California Currents

NEWSLETTER FOR THE CALIFORNIA CHAPTER OF THE AMERICAN MASSAGE THERAPY ASSOCIATION Fall Issue 2018

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Greetings from Your President

Welcome to October! The last few days have been busy. We had 2 sold out sport's classes. One in Santa Ana, and another in Emeryville. At the Santa Ana training we accomplished a membership meeting and the members approved online voting for our chapter elections. I'm very excited that every member in our Chapter will have the opportunity to vote for their candidates. Our members can do this with no travel costs as it no longer needs to happen at our State Conference in person.

Hopefully this move to electronic voting will encourage more folks to run for office. If you have thought about volunteering for the chapter board this is your chance. Expect more information about the election process to be coming out soon.

We do have a venue for our State conference so please **Save the Date** as we get to learn in **Sacramento at the Hilton on March 16th**. Classes are being solidified and once the contracts are complete expect an announcement.

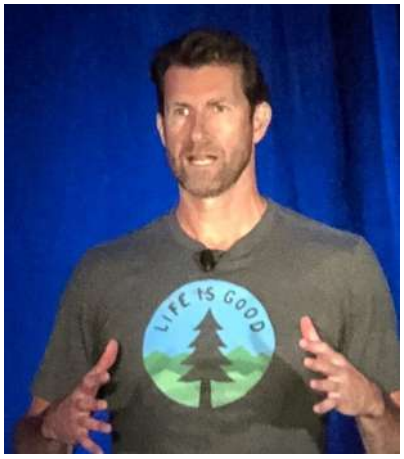
As we move into our fall season one of my favorite holidays is approaching. I am a big Thanksgiving fan. I love spending time in the kitchen and with my family during that time. Here are some folks that I am thankful for.

I am thankful for John Combe for teaching 2 wonderful workshops. I am thankful for the Chapter board supporting me and this Chapter. Michael, Bonni, Liz, and Patricia you make this job easier with your support. Our management company CALMA has been a huge support with setting up our events and finding a great venue for our conference in March. Jeff and Sedina you are so appreciated. Chris Voltarel and Andrew Smith from our National office have been a big help in training me and the rest of the board to perform our duties to this association. Lastly, I want to thank you our members. You are the reason we have a Chapter, why we have events, and know your voice matters.

` Thanks again, and I hope to see you in March!

John Lambert , CMT #278

Did you miss the National AMTA Convention in Washington, DC?
Here are some pictures that were shared (and a few CA attendees).



Photos: Bert Jacobs, Life is Good, Keynote Speaker, Jeff Foreman, Presenter, Chris Voltarel, National Staff/Chapter Relations, Michael Roberson with Srgt Noah Galloway, Closing Keynote Speaker, CA Delegates, Patricia Rusert Gillette and Rio Sanford, Mark Dixon at the Washington Nationals vs Atlanta Braves, the First House of Assembly. You can view more pictures on the Facebooks pages of Massage Therapy Foundation, American Massage Therapy Association—AMTA, and Amta CA American Massage Therapy Association California Chapter. If you have photos from attending the National Convention, please feel free to share on any of these pages.

Change Makers

Our Members "Heroes" at Work

September 8

Camp Pendleton Family Day Massage Event, Del Mar Beach, Camp Pendleton, San Diego

This is the 11th annual event we have participated in providing Marines and their families from 3rd Track complimentary massages in a outward gesture of "Thank You for Your Service!" Kevin Whitfield and Faye Crane managed the massage team this year. Than you for providing an opportunity for the Family to have an experience they may not have been able to afford, otherwise.

September 8

Best Buddies® Challenge, Hearst Castle, San Simeon

This is the 10th year we have participated in this event. A great massage team of 34 volunteers, lead by and coordinated by Massachusetts AMTA member, Cynthia Sykes. We provided post massage to about 50% the athletes completing 100 miles (or less) and to those who participated in the 5k Run-Walk. To say how great this event is, of the 34 volunteers, only 1 person was a current student, and 29 of the 34 volunteers were all veterans from working this event! The hard working volunteers were treated to 2-nights shared room accommodations, car pooling stipend, T-shirt, door prizes, free food and SWAG bag. All of this and a great location near Hearst Castle, on the coastline.

September 16

SuperFrog® IRONMAN®, Imperial Beach, San Diego

Michael Roberson lead the 10 person massage team at this IRONMAN® . This SuperFrog® IRONMAN® is unique in that most of the athletes are in military service here and around the world and provides and opportunity to members of the military to qualify for the World's Championship IRONMA® in Kona, Hawaii and has about 80% military participation. With a great view at the Boardwalk of Imperial Beach, the day was busy with those who made it through the Navy Seal designed course

Correction: *In the Fall Issue of the California Currents, within the article, "Wanted: Heroes–Apply from What's Within", the membership numbers were incorrect; Nationally, AMTA is about 85,000, not yet at the 100,000 as published. The California membership number was correct at 6,500 (and growing).*

Sports Massage Specialty Certificate Program

Your California Chapter hosted 2 workshops in October, one in Santa Ana and the other in Emeryville with John Combe as the instructor for both.

The workshops were a great success as both we SOLD OUT to capacity. The workshop offered will meet the hands-on requirements for this specialty certificate.

For more information on this and other specialty certificates offered by NCBTMB can be found at www.ncbtmb.org

Here are some photos and a few words from those attending these workshops.

"Today I took a class from John Combe for the AMTA and NCBTMB Sports Massage Specialty Certification. The class was very informative but not what I was expecting, … **it was more!** It delved into more than just Sports Massage and into assessing the entire body and what that individual needs in regards to their specific care. We focused on the "athlete", being reassured this work can and should be used on EVERY BODY. The class was informative and John reiterated that EVERY BODY is different and we should remember that. The class was based on all the online classes that is now available for the new Sports Massage Specialty Certificate available for all of us through AMTA and NCBTMB."
Ambra Welch-Quintanilla

Pictured: Santa Ana workshop (10.25), Emeryville workshop (10.27) John Combe, Instructor, Group Shot from Santa Ana and Group Shot from Emeryville

Thank you Courtyard by Marriott, Santa Ana and NHI Emeryville for hosting our workshops. And Thank you! For all those who attended!

Electronic Voting

Allowing your voice and choice be heard!

AMTA California Chapter to Hold Online Elections for First Time in 2019

For the first time ever, in early 2019 all AMTA-California Chapter members will have the opportunity to vote online for AMTA-California Chapter elected board members and delegates from the comfort of their homes.

AMTA members at the October 25 Chapter Membership Meeting approved a standing rule permitting this Chapter to conduct annual elections for chapter board positions via online voting. We would like to thank the members that voted in favor of this standing rule which provides an opportunity for a larger portion of our Chapter membership to exercise their member benefit and vote online for Chapter officers and delegates.

This process goes is to effect for our 2019 election cycle. Please be on the lookout for emails with the Call for Candidates and the online ballot. Exact due dates will be shared as we know them.

- January 2019: Call for Candidates with Candidate Application emailed to all AMTA-CA Professional Members (this includes Professional, Retired, Inactive, and Graduate Members)
- February 2019: Due date for candidate applications
- February 2019: Members sent confidential online ballot. Voting is anonymous.
- March 16, 2019: Election results announced at AMTA-CA Annual Meeting

We are excited to join 30 other AMTA chapters that have been successful participating in online voting. If you have any questions about the online elections process, or are interested in volunteering with the Chapter, please contact info@amta-ca.org.

