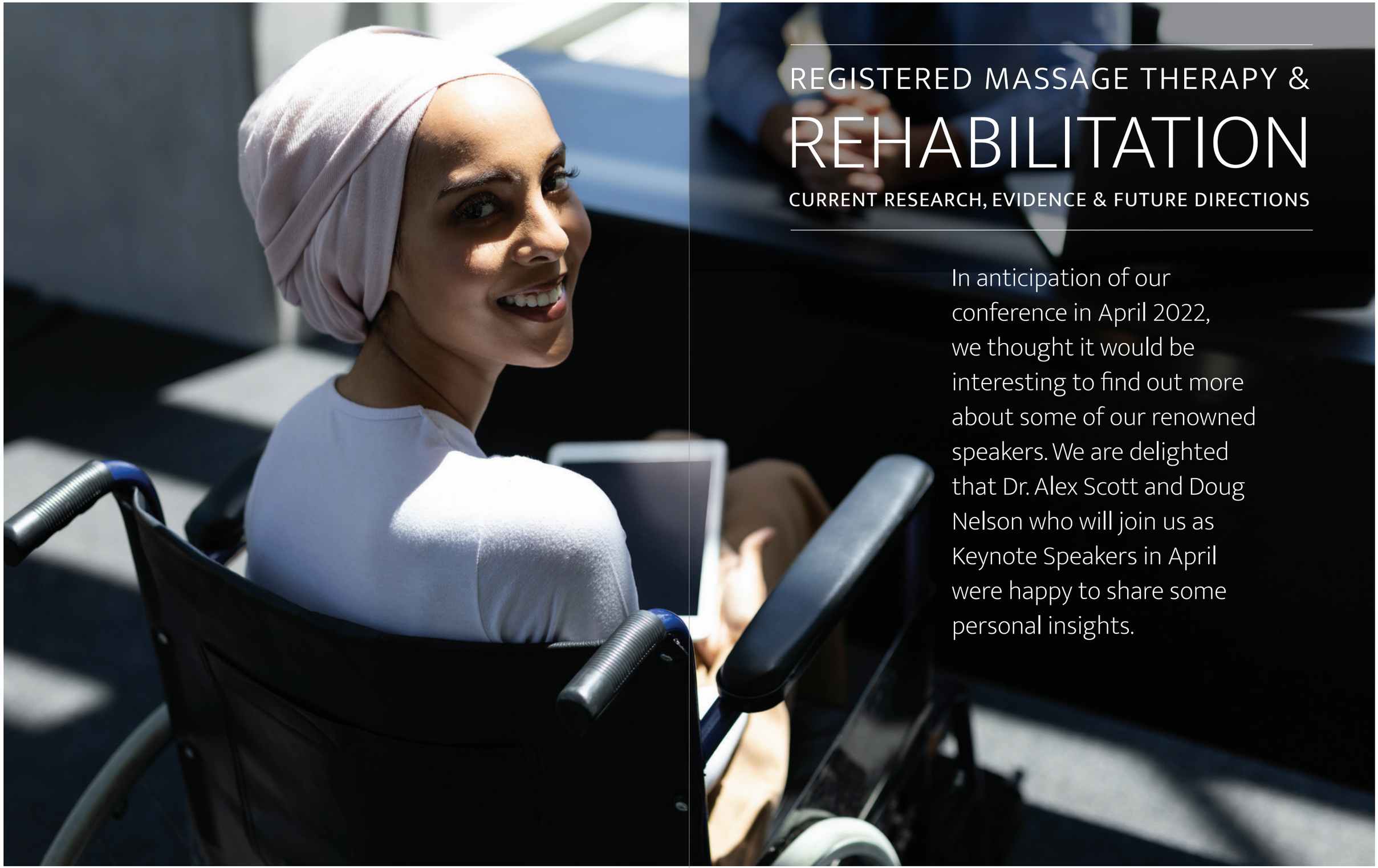
2. Determine the extent to which Canadian RMTs experience concerns or fear regarding the possibility of being subjected to some form of sexual harassment or assault by a client;

3. Characterize client behaviour and responses in these contexts;

4. Generate estimates of the extent to which incidents were reported or disclosed to others, as well as perceived safeguards and risk factors for sexual harassment and assault; and,

5. Understand in greater detail the responses and practices Canadian RMTs have had regarding these experiences of sexual harassment and assault and, in particular, the personal and professional consequences of these events.

RMTBC members may be contacted to participate in this research. As always your participation is voluntary and at your discretion.



REGISTERED MASSAGE THERAPY & REHABILITATION

CURRENT RESEARCH, EVIDENCE & FUTURE DIRECTIONS

In anticipation of our conference in April 2022, we thought it would be interesting to find out more about some of our renowned speakers. We are delighted that Dr. Alex Scott and Doug Nelson who will join us as Keynote Speakers in April were happy to share some personal insights.

KEYNOTE SPEAKER INTERVIEWS

DR. ALEX SCOTT

"My research team is working on a new technology (hardware & software) which can help patients set targets, provide feedback on their tendon loading, and stay motivated."

How and why did you enter your profession?

I knew I wanted to work with musculoskeletal injuries, but wasn't sure if chiropractic, massage therapy, or physiotherapy would be the best fit. I was also really interested in medical research. Because the physiotherapy training is based at UBC I thought that would open possibilities to incorporate research into my career.

Dr. Alex Scott

Dr. Scott is an Associate Professor at UBC, in the department of physical therapy. He has graduate degrees from UBC in exercise physiology and experimental medicine. Dr Scott's research targets a widespread problem, overuse injuries and chronically painful tendon disorder in workers and athletes.

What advice would you give yourself if you were just starting out in your career?

You've got this! Keep believing in yourself, working hard and following your instincts, and your career and research will unfold in the right way.

What's next for you as you continue in your profession (ie. Research, special projects)?

I'd love to be able to provide patients with better options for tendinopathy rehabilitation. My research team is working on a new technology (hardware and software) which can help patients set targets, provide feedback on their tendon loading, and stay motivated.

What or who is your greatest inspiration and why?

My big brother! He's the human being I most aspire to emulate – full of creativity, passion for teaching (he teaches at Mohawk college in Ontario), a love of science, and a strong moral compass. He also gave me tips when I was writing my first scholarship application, I'm not sure if my academic career would have taken off without his advice.

If you could have a conversation with any person living or dead, who would that be and why?

