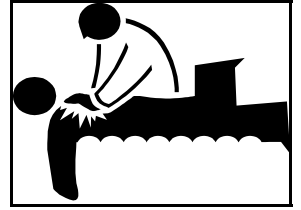


Winter 2002/2003

Massage Kawartha

Kawartha Region Chapter of the Ontario Massage Therapists Association



Strong Voice for Local Massage Therapists

By Ravi Inder Soligo

For the past six years the Kawartha Chapter of the OMTA (Ontario Massage Therapists Association) has provided a strong voice for local massage therapists.

At the inception of the chapter, we articulated a mandate based on the perception that there were four main

areas of concern and need within the local MT community. Today, these goals continue to be our priorities:

1) **Promotion and public education of massage therapy.** Every year during National Massage Therapy Awareness Week the Chapter has organized PR events such as public talks and information booths at local malls. In addition we have volunteered our services at numerous fundraising events such as the Dragonboat Races for Breast Cancer Research, Ride for the Y, MS walkathon etc.

2) **Professional Development.** Over the years we have organized and sponsored several day long and weekend workshops. Our goals have been to provide quality educational opportunities locally and at low cost to the participants.

3) **A forum for discussion of issues of concern to MTs.** Through constructive dialogue within our Chapter we were able to provide valuable input to the Collis and Reed Report, and the CMTO's Quality Assurance Programme and Peer Assessment review. We also engaged in a letter writing campaign to convince the CMTO and OMTA to make planned growth of the profession more of a priority.

4) **Peer support.** We have provided a venue for massage therapists in the area to socialize and get to know one another, to seek support when needed

and develop a sense of camaraderie with others in our profession. We have also made a very conscious effort to welcome new therapists, including recent graduates, to the area, and all MTs including non-OMTA members, to the association.

For many of us, joining the Kawartha Chapter of the OMTA has brought us out of our relative isolation and helped us become more effective and energized in our practices. The foundations have been laid.

What the Chapter needs now is for more individuals to become involved in creating a more cohesive dynamic, relevant and fun association. This is a critical time in our profession. With our numbers growing rapidly it is imperative that we all do our part in creating a professional environment that will allow us all to thrive in the coming years.

Upcoming Meetings

**All meetings are held at:
St Joseph's Alternative Health
Care Centre
Rogers Street
Peterborough**

Dec 16/02 - Christmas Social
and Pot Luck (Boardroom)
7 - 930 pm

Jan 20/03 - Training Room A
730 - 930 pm

Feb 17/03 - Training Room A
730 - 930 pm

Mar 17/03 - Training Room A
730 - 930 pm

Apr 14/03 - Training Room A
730 - 930 pm

May 12/03 - Training Room A
730 - 930 pm

Jun 16/03 - Training Room A
730 - 930 pm

Board of Directors

President: Betty Ann Harris

Past President: Ravi Inder Soligo

Vice President: Patricia Higgs

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Treasurer: Colleen Tedfor

Media and PR Rep: Ania Klein

Chapter Rep: Jim Smyth

**Professional Development:
Ravi Inder Soligo**

Weight Training Is Not Just for the Young

By Nancy Phillips-Smyth

Weight training is definitely not just for the young and fit any more. People with fibromyalgia, osteoporosis, arthritis and obesity, to name just a few, are coming to us for basic advice on how to get started.

Often they don't know a leg press from a bench press, or worse, they've had a bad experience with a so-called "trainer" who did not understand their specific needs.

Knowledge, patience and empathy are imperative as well as a broad support system to refer clients on to, when needs exceed our mandate. The initial consultation and assessment is an essential information gathering session. Assessing the flexibility, strength and range of motion of the large muscle groups, and then carefully recording results, helps us to determine how best to proceed.

I find it most helpful to attach the assessment results to the program chart so I can refer to them often. It must be very frustrating for a person to be advised by a gym attendant to increase the weight on the leg press for example, or to be off-handedly told to increase the range of motion, when the initial consultation and assessment indicated a degenerative hip problem and arthritic knees. These circumstances, when recorded and accessible, enable the trainer to appreciate that small improvements are commendable. Even maintenance is notable for someone who has been becoming progressively less functional.

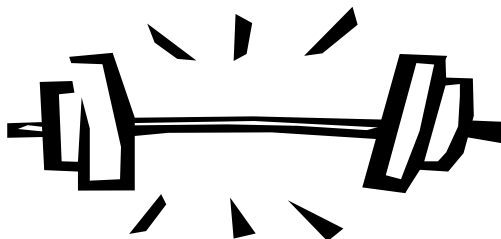
Although I had heard of "functional exercises" or "activities of daily life" (ADLs) it wasn't until a new client put it all together for me that I realized their importance. He looked around the gym, examining all the equipment carefully, with me explaining the functions of each piece as we went. Then he said, "You know, all I really want is to be able to lift my grandchildren. Can you help me with that?" (I noted this goal on the assessment form!)

I demonstrated to him a lunge and a hammer curl and explained that a combination of exercises for those muscle groups plus their antagonists and synergists can

help with all kinds of ADLs.