Open Chapter positions that will appear on the ballot:

President	1 year term (2019-2020) *Special 1 year term
Board Member	2 year term (2019-2021)
Financial Administrator	2 year term (2019-2021)
Delegate – 2	2 year term (2019-2021) and 1 *Special 1 year term (2019-2020)

The candidate application process will begin in **January 2019**. Position descriptions and eligibility requirements for each of the above positions can be found at **xxx.** We hope that you will consider volunteering as a way to give back to the profession and engage in the AMTA community through education, advocacy, and networking.

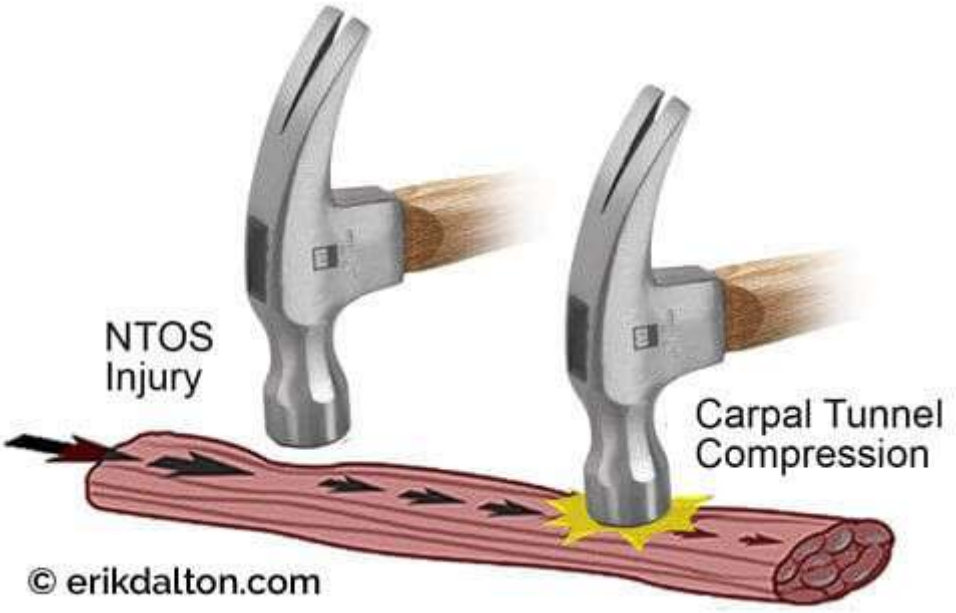
Assessing Neurogenic Thoracic Outlet Syndrome

Double Crush Syndrome

Erik Dalton, Ph.D.

Image 1: Double Crush Syndrome

The term double crush syndrome (DCS) was coined by Harvard University plastic surgeons Albert Upton and Alan McComas, who wrote, “Neural function is impaired when compressed axons at one site cause the nerve to become especially susceptible to damage at another site” (Image 1). Their double crush research began after observing that many carpal, cubital, and radial tunnel patients also complained of unilateral shoulder, chest, and upper back pain.[1] While the DCS mechanism is not completely understood, it likely



involves nerve sensitization and neuroplastic changes in the pain-modulating systems of the brain and spinal cord.

Neural compression of the brachial plexus is suitably called neurogenic thoracic outlet syndrome(NTOS). These clients present with a variety of symptoms, including painless atrophy of intrinsic hand muscles and nighttime paresthesia. Athletes may have difficulty grasping a racquet or ball, and some report pain. However, I’ve found that rather than being a main pain event, NTOS is more of an enhancer of symptoms at a distal site, such as the carpal tunnel. Put simply, the brain pays more attention to double crush nerve insults and is more likely to respond with pain or spasm.

Although most clinicians feel that NTOS is an underestimated cause of DCS, assessment is often difficult due to vague, fluctuating symptoms. Instead of chasing the pain, I’ve achieved superior outcomes by palpating and releasing all fibrous connective tissue sites that may be kinking, stretching, or inflaming the brachial plexus. I address carpal and radial tunnel compression sites, then palpate and release NTOS contractures at the interscalene triangle, costoclavicular canal, and retropectoralis minor spaces (Image 2).

(Dalton continues on page 7)

Erik Dalton serves as Executive Director of the Freedom From Pain Institute, a school committed to the research and treatment of chronic pain conditions. Dr. Dalton shares his wide therapeutic background in massage, Rolfing®, and osteopathy in his entertaining continuing education (CE) workshops, home study courses, books, and videos.

With over thirty years educating massage therapists around the world, Erik Dalton is among the best teachers a professional bodyworker could ever study with. He has worked tirelessly to develop a system of manual therapy that addresses and heals pain patterns at their very core. Armed with a comprehensive understanding of the intricate interplay between mind and body, structure and function, massage therapists who’ve studied Myoskeletal Alignment Techniques with Erik Dalton are changing the face of chronic pain the world over. For more information on Erik Dalton and his Mayoskeletal Alignment Technique, please go to: www.erikdalton.com

(Dalton continued from page 6)

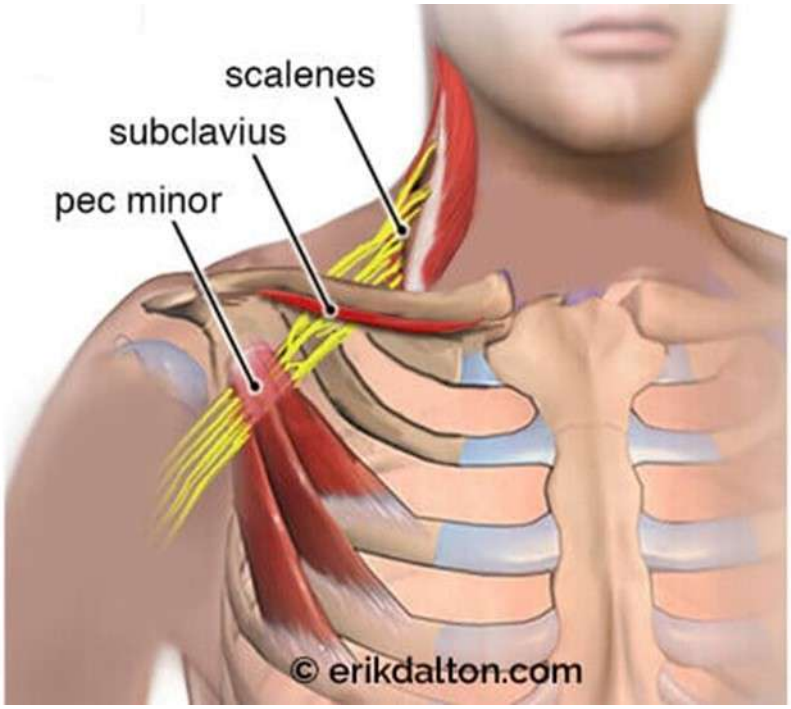


Image 2: Interscalene costoclavicular, & retropectoralis compression sites

INTERSCALENE IMPINGEMENT

Nerve fibers originating at the spinal cord travel from the neck, through the thoracic outlet, and into the hand, providing sensation and movement during daily tasks. Certain postures or sleeping positions may increase tension and pressure on entrapped nerves.