My first wife. She passed away 12 years ago. I would love to tell her about all the things that have happened and tell her how our kids are doing.

What is your favourite food or cuisine?

Anything I can eat with my fingers, rather than cutlery or chopsticks.

What is your favourite pastime (hobbies or interests)?

Walking and talking in the fresh air and sunshine - letting my legs and mind go wandering in the company of friends, old and new.

During your travels, what place (country, city or continent) has had the greatest impression on you?

A couple of years ago, I walked right across England, along the Coast to Coast path. I was born in England, and my family left when I was three. It took a couple of weeks to walk the whole distance. The gentle beauty of the ancient countryside which my ancestors have occupied for generations made me feel a deep inner peace. I can still conjure that feeling up when I remember the trip.

KEYNOTE SPEAKER INTERVIEWS

DOUGLAS NELSON

"The better we therapists get at creating results, the busier the practice becomes. The busier the practice, the harder it is to do the study and research time that created the success in the first place."

How and why did you enter your profession?

My early life was focused on pursuing a career in music. While my best friends went on to amazing careers in music, I realized that my path would lead to a different road, but still be influenced by the arts. Not knowing what else to do, I began teaching lessons, realizing that many of my students struggled to get their body to perform what their mind envisioned. This mind-body connection fascinated me.

Douglas Nelson LMT, BCTMB

President at the Massage Therapy Foundation, Douglas Nelson began his career in massage therapy in 1977, and he maintains a very active clinical practice. His particular interest has been the role of soft tissue in performance, serving as a neuromuscular consultant to teams in the NBA and NFL, in addition to dance companies and high level musicians.

This lead me to a yoga teacher training, where I was also introduced to the discipline of massage therapy and then never really looked back. I was very drawn to the power of manual therapy to make a difference in the soft-tissue pain that our health care system, then and now, often struggles to address. More than forty years later, this mission is ever clearer.

What have been some of your biggest challenges throughout your career?

My role in this profession is three-fold, as I am a therapist, a clinic owner, and also an educator. Each domain has its unique challenges and growth opportunities.

As a therapist, the better we therapists get at creating results, the busier the practice becomes. The busier the practice, the harder it is to do the study and research time that created the success in the first place. This time dilemma is a constant struggle for me. Honestly, it is also one of the major reasons for me to teach, as it necessitates time away from seeing clients.

As a business owner, the skills that made me a successful therapist are not the skill sets needed to run a clinic with 20 therapists. I have had to learn about what it takes to be an effective leader for my staff. Being honest, authentic, unafraid to be vulnerable have been valuable lessons, especially during the pandemic years. There were many instances of uncertainty where the path forward was unclear and choices had to be made. The uncertainly of it all escalated the stress level for everyone, clients and staff alike. But, this struggle drew my staff and I ever closer as we navigated these uncharted waters together.

As a continuing education provider, one of the biggest challenges is how to realistically inspire and foster the skill sets needed for those who take our courses. One cannot learn or absorb everything in a short course, but how do we educators best both convey information and inspire people to devote time to learning and development? It is a never-ending struggle to do this in the best way possible.

What advice would you give yourself if you were just starting out in your career?

Getting a really sound initial education is important, but perhaps more important is the realization that learning is a life-long process. The deeper your understanding, the more effective you will be. If I were starting over, I'd pick an area in which to specialize and dive deeply. This can be

KEYNOTE SPEAKER INTERVIEWS

DOUGLAS NELSON

advantageous for at least two reasons. One, it is far easier to market yourself when your have a clear focus of practice. If you are incredibly effective at treating foot pain, for instance, you will have no trouble finding clients seeking your services. On the personal side, it is generally far more enriching to explore a specific subject material rather than possessing a more superficial knowledge of many things. Moreover, the skill sets learned in deep exploration can be translated to other subject areas. Deep learning skills are a lens, which can be focused on any topic needed.

What type of community or volunteer activities do you participate in?

I have been very active in Rotary at the local level as a club member and also at the district level as a trainer. It is a wonderful way to give back and make a difference in the world.

My wife and I are also very active volunteers in our local performing arts center, Krannert Center for the Performing Arts. This is an amazing arts center, with 300 plus concerts annually, robust educational programs, and also underwriting and supporting the creation of new works. It is a center like few others in the country and we have been chairing various committees there for years. We feel very strongly about the role of the arts in society and work hard to be worthy ambassadors.

I am also very passionate about building a bridge between the town and gown in my community and have worked extensively to that end. One such project I created was The Art of Science, an initiative that displayed scientific research images as art, exposing non-scientists and the business community to significant research efforts through the lens of spectacular esthetic images. Now in its eleventh year, the project has expanded far beyond my wildest dreams and has been an excellent engagement initiative for the University of Illinois.

What's next for you as you continue in your profession?

Being (I guess) an elder in the field, my concerns now have changed from more personal endeavors to the health and strength of the field as a whole. I want to make sure that my clinic lasts long after I no longer own it, as it serves an important role in our community. I have deep concerns about the health and strength of the field of massage therapy in general and am always looking for ways to ensure the good we bring to the world will be here for generations to come. That is one reason I have been active with the Massage Therapy Foundation and am deeply grateful to RMTBC for its support in that effort.

What or who is your greatest inspiration and why?

Yo Yo Ma is truly an inspirational figure for me. His commitment to making a difference on the planet through the arts is forever inspiring to me. I have had the opportunity to hear him speak and am always impressed with his breadth of knowledge that spans far beyond the arts, one that fully embraces the human condition. This is likely inspired by his mentor, Pablo Casals. Casals often stated that he is a human being first, a musician second, and a cellist third. I have adopted that for my own discipline as well. First and foremost, in the treatment room, I am first a fellow human being first. That demands responding to people with genuine care and concern, person to person. Next is being a responsible health care provider, with the client's welfare first, then followed by embodying and representing my chosen field of massage therapy to the very best of my abilities.

If you could have a conversation with any person living or dead, who would that be and why?

On the professional side, I had the opportunity to study with Moshe Feldenkrais when I was very young and inexperienced and probably understood very little of what he was teaching. I'd love to have that conversation with him now.

What is your favourite food or cuisine?

Being a lover of great wines, I enjoy foods that pair well with wines from around the world. I have traveled to vineyards in many different countries and am always inspired at the care and attention to every detail in the wine-making process. My travels in Italy taught me that wine is food, and should be treated with great respect. There is so much to learn and I find the process fascinating. When I walk through the vineyards, I have a sense of coming home like no other.