Another new client told me recently of her low back discomfort. When asked if she knew what irritated the condition, she emphatically blamed a window in her home that she fought with to open. The situation screamed poor posture and lifting skills. Her consultation and assessment revealed a kyphosis and multiple abdominal surgeries (three caesarian sections and a hysterectomy). Although the last surgery had been over 20 years ago, her abdominal strength had never been regained. Add a little patella femoral syndrome to the equation and I realized that she really needed help. Thankfully she had been to a physiotherapist years before and had exercises for her knee condition, but like many people she was discouraged by a slowness to respond, so she reverted to drugs.

It is incredibly rewarding to see someone's posture correcting, their pain lessening or a bone density test demonstrating an improvement. In this relatively new field of ours, I feel fortunate to be a trainer who has been at it long enough to witness some of these remarkable results. There are similar successes available to all of us. We can make a difference in people's lives.



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Publisher

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of the Ontario Massage
Therapists Association

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Seaero Communications

**Deadline for articles/ submissions for the next issue
of the Newsletter is January 15, 2003**

Please email submissions to:

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Or mail to:

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Peterborough ON K9K 1N1

Cranialsacral Therapy for Children

By Ravi Inder Soligo

The craniosacral system is a very delicate mechanism. The gentle rhythmic fluctuation of cerebrospinal fluid around the brain, through the ventricles and down the spinal cord, what could be termed the breathing of the nervous system, can be easily disrupted by membranous and bony restrictions. This is especially true of newborns. At birth, the cranium is still largely cartilage and many bones such as the frontal, occipital, sphenoid and temporals are in two or more pieces. The alignment of the bony plates is maintained by the dural membranes to which they are all firmly attached.

During its passage through the birth canal, the baby's head undergoes tremendous pressures as it moulds to conform to the shape of the mother's pelvis. It can often become stuck along the way due to faulty presentation of the head or the baby's head catching on a bony prominence of the mother's pelvis or sacrum.

After the baby is born, under normal circumstances, the activities of crying and sucking mobilize the dural membranes to realign the cranial bones. This is how the



baby loses its conehead! Often however the realignment is incomplete due to the severity of the birth trauma and the baby is left with cranial restrictions which may result in physiological dysfunction.

Clinically, we sometimes see overlapping of the frontal and parietal plates though this is rare. More common is compression of various parts of the cranial base. One such scenario occurs when the condylar portion of the occiput remains compressed against the petrous ridge of the temporal bone thereby compressing the ipsilateral jugular foramen and its contents,

namely the jugular vein and CN IX, X, and XI. Irritation of the vagus nerve (X) will upset the parasympathetic supply to the viscera, often resulting in colic, the most common affliction of newborns.

Medial compression of the occipital condyles is common during the birth process, either due to natural factors or the use of forceps. This results in a narrowing of the foramen magnum which can lead to irritation of the brain stem and lesions of the atlanto-occipital joint.

These dysfunctions can be addressed very effectively with Craniosacral Therapy. In colic, the key is to promote decompression of the affected jugular foramen by releasing the restriction between the occiput and temporal bones on the compressed side. Usually just one or two treatments are sufficient because, in babies, dysfunctional patterns are not entrenched as they often are in adults and the tissues' memory of inherent health is much stronger.

Other conditions that respond well to craniosacral work include: developmental delays, learning disabilities, ADD, hyperactivity, recurrent otitis media, repeated vomiting, weak sucking response, "failure to thrive", asthma, dyslexia and autism.

A medical doctor who learned Craniosacral Therapy at the Upledger Institute performed CST on all newborn infants at the hospital where he was on staff in Maine. He did this over a period of five-plus years. All infants were treated at least once before they left the hospital to go home. During the first year of life he found that the incidence of illness requiring hospitalization for the CST-treated infants was less than half the incidence for infants born at a neighbouring hospital where they did not receive CST.

It is not easy to perform CST on moving subjects, so working on infants and

small children comes with its unique challenges. I am invariably grateful when an infant arrives or ends up asleep on my table. Of course fussy babies settle down when they are being nursed, so treating the infant while it is being held and fed by its mother is another option.

Nonetheless, one learns eventually to feel a body's subtle physiological movements underneath the voluntary movements it is making. I usually begin the evaluation and treatment with an occipital-sacral hold. This allows me to assess the quality of the craniosacral rhythm through the synchronous movements of the occiput and sacrum. Because these bones are the two ends of the dural tube the therapist, using the same hand contact, can release the spinal dura and any torsions in the spine and pelvis. Anterior-posterior holds can be used to release any tensions in the viscera, diaphragm or thoracic inlet.

Key areas to evaluate and treat in the upper body are the SCM muscle, the clavicles, C1 and the cranial bones and sutures, with particular attention to the cranial base and the relationships between the occiput, sphenoid and temporal bones. I invariably feel privileged to work on infants and children because of the intimate connection one is able to make with these wise beings. It is obvious that at some level they can sense things shifting and changing within their bodies and they respond (usually through their eyes) with a mixture of curiosity, wonder, emotion, contentedness, and recognition.

It is worth mentioning that Craniosacral Therapy is also wonderfully beneficial for the mother during pregnancy, delivery and post partum. CST has been shown to be an effective modality for relief of back pain, pressure build-up in the abdomen and pelvis, pregnancy-induced Bell's Palsy, post-partum blues and for natural induction of labour.