Further complicating the nerve's journey through the thoracic outlet, researcher David B. Roos, MD, FACS, discovered irregular fibrous bands that increased brachial plexus stiffness and decreased movement.[2] Roos classified 10 types of contractures that can stiffen the already unforgiving boundaries of the thoracic outlet container. Despite all the neural roadblocks, it has been my experience that many DCS clients respond well to massage, movement, and any type of cognitive training that lowers the brain's threat level during movement. In Image 3, I demonstrate my favorite anterior and middle scalene stretch to create space at the interscalene triangle.

Image 3: Interscalene triangle: (A) With the client's head left rotated, my soft-cupped fingers wade behind the sternocleidomastoid and onto the scale attachments at the transverse processes. (B) By left-rotating and slowly extending the client's neck, I palpate for scalene adhesions and pin stretch to release.

SUBCLAVIUS AND THE COSTOCLAVICULAR CANAL

In clients with a drooping clavicle, the underlying subclavius muscle can reduce the costoclavicular canal size and compress the brachial plexus against the first rib. Upper chest breathing can exacerbate the problem, as the first rib elevates during inhalation and can get stuck there. A 2015 study published in BMC Research Notes also noted brachial compression from the subclavius posticus muscle, which ties the first rib to the superior border of the scapula.[3] Rather than dig in to the sensitive tissues under the clavicle, I always begin with the subclavius stretch demonstrated in Image 4. This slow, gentle, graded exposure stretch is designed to reassure the brain that it's now safe to move in previously painful positions.

(Dalton continues on page 8)

(Dalton continued from page 7)

Image 4: Subclavius stretch: The client's arm rest on my shoulder, and my right hand's curled fingers snake behind the clavicle and brace while my left fingers wade in front of the upper trapezius and contact the scalenes where they attach to the first rib. To create space and stretch the subclavius, I simply extend my knees and abduct her arm, allowing my fingers to spread open the thoracic outlet.

RETROPECTORALIS MUSCLE IMPINGEMENT

Repetitive movements of the arms above the head, common among tennis enthusiasts, may cause friction and overstretch the nerve plexus under the pectoralis minor at the coracoid. The least irritating way I've found to create space here is by stretching the distal fibers that attach to ribs 3, 4, and 5. Notice in Image 5 that the stretch is directed at a 135-degree angle, which is the approximate pectoralis muscle fiber angle from coracoid to the rib insertions.

Image 5: Pectoralis minor: With the client's hand resting on her neck, my left hand grasps her arm, and my right palm braces her scapula. As she inhales and gently pulls her elbow toward the therapy table, I resist to a count of five. Upon exhalation, a counterforce is created as I pull with my left hand and brace with my right hand, feeling for a stretch in the pectoralis minor fibers at ribs 3, 4, and 5

Many NTOS studies recommend postural correction, including muscle strengthening and lengthening for double crush complaints. However, there is no consensus in the literature as to exactly which muscles should be targeted. Posture is dynamic and the best results are gained through whole-body strengthening and balancing programs such as swimming, yoga, and martial arts. The bodywork goal is to bring mental awareness to areas of restriction and to teach the client it is safe to move through those previously painful barriers. *(References for this Erik Dalton article can be found on page 9)*

(Dalton continued from page 8)

*References for Erik Dalton's "*Assessing Neurogenic Thoracic Outlet Syndrome, Double Crush Syndrome"

Erik Dalton is the executive director of the Freedom From Pain Institute, developer of Myoskeletal Alignment Techniques and author of Dynamic Body. Educated in massage, osteopathy and Rolfing, He resides in Oklahoma City, Oklahoma and San Jose, Costa Rica.

Notes

1. A. R. Upton and A. J. McComas, "The Double Crush in Nerve Entrapment Syndromes," Lancet 2, no. 7825 (August 1973): 359–62.

2. D. B. Roos, "The Thoracic Outlet Syndrome is Underrated," Archives of Neurology 47, no. 3 (1990): 327–28.

3. J. Muellner et al., "Neurogenic Thoracic Outlet Syndrome Due to Subclavius Posticus Muscle with Dynamic Brachial Plexus Compression: A Case Report," BMC Research Notes 8, no. 351 (August 2015). doi:10.1186/s13104-015-1317-3.

As another great National Massage Therapy Awareness Week comes to a close, share how you celebrated the benefits of massage therapy in your community. Send your pictures and stories to editor@amta-ca.org and to National at NMTAW@amtamassage.org.#NMTAW This is how we share what we LOVE to do with others. Thank you for being a part of this year's event! And we look forward to reading your stories how your promoted NMTAW.

A CranioSacral Approach to Chronic Depletion

Eric Moya CST-D, Ms/Mfct

Sometimes clients can seem so complex, so hypersensitive, so . . . depleted. Over the past 18 years of practicing, these complex clients seem to be more numerous, both in my practice and in conversations with other practitioners.

Earlier this year, I had a new client referred to me by a local psychotherapist. They were doing some wonderful therapeutic work together for a variety of physical and psychotherapeutic concerns, and the psychotherapist referred the client because she had heard that CranioSacral Therapy (CST) might be able to help with some of the physical symptoms related to severe exhaustion, muscle fatigue, eye sensitivity, emotional depression, etc.

When the client called me, she understandably had questions about CST and whether it would be helpful for her. She wanted to know what CranioSacral Therapy was and how it worked. She wanted to know what the likelihood might be that this type of work might help her. She also wanted to know what my previous experience was with clients similar to her. I should mention, of course, that by profession, the client is a well-trained and practicing physician's assistant (PA). Understandably, part of the discussion involved letting me know that she and her colleagues had been through the full battery of tests and differential diagnoses for her symptoms. Her particular symptoms continued to evade an easy path of treatment. As we talked, it was clear that she had many symptoms across multiple body systems, as well as many ongoing stressors in her life. Wonderfully, she was also fully committed to turning around her own health and regaining a sense of resilience in her life again. The work she was doing with her psychotherapist was helping tremendously, and she was also engaging in regular meditation practices and was truly open to anything that might help. As we talked, I was able to describe a little bit of how CranioSacral Therapy might view chronic depletion, and I was able to give her a bit of a sense of how previous clients have progressed through treatments. I was also able to give her a good sense of how the first session might look. My overall message was to convey that it was worth a first session and to reinforce that her full professional experience as a PA was welcome in the session, and to reassure her we would work together to empower her to make her own best decisions about her health and treatment plans.