What is your favourite pastime (hobbies or interests)?

I am a relatively new cello student and I very much enjoy the process of learning and practicing this wonderful instrument. I find that being a cello student has helped me be a better teacher as well, as I am constantly challenged and humbled as a student. I think it important for any therapist to have an artistic endeavor, as it teaches many life lessons that can be broadly applied.

During your travels, what place (country, city or continent) has had the greatest impression on you and why?

In 1992, I had the opportunity to travel to Japan for six weeks on a scholarship from Rotary. That trip was life-changing for me and I will be forever grateful for the opportunity to spend so much time in another culture. The dynamics of this trip provided me access to aspects of Japanese culture that tourists would never have access to. I stayed in people's homes, spent time with amazing Rotarians who made a difference in the world, and began to see the world through the lens of another culture. After coming home, I realized that something deep inside me had shifted. I realized that I more deeply understood my own culture, now being able to contrast that with another. A system can never know itself from the inside. Moreover, I realized I had fundamental choices, that I could select the best of both cultures to create how I wanted to be in the world and the society in which I live. So many aspects of my present life are in direct relationship to insights first realized on that trip.

RE HABIL ITA TION

This article was first published by the International Journal of Therapeutic Massage & Bodywork, highlighting important work in the field of Registered Massage Therapy and patient rehabilitation.

WINNER OF THE CASE REPORT COMPETITION, IDA P. ROLF RESEARCH FOUNDATION, BOULDER, CO, USA
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PRACTICE

STRUCTURAL INTEGRATION CASE REPORT: A GLOBAL INTERVENTION CHALLENGINGTHE LIMITATIONS OF LOCAL REHABILITATION

INTERNATIONAL JOURNAL OF THERAPEUTIC MASSAGE AND BODYWORK—VOLUME 14, NUMBER 1, MARCH 2021

Bernice Landels, Bachelor Health Studies
Health Studies (Massage & Neuromuscular Therapy), Board Certified Structural Integrator (IASI)

BACKGROUND: Conventional rehabilitation for musculoskeletal injuries post-surgery is generally site-specific and aims to return the person to 'normal' function. Commonly, conventional treatment focuses locally and little or no attention is given to comorbidities, other symptoms, postural compensations, or adaptations either pre-existing or resulting from the injury. Structural Integration (SI) is a manual therapy applied to and focusing on fascial continuities throughout the whole body. This case report explores SI as a global, whole-body intervention for rehabilitation.

PURPOSE: To examine the effects of a whole-body approach that addresses local and global symptoms following ankle surgery.

METHODS: The Anatomy Trains Structural Integration (ATSI formerly KMI) 12-series protocol was applied and a selection of outcome measures were used to track progress and assess the efficacy of SI. Ankle mobility and function was assessed primarily using Weight-Bearing Lunge Test and Lower Extremity Functional Scale. Local pain was reported using the McGill Pain Questionnaire. General wellbeing was evaluated using subjective questioning and the WHO Quality of Life Questionnaire.

RESULTS: Local results included increased mobility and function to affected leg, and reduced pain and swelling. Global results included an improvement in physical and psychological well-being, with the reduction of pain and dysfunction in other areas.

CONCLUSION: This case report demonstrates global benefits of a whole-body approach when structural integration is applied during rehabilitation. More clinical research that includes SI is needed to determine if the local and global results shown in this case study can be demonstrated in additional rehabilitation populations.

KEY WORDS: anatomy trains; structural integration; fascial; rehabilitation; ankle surgery.

THE GLOBAL BENEFITS OF A WHOLE-BODY APPROACH

INTRODUCTION

Ankle injuries are a common occurrence in sport, and in field hockey account for nearly 25% of all injuries.[1] A trimalleolar fracture with syndesmosis dislocation,[2,3] classified as a Weber C fracture[4] (https://radiopaedia.org/articles/weber-classification-of-ankle-fractures), requires surgical intervention involving open reduction and internal fixation (ORIF) to stabilise the joint. Without surgery, instability, dysfunction and chronic pain may arise as future issues.[5]

Physiotherapy and advice leaflets[6,7] providing injury specific protocols are provided by the National Health Service (NHS) for post-surgery rehabilitation in the United Kingdom. Secondary symptoms and pre-existing conditions or pre-disposing factors, such as posture or movement patterns, are given little consideration.

Manual therapy (MT) to aid recovery has to be sourced and paid for privately in the UK. There is a risk that these, too, will focus only on local symptoms relating to the injury/surgery.

Structural Integration (SI) is a unique 'whole-body' MT developed by Dr. Ida Rolf (1896–1979).[8] With a set number of sessions [10–12] and a systematic approach,[9,10] SI focuses on whole-body functionality rather than individual areas or symptoms. The International Association of Structural Integrators[11] (IASI) describe SI as bodywork focusing on connective tissue or fascia to "help an individual experience an optimal way of moving by increasing strength, adaptability and resilience".

Published literature on SI and rehabilitation is limited.[12,13] Despite few clinical case studies or trials, the results recorded show positive effects on posture, gait, range of movement (ROM), balance, musculoskeletal pain, and well-being.[14,15]

Myers,[16] in his article 'Past as Prologue: The "Future" of SI', posited whether SI practitioners could bring value to people outside the confines of private practice, by assisting with rehabilitation during healing and recovery, and after surgery. This prospective case report explores Myer's question, and further investigates the benefits of a whole-body, global approach compared to local rehabilitation practices.

CASE PRESENTATION

Client Information

A 45-year old female paramedic injured her left (L) ankle whilst playing field hockey (Figure 1). She presented with pain and limited mobility in her L ankle, three months post-ORIF and syndesmotic reconstruction surgery (Figure 2). Pain in L hip/groin, tightness in the L knee on movement and right (R) superior neck pain with occasional "locking" as described by the client, were all secondary symptoms.

Figure 1. Client left ankle at time of injury.

Figure 2. Lateral view post ORIF & syndesmotic reconstruction surgery.

Bilateral lower leg pain and discomfort had been present since 2002. Past treatment included a bilateral posterior compartment release (2008); a high-volume injection (HVI) to R achilles (2015); eccentric and isometric exercises, anti-inflammatories, night splints and local massage. Initial client comments were: "I don't like my legs, ever since they started giving me grief in 2002" and "I feel flatfooted, no spring".