* * * * *

It seems that clients like this are much more common these days then when I first began practicing. Sometimes clients come in seeking relaxation or general well being, but more often than not, clients seem to be presenting with a myriad of complex problems that seem unrelated to each other and a medical system that is working to treat the various symptoms individually. Additionally, clients with these hosts of problems can sometimes have adverse treatment reactions. It's as if their systems are hypersensitive and over reactive, and what would normally be considered a VERY gentle treatment, might result in several days of discomfort. It's common in body workers' circles to talk about a "healing crisis," but that explanation alone is rarely satisfactory for someone in distress and does little to solve the problem. In worst-case scenarios, the "healing crisis" explanation really only functions to absolve a well-intentioned practitioner of responsibility for a treatment that actually pushed an overly sensitive system a bit too far.
(CranioSacral continues on page 12)

Eric Moya CST-D, Ms/Mfct is a lecturer and instructor on manual therapy and CranioSacral Therapy for the Upledger Institute and former Director of Education at the Esalen Institute. His professional backgrounds are in massage therapy and psychotherapy. Currently, he lives in Monterey, Ca and has private practices in Carmel and in San Francisco. For more information about Eric and his workshops, please go to his website at www.ericmoya.com

(CranioSacral continued from page 11)

Basically, it is time for manual therapists to rework our understanding of what is happening and adopt our skills to match what appears to be an increasing problem.

So, how do we do that?

In short, the world around us is becoming more complex. In the modern world, the innovations of technology, communication, mobility, and information are exposing us to an increasingly complex landscape around us that is changing faster than we can easily adapt. In the recent past of even 100 years ago, people may not have traveled or been exposed to ideas, people connections outside of their immediate social community. Individuals were not exposed to the same level of diversity, interdependence, connection, or need for adaptation that we consider normal now. By any measure, the world is becoming more complex, socially, economically, politically, physically, ecologically, biologically.

We have to evolve. Yet evolution is a slow process by which a system is put under stress and is either able to adapt or not. The gap between our stressors and our capacity for compensation is growing with each year at an accelerating rate. Our body-mind-spirits are showing the effects of this complexity and stress.

As manual therapists, we are privileged to be at that intersection of the individual and the world and our clients are presenting with a host of stress-related challenges: sleep difficulty, TMJ problems, digestive disorders, muscle tensions, emotional difficulties, pain disorders, autoimmune difficulties, environmental sensitivities, changes in sex drive, etc. Most of these problems defy single session answers and too much time can be wasted looking for a "cause" to what is really a much more global problem of a system burdened by patterned and chronic stressors. AND, our clients are looking for help.

One of John Upledger's DO,OMM. greatest gifts to CST was the deep core belief that the client is the best teacher. The idea that when we listen and are present with a client's body-mind-spirit system, it will show and guide the practitioner on how to work with it. Now, on a systemic level, practitioners are having to learn new skill sets for working with chronic depletion. Upledger CST with its philosophy and core beliefs of 1) a person having the inner resources necessary for healing (inner wisdom) as well as 2) a chosen value of using the least amount of influence necessary to get the job done is a perfect approach to both conceptualize and work with the problem of chronic depletion. To begin with, depletion and/or resilience is just understood as the gap between stressors and the capacity for compensation. Pretty easy really -- If a person's stressors are greater than their ability to compensate, then they are in a depletion phase. If the opposite is true, then he or she would be gaining resilience. It is natural in the course of life for us to flow from resilience to depletion and back as we adjust accordingly. When stressors are too great or too patterned/ongoing, however, sometimes a person can end up severely depleted: body, mind, and spirit. Eventually, a system becomes so severely depleted that any new stressor basically causes a new crash. The colloquial phrase, "straw that breaks the camel's back" begins to convey that sentiment a bit. I'm reminded of a different client many years ago, who when asked to describe her experience of what general adaptation syndrome was like (severe adrenal burnout), she described sitting on the couch and being unable to do anything, and then the phone would ring and she would just break down into tears. Once a person's system has achieved this level of hypersensitivity, we would definitely call them chronically depleted.

It's possible to assess and evaluate this in CranioSacral Therapy. From a craniosacral point of view, the vitality and quality of the system becomes almost non-existent and the resources for healing become so diminished that there is little available to correct even the most basic of tissue restrictions. Also, any minute stressor, even that of normally gentle bodywork can easily send the system into a hyper reactive state. Basically, with a chronically depleted client, releases are slow, adverse treatment reactions are common, and there are a lot of factors coming together which make it likely for the therapist to feel unsuccessful, the client to terminate early, and yet it is a population in great need of support.

So, to work with chronic depletion, we have developed a different dimension to blending with the body-mind-
(CranioSacral concludes on page 13)

As a massage therapist, you take care of so many. That is why AMTA provides you with exclusive low group and individual rates. Make sure you and your family are protected at all times. From Disability to Auto and Home Insurance, AMTA has got your back! Check out all of the benefits your membership has available at

www.amtamassage.org

(CranioSacral Continued from 12)
spirit so as to begin to palpate the qualities of chronic depletion. We have also developed different processes of treating a hypersensitive system. Processes which are based more upon identifying patterns of restrictions as opposed to finding individual restrictions. And, processes of treating *relationships* between restrictions rather than the restrictions themselves. This process is called working with "Epicenter" and is a very gentle way of working with great specificity without sacrificing the global view of how the system is reorganizing itself for better health.

Imagine a mobile hanging from the ceiling. It is a beautiful mobile with many different parts all in exquisite balanced relationship with each other. When you pick up the mobile from its core attachment, the entire pattern becomes apparent and balanced. If you try to pick up the mobile from anywhere else, however, the pattern collapses and isn't accessible any longer. Working with epicenter is kind of like identifying a pattern of restrictions and contacting them at the balance point for the network.

When working with chronic depletion, we are also careful to take a multi-session and multi-factorial approach to improvement. Good client education, tracking progress across multiple sessions, and thinking in terms of a "contributing factor" approach rather than "causes" are all part of the picture when working with a chronically depleted client. In other words, working with chronic depletion is usually a "marathon, not a sprint." It's a gentle and holistic way of working with a complex situation while maintaining true to core CST principles of supporting the body's innate healing capability and using the least amount of influence necessary to get the job done.

Most importantly, people get helped.

When the client came in for the first session, her system did show signs of being chronically depleted – both in the whole body evaluations and in the story she told about her experiences. And in the treatment process, we were able to find a way to work with her patterns of dysfunctions rather than focus on individual restrictions. The result was a gentle, but powerful session which did not throw her system into chaos, but instead helped her system resources reorganize more functionally.

Thus far, we have had eight sessions together over three months of time and over the course of those eight sessions, her system has begun returning to resilience, her sleep patterns have improved, her digestion has improved, her level of physical fatigue has diminished, her eye sensitivity has diminished, and she has a deep sense of returning back to her "self." She is also tapering off her treatments and no longer sees the same "need" for the treatments that she did at the beginning of the therapeutic relationship. There may very likely be more work to be done, but it is a great sign of progress to be able to begin talking about tapering off!

DECIPHERING ELUSIVE SYMPTOMS OF NERVE INJURY

by **Whitney Lowe**

One of the most challenging situations facing practitioners who work with pain and injury conditions is correctly interpreting nerve injury symptoms. It seems that in so many massage therapy training programs the nervous system gets only cursory attention, yet pain originating in the nervous system is a critical factor that drives people to our practices. The key to understanding nerve injury lies in a solid grounding of the structure and function of these crucial nerve tissues throughout the body.

Let's explore these tissues moving from the center out to the periphery and how various injuries or dysfunctions affects these tissues. The brain and spinal cord make up the central nervous system. The nerves which exit the spinal cord and permeate the entire body make up the peripheral nervous system. It is the peripheral nervous system which is of greatest concern to massage therapists as the cause for many pain complaints.

Nerve Root Level

There are two sets of nerve fibers that connect with the spinal cord on each side. Fibers from the dorsal root enter the spinal cord toward the posterior side, while fibers in the ventral root exit the spinal cord on their way to the periphery (Image 1). The dorsal nerve root contains sensory fibers bringing all the body's sensory information back to the spinal cord on the way to the brain. The ventral roots contain motor fibers for sending signals from the central nervous system out to various target tissues such as the muscles.

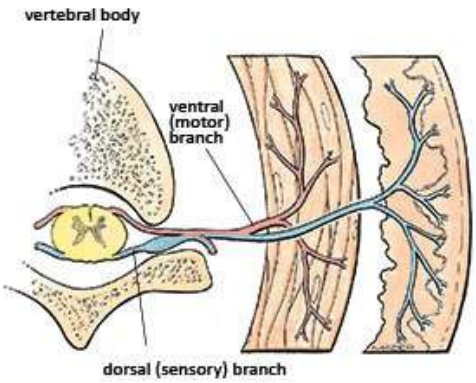


Image 1: Dorsal and sensory nerve roots

(Whitney Lowe continues on page 16)

Whitney Lowe, *directs the Academy of Clinical Massage, offering certification and advanced training to therapists worldwide. His career spans two decades and includes extensive clinical work, research, publication and teaching in advanced and orthopedic massage. He is the author of* Orthopedic Assessment in Massage Therapy. His Academy of Clinical Massage can be found at:

https://www.academyofclinicalmassage.com/

Where workshops, blogs (like this one), books and other resources are available for your use.

(Whitney Lowe continued from page 15)

Just distal to the spinal cord the nerve fibers bundled within the dorsal root and the ventral root join together encased in a single bundle. This bundle is generally referred to as the *nerve root* at that particular spinal level. For example, the nerve root that exits just below the L4 lumbar vertebrae is referred to as the L4 nerve root (Image 2).

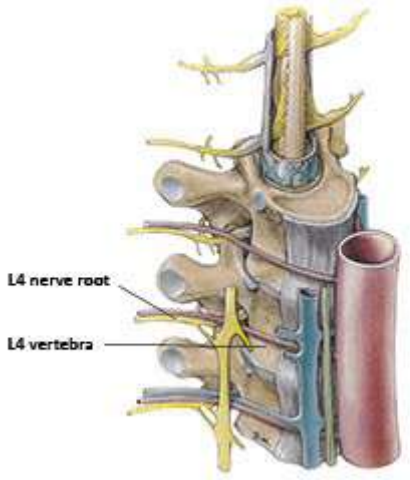


Image 2: L4 Nerve root level

Formation of Peripheral Nerves

Moving distally, nerve roots join with fibers from other nearby nerve roots. At this level the connection of nerve fibers is referred to as a *plexus* (Image 3). There are four major nerve plexuses with nerve roots that exit the spinal cord. The most superior is the *cervical plexus*. It is composed of nerve roots from the C1 to C4 level. The nerves that form out of the cervical plexus remain in the cranium and cervical region.

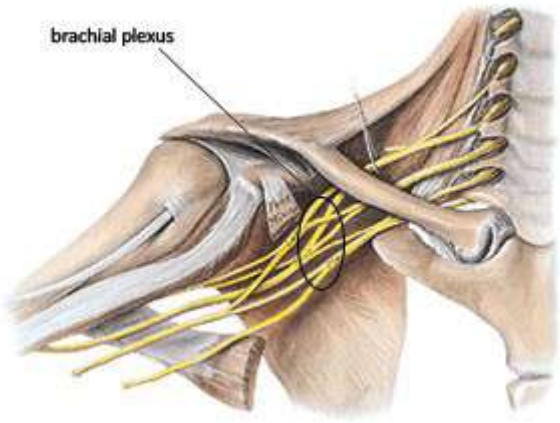


Image 3: Collection of nerves in the brachial plexus

Nerve roots in the C5 to T1 level make up the *brachial plexus*. Nerves that eventually form out of the brachial plexus contain branches that terminate in the neck, shoulder or extend down the entire length of the upper extremity. The brachial plexus is routinely involved in various pain and injury conditions because it is easily exposed to adverse forces due to its location in the neck. *(Whitney Lowe continues on page 17)*

(Whitney Lowe continued from page 16)

The nerve roots in the thoracic region don't blend together to form a plexus, but simply innervate local muscles and other tissues in the area. The remaining two plexuses are in the lumbar and sacral areas. The *lumbar plexus* has contributions from the T12 nerve root and the first four lumbar vertebrae (L1-L4). Fibers from the lumbar plexus have sensory innervation to regions of the pelvis and thigh and motor branches which focus on pelvic and thigh muscles.

The *sacral plexus* has nerve fibers that emerge from lumbar and sacral nerve roots from L4-S4. Fibers from the sacral plexus innervate the pelvic region, but also emerge to form the body's largest nerve, the sciatic nerve, which runs the entire length of the lower extremity and has terminal branches all the way into the plantar surface of the foot and toes.

One of the more fascinating aspects of nerve fibers that many don't realize is that individual nerve cells run the entire length of the nerve. That means that for the nerve fibers within the sciatic nerve that eventually go into the foot, there are individual cells extending from the spinal cord all the way to the foot. These are exceptionally long cells! The importance of these long nerve cells and how they relate to various pain complaints is illustrated by impairment of axoplasmic flow, which is discussed below.

Most of these major nerve trunks carry both motor and sensory fibers and are referred to as *mixed nerves*. Some smaller peripheral nerves may carry exclusively motor or exclusively sensory fibers. A peripheral nerve has fibers that originate from multiple nerve roots. Similarly, fibers from one single nerve root may blend into and terminate in different peripheral nerves. Having fibers from different nerve roots within a peripheral nerve reduces the likelihood of complete nerve dysfunction if a single nerve root is injured or damaged. However, it also makes identifying certain types of nerve injury more challenging for the clinician.

Terms of Nerve Injury

There are two terms that are used to describe nerve injuries and which indicate the location of the pathology. The first is *radiculopathy*, which is a nerve pathology that occurs at the nerve root level. A common radiculopathy is the herniated nucleus pulposus (HNP) or herniated disc, in which the disc presses on the nerve root.

Earlier we noted that nerve roots contain fibers that eventually make up different peripheral nerves. Therefore pressure on a nerve root can affect fibers that make up more than one peripheral nerve. Consequently, pressure on a single nerve root can produce sensory symptoms along a wide area of the extremity. The area of skin supplied by fibers from a single nerve root is referred to as that nerve root's *dermatome* (Image 4). A radiculopathy or nerve root dysfunction can produce symptoms anywhere along that nerve root's dermatome.