Surgery at eight years of age for an R inguinal hernia, a recent tooth extraction, past incidents of whiplash, and a jaw injury from playing ice hockey, as well as concussion from a fall while snowboarding, were also reported.

Assessed by NHS physiotherapists as functioning "above normal", she was discharged shortly after surgery. Seeking help to improve function and mobility, she contacted the practitioner and began a series of SI. Consent was gained for this case report.

Clinical findings from initial assessment

- Pelvis shifted and rotated R;
- R foot turned outward and pronated, driving the lower leg into internal rotation and dorsiflexion at the talocrural joint (ankle);
- R knee flexed and externally rotated, causing the femur to tilt posteriorly;
- L leg externally rotated and abducted relative to the pelvis;
- Pelvis anteriorly shifted relative to the ankles and upper body compensates by tilting thorax posteriorly;
- Head shifted anteriorly, tilted posteriorly, tilted L and rotated R;
- Shoulders neutral to pelvis with a slight L rotation;
- Bilateral scars (30 mm) midposterior calves;
- Local oedema in L ankle & muscle atrophy in lower leg; and
- Vertical scar (80 mm) on lateral L ankle from ORIF surgery.

Client walked with a limp, with no heel strike occurring on the L. Activities, such as going down stairs and putting on calf-high rubber boots, were challenging.

Assessment Measures

Baseline measurements were established comparing lower limbs, including range of movement (ROM) and function using the weight-bearing lunge test (WBLT)[17,18] and lower extremity functional scale (LEFS).[19,20] Photographs were taken throughout and leg circumference was a late inclusion at Session 3 to monitor local oedema. Subjective data were collected using the McGill Pain Questionnaire (SF-MPQ-2)[21,22] and World Health Organization Quality of Life questionnaire (WHOQOL)[23,24] (Table 1).

Therapeutic Intervention

Anatomy Trains SI (ATSI), based on the work of Dr. Rolf, was developed by Tom Myers[25] and follows myofascial lines (or meridians) in a sequential order over 12 sessions (Table 2).[9,10] The lines show connections throughout the body and provide a map that can help explain distribution of strain, tension, and postural compensations. A systematic review looking at the evidence behind the lines[26] found there is strong support for the Superficial Back Line (SBL) and moderate for Lateral Line (LL) and Spiral Line (SPL). A study of self-myofascial release to the plantar surface of the foot showed an increase in hamstring and lumbar ROM[27] in one foot, and stretching the calf and hamstring increased cervical ROM in another,[28] both contributing to the evidence towards the continuity of the SBL.

TABLE 1. Description of Measurement Tools Used with Supporting Rationale and Sequencing

Measurement Tool	Rationale	Session
Weight-bearing Lunge Test (WBLT)[17,18]	Measure dorsiflexion in ankle joint, track progress	1, 3, 6, 12 & F/up
Lower Extremity Functional Scale (LEFS)[19,20]	Measure activities of daily living relative to the lower limbs	Pre 1 Post 12
McGill Pain Questionnaire (SF-MPQ-2)[21,22]	To measure pain levels and types of pain relative to the L leg	Pre 1 Post 12
Quality of Life Questionnaire (WHOQOL)[23,24]	Measure impact of injury on everyday life and any emotional effects	Pre 1 Post 12
Leg circumference	Measure local oedema	Pre 3 Post 12

Table 2. ATSI 12 Series Protocol Overview [9,10,25]

Session No.	Standard Protocol	Key Structures
Superficial 1–4	Superficial front line & front arm lines (SFL/SFAL)	Ankle retinacula, crural fascia Subcostal arch, sternal fascia, sternocleidomastoid Pectoralis major, latissimus dorsi
	Superficial back line & back arm lines (SBL/SBAL)	Plantar aponeurosis, hamstring fascia Erector spinae, sub occipitals Trapezius, deltoid
	Lateral line (LL)	Fibularii fascia, iliotibial tract Lateral ribs, quadratus lumborum, scalenes
	Spiral line (SPL)	Rhombo-serratus complex, abdominal obliques Tibialis anterior/fibularis longus sling
Core 5–8	Deep front line (DFL)	Deep posterior compartment of leg Adductor group, psoas complex
	Deep front line & deep front arm line (DFAL)	Psoas, diaphragm Anterior longitudinal ligament/visceral attachments Deep laminae abdominal fascia Pectoralis minor
	Deep back line	Piriformis, deep lateral rotators, pelvic floor Calcanei, multifidi/transversospinalis
	Deep front line	Sphenoid, temperomandibular joint, hyoid complex Cervical vertebrae/deep anterior neck
Integrating 9–12	Pelvis & walking	Pelvis and legs
	Torso & breathing	Rib basket and breathing
	Arms & manipulation	SFAL - Pectoralis major/latissimus dorsi, medial intermuscular septum (IMS), flexors & carpal tunnel SBAL - Trapezius, deltoid, lateral IMS & extensor group DFAL - Pectoralis minor, biceps brachii, radial periosteum/ collateral ligaments & thenar muscles DBAL - rhomboids, levator scapulae, rotator cuff, triceps brachii, ulna periosteum/collateral ligaments & hypothenar muscles
	Spine & tensegrity	Spine and integration with body

“WALKING WAS CLOSER TO ‘NORMAL’ AND THE CLIENT RETURNED TO HOCKEY TRAINING (LIGHT) WITH HER TEAM WITH NO ADVERSE REACTIONS.”

Fascial release techniques (FRT) are applied using fingers, hands, soft fists, forearms or knuckles.[29] The client is actively involved during application, moving (concentric and eccentric contraction) the area/ muscle being treated. A variety of positions (seated, standing or lying) are used during the session. Depth and direction are determined by the client’s tissues and assessment findings, and are applied with the intention to lift or drop, to open, differentiate or balance tissues and structures.

The ATSI 12 series took place over 12 weeks, with a follow-up session five weeks after completion. Superficial sessions (1–4) occurred regularly on Fridays and Mondays at 9:30 a.m.; core and integrating sessions (5–12) were less regular due to holidays and the client’s return to work. All sessions were a maximum of 90 minutes in duration. Whilst each session has clear goals and structures to address (Table 2), variations arise based on the client’s needs and presentation (Table 3).