(Whitney Lowe continues on page 18)

(Whitney Lowe continued from on page 17)

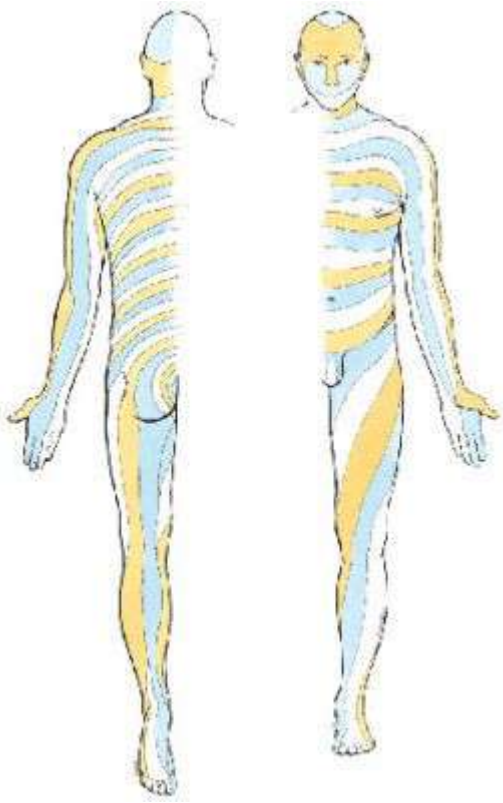


Image 4: Common dermatome map
Mediclip image copyright (1998) Williams & Wilkins. All Rights Reserved.

Farther along its length each individual peripheral nerve innervates a particular region of skin with its sensory fibers. The region of skin innervated by fibers from a single peripheral nerve is referred to as that nerve's *cutaneous innervation*. The cutaneous innervation for a particular nerve is always smaller than a dermatome because the dermatome includes fiber innervation from other nerve roots as well.

A good comparison is to look at the C8 dermatome which extends the length of the upper extremity and compare that with the cutaneous innervation of the ulnar nerve. Cutaneous innervation of the ulnar nerve is only on the ulnar aspect of the hand but does not include the medial aspect of the forearm or upper arm that is included in the entire C8 dermatome (Image 5). There can be some variation in these dermatome locations so maps may differ slightly.

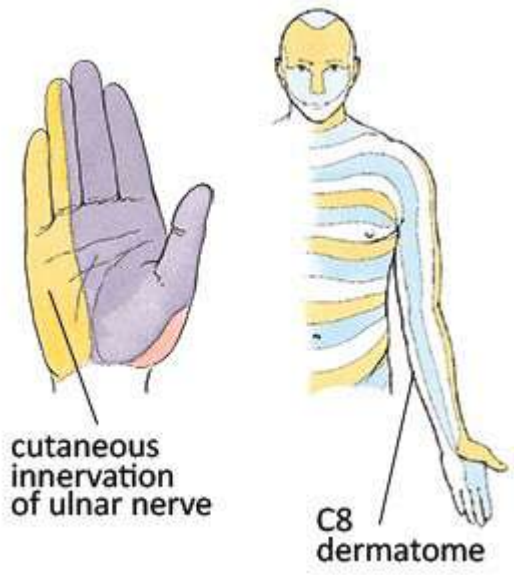


Image 5: Cutaneous innervation and dermatome comparison
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A single nerve root has fibers that blend into different peripheral motor nerves. The group of muscles supplied by fibers from a single nerve root is referred to as a *myotome*. If a nerve root is being compressed, weakness or atrophy in any of the muscles that have fibers supplied from that nerve root (the nerve root myotome) could exist. Recognizing dermatome or myotome symptom patterns is a key facet of locating a site of peripheral nerve injury.

(*Whitney Lowe continues on page 19)*

(Whitney Lowe continued from page 18)

The second key term of nerve injury is *peripheral neuropathy*. Pathology farther along the length of the nerve is called a neuropathy. Neuropathy literally means damage to or disease affecting the nerves. It is also called a peripheral neuropathy indicating that the injury is in the peripheral nerves, distant from the nerve roots and spinal cord. Many nerve compression syndromes, such as thoracic outlet and carpal tunnel syndromes, are examples of peripheral neuropathies. Both motor and sensory symptoms can occur from peripheral neuropathy. In some cases the symptom pattern may give an indication of the severity of the injury. For example, there is a greater percentage of sensory fibers in the distal median nerve compared to motor fibers. That is why people who develop carpal tunnel syndrome tend to develop sensory symptoms first. If motor symptoms (weakness with grip strength) are present, this indicates a greater degree of nerve injury because more fibers (including more motor fibers) are affected. Peripheral neuropathies also produce motor symptoms. If the motor nerve root fibers are being compressed, weakness or atrophy of the muscles being supplied by that nerve will result.

The location of nerve entrapment or impairment has a direct bearing on which muscles will be affected. The more proximal is a nerve compression pathology, the greater number of muscles that will be affected. For example, there are three muscles innervated by the same nerve indicated in image 6. If compression is occurring at Location A, all three muscles could be affected with weakness or atrophy. If compression is occurring at Location B, weakness or atrophy would only be expected in muscles two and three.

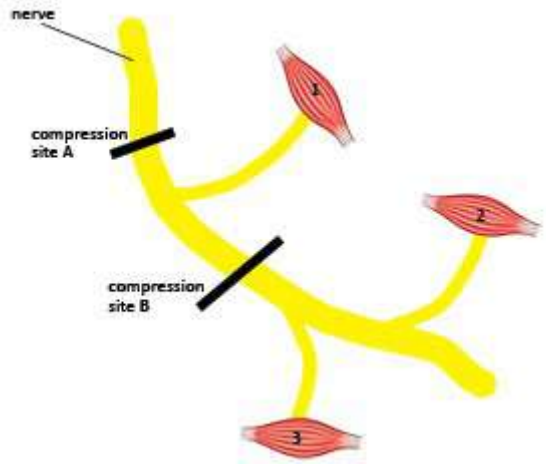

Image 6: Location of symptoms in relation to nerve fiber innervation of muscles

Knowledge of common nerve entrapment sites is therefore crucial to knowing what type of symptoms should be expected. If a nerve compression is more proximal, there is a greater likelihood that more motor and sensory regions would be impacted. The more distal is the site of nerve compression the fewer motor or sensory fibers will be affected. Knowing when a nerve is purely motor or purely sensory is also very helpful because the pathology may produce only motor or only sensory symptoms because the affected nerve is not a mixed nerve.

(Whitney Lowe continues on page 20)

(Whitney Lowe continued from page 19)

Biomechanics of Nerve Injury

Nerve injury can occur from either compression or tension (pulling force on the nerve). Compression injuries are more common and make up the large majority of peripheral neuropathies that you hear about, such as carpal tunnel syndrome or thoracic outlet syndrome. Nerve injuries generally develop from compressive loads, such as a direct blow to the nerve or a chronic lower level compression.

Tension injuries on nerves don't receive as much attention as compression injuries yet are increasingly recognized as a likely cause of many nerve-related symptoms. With excess tensile stress the overall diameter of the nerve decreases thereby compressing the fibers within the nerve; this condition is called *adverse neural tension*. Recognizing the biomechanical forces of compression or tension on nerves helps determine how they may be involved in various clinical presentations.

Pathological changes also develop in the nerve if there is a *double or multiple crush* phenomenon. Multiple crush describes a situation where there is more than one site of nerve compression. With more than one site of compression along the nerve, symptoms are often magnified due to the multiple sites of impairment.

The best analogy to understand the multiple crush is to think of the nerve like a hose with water flowing through it. Step on that hose somewhere along its length and the water flow at the other end will be decreased. If you step on it in a second location the water flow is decreased even further.