RESULTS

Objective

WBLT improved with the difference between L and R toe-to-wall measurement reducing from 9.5 cm (34.2º) to 3 cm (10.8º) (Table 4). L lower leg oedema was reduced (Table 5 & Figure 3), and muscle tone was improved (Figure 4); realignment of the ankle was also observed (Figure 5). The R pelvis rotation reduced and the client’s posture (sagittal) changed with a slight posterior shift and tilt of the pelvis, softening the thoracolumbar hinge in the spine (Figure 6). Walking was closer to ‘normal’ and the client returned to hockey training (light) with her team with no adverse reactions.

Subjective

SF-MPQ-2 showed changes in the type and intensity of pain experienced in L ankle. The intensity reducing in all types except aching pain, and two new types of pain reported at F/Up (Table 6), and overall present pain intensity (PPI) was reduced. Perceived daily functioning improved, with the LEFS score increasing from 74% to 95%. QOL responses showed improvement in overall physical and psychological well-being. The initial negative comments changed during the series to feelings of “lightness, fluid and freedom”. In Session 7 the client reported, “for one day I almost felt normal”. The client reported improvement in neck, groin, and knee symptoms.

Table 3. Variations to the Standard ATSI Treatment Protocol

Week	Day	Session	ATSI Focus	Variations from Standard ATSI Treatment Protocol[25]
1	Fri	1	SFL/SFAL	Lift of SFL foot to head. Arm lines not included.
2[a]	Mon	2	SBL/SBAL	Drop of SBL, lumbar tissues worked laterally. Arm lines not included.
	Fri	3	LL	L lower lifted, upper differentiated R lower dropped from knee and lifted to head Pectoralis minor and serratus anterior not included
3[a]	Mon	4	SPL	R upper and lower SPL. L upper SPL omitted
4[a]	Wed/Fri	5	DFL (lower) & LL	Lift lower compartment DFL. Lift L anterior adductors, drop posterior, reverse on R. Treatment spread over 2 due to tenderness experienced in earlier sessions, this allowed for a lighter introduction to the DFL and more acceptance by the client.
5[a]	HOLIDAY — No treatment			
6[b]	Tues	6	DFL (upper), DFAL	Client disclosed R inguinal hernia surgery during session in response to tenderness on R. Adjusted pressure and noted scar.
	Thurs	7	7 Deep back line/ primary & secondary curves	Lumbar/upper thoracic opened laterally, lower/mid thoracic worked toward midline
7[b]	Fri	8	Neck, jaw and head relationship to DFL	Structures addressed for R rotation/tilt and posterior tilt of head relative to neck; jaw tracking to L.
8	HOLIDAY — No treatment			
9	Mon/ Thurs	9	9 Integration with emphasis on gait and pelvis	Integrated with gait over 2 sessions — L forward lunge to weight bear on L, dorsiflex L ankle; external rotation of R femur/ leg. R forward lunge to rotate pelvis L and extend L knee and plantar flex ankle.
10	Wed	10	Integration with emphasis on breathing and trunk	Integrated pelvic and respiratory diaphragm through focused opposing movement in standing of pelvis/ribs with breath and relative neck movement.
11	Fri	11	Arm lines & shoulder	Balancing arms and scapula relative to ribs.
12	Thurs	12	Balance of body and movement integration	Overall goal of session: Find heels, allow pelvis to tilt/shift posteriorly and lengthen lumbars. Breathe up and out rather than arch back at thoracolumbar junction (TLJ). Awareness of pelvic-respiratory diaphragm balance.

[a]Denotes Occupational Physio (OP) session same week.
[b]Denotes OP same day.

Table 4. Comparative Results for Weight Bearing Lunge Test;[17,18] Degrees of Dorsiflexion Achieved (Toe-to-Wall Distance cm)

WBLT (cm)	R	L	Difference
Session 1	**34.2° (9.5)**	**0° (0)**	34.2° (9.5)
Follow-up	**28.8° (8)**	**18° (5)**	10.8° (3)

Table 5. Comparative Results for Lower Leg Circumference Measured 20 cm from Floor

Leg Circumference (cm)	R	L	Difference
Session 3	**29.6**	**28.8**	0.8
Follow-up	**28.8**	**28.7**	(-0.1)

Figure 3. Lateral view of left ankle post treatment.

Figure 4. Left triceps surae activation pre- and posttreatment.

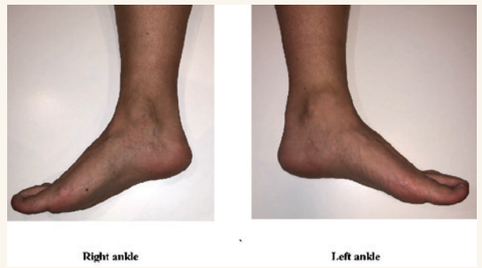


Figure 5. Bilateral comparison of medial ankle posttreatment.

Figure 6. Client profile.

DISCUSSION

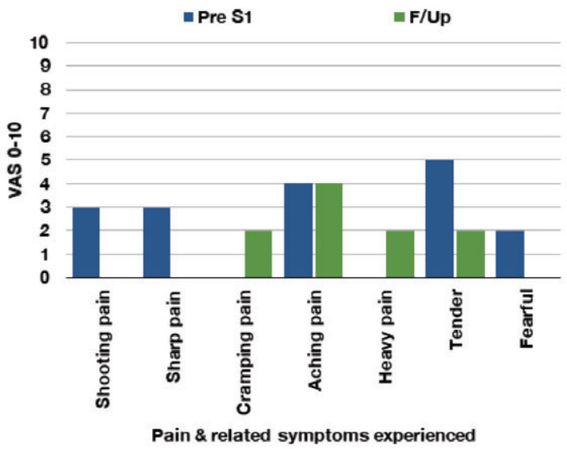
Overall results of this case report demonstrate SI has the potential to assist in the healing process and recovery post-surgery, addressing local and global, primary and secondary symptoms, and meeting the client's goals.

Improvement in mobility and function were primary client goals. As pre-injury ROM of the L ankle was unknown, R ankle baseline measurements were established as 'normal'. The average range for non-WB ankle dorsiflexion (DF) is 20°,[30] normal walking gait requires 5–10°, while running requiring more. Toe-to-wall measurement in WBLT is calculated at 1 cm = 3.6° DF.[17] In Sessions 1 and 3 the client recorded 0° DF on the L, a contributing factor to the limp and inability to heel strike. At follow-up the client achieved 18° DF, within the normal

range for walking and closer to the range of her R ankle. Whilst there are more biomechanics involved in walking and running, DF is easily measurable and felt by the client, and restoring it is an important goal in the management of ankle injuries.[31]

AT lines, with the exception of the arm and functional lines, have connections in the foot and ankle.[25] Applying FRT to structures such as the ankle retinacula, plantar, and crural fascia over multiple sessions may have assisted with improving local tissue glide and improving structural relationships to enable more movement and stability.

Table 6. Results of SF-MPQ-2[21,22]



Active movement by the client, in and out of gravity whilst FRT are applied, may also contribute to tissue glide. Eccentric contraction is an important mechanism of how movement is controlled and stabilization occurs in everyday life. Eccentric loading of muscles through exercise is widely used in rehabilitation.[32,33] The client's past history of lower leg issues and objective assessments suggest that the triceps surae and lower SBL were held under tension, layers of tissue held taut and compressed together. Differentiating these tissues may have contributed to improved mobility, increased tonicity (Figure 3), and reduction in local oedema (Table 5). Working intentionally with depth and direction, actively involving the client, and the plasticity of fascia, may all contribute to the physical results.

Reduction and change in pain may also be attributed to freeing the layers of fascia around the ankle joint. The ankle retinacula are rich in nerve fibres and mechanoreceptors that contribute to proprioception. It would have been damaged by the mechanism of injury, specifically the flexor retinaculum.[34] The ankle retinacula attach into periosteum of the tibia and fibula and are inseparable from the crural fascia and the deep fascia of the foot. Further scar tissue may have occurred during surgery; as a vertical incision is made through to the bone, tissues are held apart, and metal rod is bolted to the fibula.

The client's description of L ankle pain during the series varied (Table 6). Despite reporting the PPI score as zero at follow up, the client was still experiencing localised pain. Pain levels were only measured for the L leg and only types of pain that scored 1 or above were included in this report. There is little research on post-operative pain for ORIF and syndesmosis reduction; one study concluded that persistent post-surgical pain up to 1 year is frequent.[35] This may be true for this client since during the series, the intermittent (shooting, sharp) and affective (fearful) pains subsided. It was the persistent pains that changed in both intensity and type (cramp, ache, heavy and tender) and remained at follow-up.

The attention that SI gives to the base of support in relationship with the rest of the body by default addressed both the injured site and symptoms elsewhere in the body. 'Biotensegrity'[36,37,38] is a model used to describe the fascial interconnected network within the body—where force is transmitted in series (longitudinally) or parallel (transversely) to neighbouring and other parts of the body. Zugel et al.[39] proposed that trauma to fascial tissues resulted in fibrotic changes effecting the entire system, thus impacting tissue dynamics and force transmission along myofascial lines and to neighbouring structures. Fracture and displacement of the tibia and fibula in relation to the talus, and surgery, will have undoubtedly affected both the compression (bones) and tensional (fascia and myofascia) components of such a model, as well as fluid dynamics. Applying the 'biotensegrity' model to AT lines helps show the myofascial connection of the foot to the hip and neck; changing tension in any part of these lines changes the relationship between structures. The gradual acceptance of more weight in the L foot, allowed for the pelvis to return to centre, taking strain off the L groin and knee. The flow-on effect up the body helps resolve the neck pain. These results and other changes observed in the client's posture (Figure 5) suggests that SI provides more whole-body benefits than those of local rehabilitation.

Changes in pain, reduced swelling, and improved ROM influenced other outcomes. The LEFS score improved significantly, with double the documented LEFS range for Minimal Detectable Change and Minimal Clinically Important Difference. This may reflect the extent of the client's restrictions prior to starting the SI series and the positive change that occurred, and there may be a correlation between the local improvements mentioned above, client awareness, and their physical and psychological improved wellness, as reported by the WHO-QOL questionnaire.

Limitation

Several limitations of this case study have been identified. The client understood the process of SI, however, would often request more focus on the L leg, detracting from the SI protocol; and the irregularity of sessions 5–12 would affect the replicability of this study. Faster local results may be achieved by MT practitioners or physiotherapists who provide a site-specific treatment. Occupational physiotherapy (OP) provided by her employer as a 'return to work' programme occurred during the series between Sessions 2 and 8 (Table 3) and may have contributed to local results. Treatment included heat and local friction to scar, ankle mobilization, and strength exercises. The final two physio sessions occurred on the same days as SI Sessions 6 and 8, both of which have an upper body focus, so there was no conflict. The Hawthorne effect was considered but dismissed, as the client was highly motivated to improve at any cost, though spontaneous recovery cannot be ruled out.

Further research on SI, the benefits of a whole-body approach, and rehabilitation would be useful for SI practitioners and clients who aren't making the improvements they'd like with conventional therapies. Results from this case report concur with those reported by Jacobson[14] and James et al.,[15] with improvement locally across a range of measures. There is great value in using outcome measures that are reliable and valid, and whilst limiting this to one body part is useful for research, it does not provide a full picture of the client. Using a tool that measures multiple symptoms— for example, subjective health complaints (SHC)[40]—may provide additional rigour to this study and others alike. It would be beneficial if SI schools trained students in the use of outcome measures and case report writing, to build a culture of investigation and evidenced base practice.

The findings of this case report suggest that SI can bring added value to the process of healing and recovery, serving the client beyond the conventional realms of rehabilitation. SI is able to help meet the normal expectations of rehabilitation of increasing ROM and it does it in a relational way, systematically working through the body to bring balance, adaptability, and resilience to the whole, not just the part. In his article, Myers[16] wrote, "essential-to-healing integration is what we do best", and SI could bring finishing touches to rehabilitation, "melding the changes into the body as a whole".

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CONFLICT OF INTEREST NOTIFICATION

The author declares there are no conflicts of interest.

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STUDENT INTERVIEW

ELYSSE CHEADLE

We are delighted to profile Elysse Cheadle who will graduate from Massage Therapy School in December.

Please tell us a bit about yourself - education/career so far/any personal facts you think would of interest and would like to share.

My background is in theatre. I have a diploma in acting from Mount Royal University (Calgary, AB), and a Bachelor in Fine Arts in theatre from SFU (Vancouver, BC), and additional training in collaborative creation, ballet and contemporary dance, clowning, Pilates, and Fitzmaurice Voicework. Between graduating in 2013 and starting school at VCMT I worked professionally as a director, writer, dramaturg, facilitator, teacher & performer.