Nerves are responsible for transmitting their own nutrient proteins throughout the entire length of the nerve. They transmit these nutrient substances through a continuous flow of axoplasm (cytoplasm of the nerve axon) within the nerve cells. Remember that nerve cells extend the entire length of the nerve fiber they are located within. With an impairment in the axoplasmic flow, distal nerve tissue is nutritionally deprived and therefore it becomes symptomatic causing symptoms such as paresthesia, numbness, or burning sensations. Nerve tissue ischemia from impairment of blood flow to the nerve can also produce these symptoms.

The multiple crush phenomenon is also a common cause for clinical confusion and improper treatment. Treatment may be directed at a distal nerve compression pathology (like carpal tunnel syndrome) assuming it is a localized disorder. Failure to recognize more proximal nerve compression that exists simultaneously could mean that symptoms perpetuate even after treatment. The multiple crush phenomenon is a likely explanation for why so many carpal tunnel treatments are unsuccessful.

The Massage Therapist's Role

The pressing question for massage therapists is what role we can play in addressing nerve compression and tension pathologies. When muscles become dysfunctional with tightness or myofascial trigger points our primary treatment strategy is to decrease their tightness and improve function. Pressure and gliding movements applied directly to dysfunctional muscles are effective in producing beneficial therapeutic changes.

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(Whitney Lowe concludes from page 20)

The strategy for addressing symptoms of nerve compression or tension pathology are quite different. Nerve tissue will be further aggravated if it is compressed or stretched when already injured. However, that does not mean massage is not an effective treatment.

The first order of treatment is to prevent any additional irritation of the nerve and this is where massage plays such an effective role. In many instances compression of the nerve is caused by tight or restricting local soft tissues. Massage is very effective in reducing tightness of these tissues that may be compressing the nerve. When pressure is relieved from the nerve, the natural healing process can proceed and the nerve can regain its optimal function.

Massage therapy treatment for nerve-related disorders is most effective when the practitioner can identify the most likely site of pathology. Treatment can then be aimed at the local tissues that are contributing to the dysfunction. However, caution in treating these areas is imperative because working on them without adequate knowledge of what you are addressing could easily make nerve symptoms worse due to mechanical aggravation of the nerve. That is exactly why having a solid understanding of many nerve-related disorders will make you a far more successful clinician.

New MTF Blog:
Interoceptive Awareness for Women in Substance Use Disorder Treatment

Cynthia Price, PhD MA LMT, a researcher at the University of Washington and a long-standing volunteer at MTF, recently completed a 5-year study funded by NIH to examine the efficacy of a therapeutic approach that she developed called Mindful Awareness in Body-oriented Therapy (MABT) for women in outpatient treatment for substance use disorder.

The study was implemented in three community clinics, and was delivered by massage therapists trained in the MABT approach. MABT (http://www.cmbaware.org/) involves manual, psychoeducational, and mindfulness and teaches clients to develop awareness of inner body sensations (also known as interoceptive awareness), and teaches related skills to facilitate self-care and emotion regulation.

The study participants had high levels of interpersonal trauma (e.g. 80% had a history of domestic violence, and the majority had a history of sexual trauma as children and/or adults). MABT is particularly helpful for people who may be disconnected from their bodies due to high levels of distress, and is designed to facilitate reconnection and awareness skills using an incremental approach. The results showed significant improvements in interoceptive awareness as well as emotion regulation indicators among those who received MABT compared to those who did not. Those who received MABT also had significantly less substance use compared to other study groups. The results of this study were recently published in Substance Abuse Journal and can be accessed at https://bi t.ly/2yAVAqR.

Welcome to Our New Members

(August, September and October)

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Annual California Educational Conference and Business Meeting

Hilton Arden West, Sacramento

Friday, 15, Welcome Reception

Saturday, 16, Education! and Business Meeting!

Online Registration will be Available Very Soon!

Look for details coming to your email box, Chapter website and Facebook page!

Recognizing Special Anniversaries

(August, September and October)

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Angela Kingshill
Cali Brady
Carlita Johnson
Carlos Nahas
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Daniel Mojica
David Da Silva
David Fischer
Deborah Fischer
Dyanne Monroe
Faustino King
Felix Mora
Grace Peterson
Heather Porter
Heather Udomrat
Ian Walker
Irma Mora
Jenna Chiu-Hugh
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Joleta Bernheim
Jongkon Rieken
Kelly Hinkson
Kelly Lawrence
Korrin Hamilton
Lin Tao
Linda Benskin
Lisa Avina
Luanda Wesley
Lucy Farrell
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Steve Bunis
Suffer Diaz
Thomas Cardoso

15 Year Anniversary

Carol Knop
Diane Evans
Jeeranan Samnuk
Jennifer Holt
John Guevara
John Lewis
Kathleen Wenzel
Lauri Proscia
Mary Riemann Wilson
Patrick Wilson
Rajam Roose
Sheila Lowerre

20 Year Anniversary

Connie Clark
Debra McCredie
Melissa Targgart
Ratka Popovic
Stanford Tate

25 Year Anniversary

Brenda Baker
Chris Voltarel
Christine Fazio
Cynthia McGovern
Linda Aja
Raymond Schuschu
William Jorgensen

30 Year Anniversary

Amy Meza
Barbara Wilson
Carol Young
Hilary Tayeb
Joseph Hutchinson
Karri Chan
Kathy Dolin
Lenore Hocking
Linda Groat
Michele Augustis
Susan Webb

35 Year Anniversary

Nancy Richeimer
Teri Rogers

75 YEARS amta american massage therapy association

2018-2019 CALIFORNIA CURRENTS PUBLICATION INFORMATION

The American Massage Therapy Association, California Chapter newsletter, ***California Currents***, is scheduled to have 4 issues a year. Currently, the *California Currents* has a circulation of over 6,500, reaching our members and massage schools. **All issues will be sent green, via email, posted to our Chapter website (www.ca.amtamassage.org) and to our Chapter Facebook page.**

Issue	Last Date for Submissions	Date to be Published
Winter	January 21, 2019	February 4, 2019
Spring	April 29, 2019	May 13, 2019
Summer	August 5, 2019	August 19, 2019
Fall	November 4, 2019	November 18, 2019
Winter	January 27, 2020	February 3, 2020

**dates are subject to change.*

Submissions of articles, pictures and advertising should be sent in .jpg format and/or word document. Submissions should be sent to Michael Roberson, Chapter Newsletter Editor, at editor@amta-ca.org

The following are Board-mandated policies regarding submission & rates.

1. First-Come, First-Served: Paid advertising in the newsletter is limited to no more than 25% of total content for each issue. Therefore, advertising will be accepted on a first-come, first-served basis based on the receipt of payment date by the Newsletter Editor.

2. One Full Page is the maximum amount of advertising that will be accepted from each advertiser for each issue.

3. Bulk Discount: Advertising rates shall be discounted by 20% when paid in advance for four advertisement placements within five sequential issues. If canceled prior to all four placements, the refund will reflect the standard single-issue rate less a service fee of 10% of the unused balance.

4. Specific Page locations: Add a 20% surcharge to the rates quoted below.

5. Only Camera Ready advertisements will be accepted – meaning ready for digital or print publications. Ads should be submitted in color as .jpg files.