Elysse Cheadle, Massage Therapy Student

Stage photo (left) by Erinn Watson

"... THE CAREER ALSO PROVIDES THE STABILITY AND FLEXIBILITY TO CONTINUE WORKING IN THE ARTS."

I make physically driven theatre that is often dark, playful, and leans heavily into the absurd. The last two shows I worked on before starting the program at VCMT were Big Bang Bang presented by Upintheair Theatre and High Water presented by the PuSh Festival. Big Bang Bang is a performance for two dancers in Velcro suits, and one musician playing a Velcro-piano. High Water is a precarious object-theatre performance that takes place in a fish tank with a slowly climbing horizon of water that is consistently shifting/erasing/destroying the landscape the actor is racing to build within it.

Alongside my work as an artist, I spent the last seven years working in event and volunteer management for an array of venues, festivals, and companies ranging from the TD Vancouver International Jazz Festival, the Vancouver Queer Film Festival, Elections Canada, the Vancouver International Vertical Dance Summit, The Cinematheque, and The Cultch. I also work as a standardized patient for UBC Medical School, portraying different medical conditions during exams for medical students.

When I have free time, I like to cook, hike, play chess, climb, putter about in my vegetable garden, read poetry, take my dog on long neighborhood walks, and listen to a truly obscene number of podcasts.

How and why did you choose massage therapy as profession?

I have always wanted to find a way to combine my interest in science and the arts. When I started university, my plan was to double major in biology and theatre (this quickly became a scheduling nightmare, and I abandoned the plan after 1 year!). I love learning about the body, and even more so about the relationship between the internal and the external. A career as a massage therapist will allow me to delve into questions about anatomy and physiology, and the impacts of personal/social histories on physical bodies.

Habitual movement patterns and postures amass over time like sedimentary layers. The jigsaw puzzle inherent in every body fascinates me! Nervous systems hold experiences of trauma, joy, weather, geography... whether treating an acute orthopedic injury, a chronic painful postural presentation, or a mental health struggle, there is a deeper story to unfold. Massage therapy seems uniquely qualified to provide patients with the time and space needed to uncover those stories, and to deepen their connection and understanding of their own bodies. What a gift to be able to support a patient through this process!

Additionally, a career in massage therapy appeals because I am a physically restless person. I like to move, perform physical work, and use my senses. The career also provides the stability and flexibility to continue working in the arts. My ultimate goal is to find a balance between working in theatre and working as a massage therapist. I think the practices will support and benefit one another, and will ultimately permit me to have longer careers in both fields.

STUDENT INTERVIEW
ELYSSE CHEADLE

What research did you do to decide where to enroll?

I thought about applying to a massage therapy program for a long time before finally doing it. I believe I may have ordered information brochures for three years in a row before attending an information night! My hesitancy was never due to a lack of interest in massage therapy, but rather about the cost of the training. It took me years of speaking with RMTs, talking to current students, attending 'student-for-a-day' events, and obsessively crunching numbers to convince myself to take the financial risk of going back to school. Ultimately, I made my decision to go to VCMT over other institutions because of their high-success rate on board exams, and because I could commute to the campus by bike.

Upon graduation and accreditation, what are your plans to practice - sole proprietorship, spa/medical clinic/ hospitals or institutions? Are you interested in any specific areas of treatment?

At this stage, I am not entirely sure what kind of model makes the most sense for me. I definitely enjoy the variety that comes with treating the general public. I am absolutely curious about opportunities to work in hospitals or hospices, but I do not know too much about how to pursue that route. I think I could feel happy in lots of different types of clinics as long as the environment supports collaboration and communication between clients, practitioners, administrators, and management, and promotes opportunities for continued learning and growth. It is also very important to me that the spaces I work in strive to be accessible and welcoming to people of all genders, backgrounds, body sizes, and abilities.

Do you or will you volunteer in the community?

I can't wait to become more involved! One of the greatest benefits I see of becoming an RMT is having the time and space to participate with different organizations, and to be involved in the community. There are so many organizations in this city that are doing amazing work; I have my eye on a couple that I'd like to be involved in that help to address food and housing insecurity, and a cycling organization who focuses on promoting the development of diversified transportation options and safer infrastructure for cyclists and pedestrians. Volunteering is not the only way to be involved: I look forward to being able to return to community forums, workshops, panel discussions, and arts and cultural events. When I worked at The Cultch, I organized a free community pancake-breakfast. I would love to make that happen again one day...

Where do you see the future of research and massage therapy?

I must admit that I don't yet know as much as I should about the state of massage therapy research, so I am not sure if this is already out there, but I would want to see research highlighting the benefit of massage in lower socioeconomic populations. I think massage therapy can be a powerful tool to help with the stress that comes from social isolation and poverty, and I would love for funding to be available for those groups to access it. I also can really geek-out on anything related to the brain or the nervous system – so I'd love to see collaborative research efforts between massage and neuroscience.

NEW DIPLOMA OF MASSAGE THERAPY AT CAMOSUN COLLEGE IN VICTORIA

Emah Christiansen, Program Chair of the new Diploma of Massage Therapy at Camosun College tells us about the new program.

What was the impetus to start the program at Camosun (please give us a little background on Camosun its origins, etc.)?

Founded in 1791, Camosun College is one of British Columbia's largest and most comprehensive post-secondary institutions. Under provincial legislation – BC's College and Institute Act – Camosun College operates and serves approximately 18,500 learners annually across its two main campuses – Interurban and Lansdowne – and six partnership sites. The Massage Therapy Diploma program is an important program in the suite of applied health programs delivered within Camosun's Centre for Sport and Exercise Education (CSEE)

Camosun's Centre for Sport and Exercise Education offers educational programs and services designed to support the health and wellness of our communities. Our educational offerings in CSEE include bachelor's degrees in Athletic and Exercise Therapy, Sport and Fitness Leadership, and Sport Management along with diplomas in Massage Therapy, Sport Management, and Kinesiology and a post degree diploma in Outdoor Education.

Five years ago, we undertook a review of our program offerings and began exploring the field of massage therapy based on feedback from community and graduates from our other programs. Given the strong connections to our existing offerings and resources, we found massage therapy to be a logical fit for Camosun and CSEE.

Please provide a description of the program and tell us how it may differ from other programs in the province

The Diploma of Massage Therapy at Camosun College consists of six consecutive, 14-week semesters. Learners entering the program and progressing on schedule will be able to successfully complete this six (6) semester program in two academic years.

As a fully accredited program, recognized by the College of Massage Therapists of BC (CMTBC), Camosun's Massage Therapy program offers an exceptional, hands on learning experience in state of the art classroom and clinical settings at our Interurban and Lansdowne campuses.

As a comprehensive public institution, Camosun College gives our students to access to on-campus student support services, including:

- Accessible learning services, including academic accommodation and disability support.
- Academic advising, admissions, assessment, testing, and student financial aid services.
- Personal and career counselling, career resources and ombudsperson services.
- Help centres (math, English, learning skills) and tutoring support.
- Services for Indigenous learners (educational, financial and community supports).
- Services for International students (homestay, advising, counselling and orientation).
- Safety and support services aligned with Camosun's new Student Mental Health and Well-being Strategy, Sexual Violence and Misconduct policy and support services.

Emah Christiansen
Program Chair of the new Diploma of Massage Therapy at Camosun College

In addition to the wide range of services and supports offered to students, Camosun's Massage Therapy Diploma program is offered as an academic credit-based program. As a credit-based program, students earn academic credits that may be recognized towards completion of programs beyond the diploma, both at Camosun and other post-secondary institutions. Credit recognition in the public-post secondary system creates greater opportunities for our students to pursue lifelong learning by permitting them to apply course work taken in one program or institution to other programs and institutions.

When it started, how many students were enrolled in the inaugural rollout – how many students are you ultimately hoping to enroll on an annual basis. How many faculty and staff? What are their qualifications?

In the summer of 2021, the first cohort of massage therapy diploma students graduated from Camosun. There were 18 successful students in this first cohort. Building on the success of our inaugural cohort, we have expanded our cohorts to a maximum of 30 students per year with split labs to keep our class sizes small and maintain a highly supportive learning environment.

Including Emah Christiansen as program chair, there are currently 5 classroom instructors and 6 clinical instructors. The faculty come from a variety of backgrounds which include Registered Massage Therapists, Physiotherapists, Certified Athletic Therapists, BA, MA & PhD graduates.

What were the challenges and successes faced trying to start a new program in the midst of COVID?

The priority of the program amidst the COVID-19 pandemic was the safety of all the students, the staff, and the patients in the public clinic. In March of 2020, Camosun College moved to primarily online course delivery for a short time. The MTD adjusted the summer semester to include two shorter 7 week "sprints". This meant that we were able to front-load the summer semester with lecture-based content, and delay in-person content until the lock-down was relaxed. In July of 2020 we were able to return to the classroom after ensuring that the MTD program was compliant with all orders from the Provincial Health Authority, as well as Camosun's WHS standards. Students returned to the classroom with masks, social distancing where possible, and increased hand and classroom hygiene.

The abrupt move to online teaching at the start of the pandemic was challenging for all concerned. Those first few weeks of lecturing to a computer screen from a kitchen table made for some very stressful and sometimes comical moments. The pandemic showed us what we were capable of and forced us to be creative and vulnerable. We found amazing online resources and re-considered how we had done things in the past. We wouldn't necessarily want to go through the experience again, but there were significant learning opportunities that we may not have had otherwise.

In the fall of 2020 treatments in the public facing clinic returned. The students all expressed relief at being back in the clinic and working with clients again. Despite the masks and lengthy routines to ensure safety and hygiene, it felt like one step closer to "real-life."

Where are most of students coming from and what types of educational backgrounds do they have prior to admission to the program?

The students of the Massage Therapy diploma program have a diverse educational background. As well, our students have diverse personal backgrounds. Examples include:

- High school graduates
- Allied Health Care professions
- Athletic Therapists
- Pre-med students
- International students
- Varied medical/legal professions

What are qualifications to get into the program?

One of:

- C in English 12
- C in English 12 Camosun Alternative
- IELTS 6.5 (no band below 6.0)
- TOEFL 90 (no band below 21)

Things you are still working on?

We are very proud of our starting point, and we have received incredibly positive feedback from many of our stakeholders. However, a strong program is always a bit of a work in progress, constantly reviewing outcomes and making tweaks to create the best learning outcomes possible. Ultimately, we want our students to feel that they are learning the most current and relevant concepts, principles, and practices, recognizing that the work to make this happen is never really done.

We are also actively working on building awareness and education within the program regarding BIPOC individuals, in particular Indigenous people. We are invested in providing opportunities for our faculty to access professional, program, and personal development and we look forward to deepening the pedagogical knowledge of our team. Currently the biggest area of focus is on supporting student, staff, and faculty mental health, and ensuring we are prioritizing compassion and kindness in all of our interactions and relationships.

camonsun.ca/massage-therapy-diploma

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Feb 3 - 5 and 10 - 12, 2022

Total Body Balancing 1: Fundamentals (TBB1-V)
Feb 17 - 20, 2022, Sep 8 - 11, 2022

Visceral Manipulation: Abdomen 1; Virtual Component (VM1-VC)
Feb 19 - 12, 2022

Lymphatic Balancing: Total Body (LBTB-V)
Mar 3 - 6, 2022

CranioSacral Therapy 1; Lecture Content; Distance Instruction; Assessment of Central Nervous System and Fascia for Full Body Treatment Protocol (CS1-VC)
Jul 30 - 31, 2022

For more online learning workshops, please visit us at iahe.com/virtual/

In-Person Workshops:

Upledger's CranioSacral Therapy 1 (CS1)

Montreal, QC	Feb 3 - 6, 2022
Calgary, AB	Feb 17 - 20, 2022
Saskatoon, SK	Apr 28 - May 1, 2022
Halifax, NS	May 26 - 29, 2022
Vancouver, BC	May 26 - 29, 2022
Seattle, WA	Jun 2 - 5, 2022

Barral's Visceral Manipulation; The Abdomen (VM1)
**This is a Lab Class. Prerequisite is a 2-Day VM1-VC (Visceral Manipulation 1: Lecture Content; Distance Instruction).*

Vancouver, BC*	Jan 14 - 16, 2022
Ottawa, ON*	Mar 4 - 6, 2022
Edmonton, AB*	Sep 23 - 25, 2022

Barral's Neural Manipulation 1; An Integrative Approach to Trauma (NM1)

Seattle, WA	Dec 17 - 19, 2021

All classes subject to change. For updates due to COVID-19, please check our website for the most updated information.

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