Advertising space is available at:

Ad Size	Dimensions	Rate
Full Page	8x10	$300
Half Page	8x5	$175
Half Page	4x10	$175
Quarter Page	4x5	$100
Eighth Page	4x2.5	$75
Business Card	4x1	$50

Ad Copy Requests and Article Submissions should be submitted to Michael Roberson, Chapter Newsletter Editor at editor@amta-ca.org and payments (in the form of checks) should be made out to **American Massage Therapy Association, California Chapter** and sent to **Michael Roberson, c/o AMTA-CA, 1924 Wallace Avenue, B101, Costa Mesa, CA 92627**. Ads will not be published until payment has been received. Your support to AMTA-CA is very much appreciated.

Position Title: **Government Relations Chair**

Time Commitment

The time commitment is approximately 2 – 5+ hours per week, depending on Chapter activities.

Purpose

The Chapter Government Relations (GR) Chair-is responsible for communication and monitoring of active legislative and regulatory issues in a state.

Eligibility

In addition to being a Professional member in good standing and signing the Volunteer Code of Conduct, she/he must meet the following requirement:

Completed one year of AMTA membership.

Accountability

The GR Chair is accountable to the Chapter Board, Chapter Members and AMTA National Board of Directors by virtue of appointment by the Chapter Board of Directors

The GR Chair agrees to uphold and abide by Volunteer Code of Conduct.

Relationship

The GR Chair works closely with Chapter Board members and appointees and National AMTA staff, lobbyist(s) if the Chapter has retained any, along with legislatures and outside groups and stakeholders that may be involved in legislative efforts. The GR chair also communicates with Chapter members, Chapter Secretaries, the Chapter Relations Committee, and/or other National volunteers, as appropriate.

Responsibilities

Keep current with AMTA's national legislative priority issues through e-mail, receiving AMTA's legislative briefings and via conference calls.

Coordinate and participate in communications between AMTA National Office staff, chapter leadership and lobbyists to ensure information and up-to-date reports on legislative activity are received by all the necessary parties.

Participate and help guide the legislative activity of the AMTA chapter in the state and encourage members to participate and be involved in the legislative process when needed.

Works on building collaborative relationships between legislators and the chapter; many chapters find doing a chair massage day at the capitol is a great way to educate legislators on the benefits of massage therapy.

If needed, form an AMTA chapter legislative committee with chapter board approval to offer additional support and volunteers for GR efforts.

Identifies, cultivates and recruits future Chapter leaders.

Directs and refers members to appropriate volunteer and National AMTA staff contacts as applicable.

Is available to receive direct feedback from members for input to the Chapter Board and to communicate appropriate information regarding actions of the Chapter Board.

Fulfills the fiduciary, due diligence and other responsibilities of Chapter Board members as described in the Volunteer Code of Conduct.

Maintains orderly records of activities and timelines relevant to her/his position during their term and supplies the Chapter with those records to ensure a smooth transition.

Ensures that all legislative and regulatory initiatives and activities are in line with the AMTA Government Relations national policies.

Vacancy

A vacancy in the Chapter GR Chair position will be filled according to AMTA Bylaws and Policy.

Removal from Office

An officer may be removed from office for failure to:
Fulfill her/his duties and responsibilities (dereliction of duties).

Abide by Chapter Volunteer Code of Conduct.

Keep AMTA membership dues current.

Removal shall occur in accordance with AMTA bylaws and policy.

Position Title: **Regional Representative (Southern Rep and Northern Rep)**

PURPOSE
The CA Chapter Regional Representative is the primary liaison between the Chapter Board of Directors and local volunteers in the Southern or Northern regions of the Chapter.

ELIGIBILITY
1. Must be an AMTA Member in good standing
2. Should reside in the regional section of the State of California to whom he/she will represent

AUTHORITY & ACCOUNTABILITY
The Chapter Regional Representatives are accountable to the membership by virtue of appointment by the Chapter President and approval of the Chapter Board

TERM OF OFFICE
Term shall be for one year or until successors are appointed

RESPONSIBILITIES
1. Attends Chapter Board of Directors meetings upon request
2. May attend regional events as needed
3. May attend Chapter annual business meeting
4. Must sign the AMTA volunteer Code of Conduct
5. Agrees to uphold and abide by National AMTA Bylaws and Code of Ethics, AMTA-CA Chapter Standing Rules, Financial Policies & Procedures
6. Coordinate with volunteers to conduct local networking events including but not limited to:
    A. Education events
    B. Networking opportunities – social gatherings
    C. GR related activities
7. Recruit and mentor future chapter volunteers
8. Submit articles to the Chapter newsletter as required
9. Provide written report of local activities to Chapter Board
10. Assume assignments as directed by the Chapter President and/or Chapter Board of Directors.

TIME COMMITMENT
The time commitment averages approximately 2 – 4 hours per week, depending on Chapter activities. The time commitment may be higher before and/or during certain Chapter or local events or actions.

VACANCY & SUCCESSION
A vacancy will be filled according to AMTA Bylaws and Policy.

REMOVAL FROM OFFICE
Individual may be removed or replaced for failure to:
1. Fulfill her/his duties and responsibilities
2. Abide by Chapter Volunteer Code of Conduct
3. Keep AMTA dues current.

Open Roles for Elections

President (Special 1 year term)

Financial Administrator (2 year term)

Board Member (2 year term)

Assembly of Delegates (2 positions, 1) 2 year term, 2) Special 1 year term)

(the roles and responsibilities were published in the 2019 Summer Issue of the *California Currents* and can be found on the Chapter website www.ca.amtamassage.org)

Appointed Positions and Chairs

These positions and roles are appointed to their duties by the Chapter President and ratified (approved) by the Chapter Board. Please send your candidate resumes to the Chapter President at president@amta-ca.org.

Regional Reps (Northern and Southern—must reside in the corresponding region)

Government Relations Chair

Newsletter Editor

Education Coordinators (Regional Areas, Central, Northern and Southern)

Sargent At Arms

Parliamentarian

Awards Chair

Social Media Coordinator

AND if you want to volunteer, but not sure where, let us know what your skills are and how much time do you want to give. I am sure we can put your talents to serve our members!

Please fill out the AMTA-CA Chapter Candidate and Volunteer Resume Form which can be found on page 32 and on the California Chapter Website, www.ca.amtamassage.org with role information.

AMTA-CA CHAPTER
Candidate and Volunteer Resume Form

Please print or type Yr joined
Name _____ AMTA I.D. # _____ _____
Home Address _____
Phone (w) _____ (h) _____
Email _____
Years in massage _____ CAMTC # _____ Massage license? _____ City/County _____
Massage school attended/# of hours _____
Date of completion _____ Other related schooling _____
_____
I am interested in volunteering in the following areas: (details can be found on the Chapter website)
Board of Directors: __President __Secretary __Financial Administrator __Board Member
__National Convention Delegate

Appointees/Chairs: __Awards __Exhibitors __Parliamentarian __Budget (Member At Large) __Government Relations __Sergeant at Arms __Committee on Candidacy __Newsletter Editor __Social Media __Conferences/Workshops __Sports Massage __Education Chair (Region: __N__C__S) __Website __Northern Rep __ Southern Rep __Other_____

You want to serve, but not sure where? What skills do you have? and How much time do you want to give? Let us know and we will reach out to you._____
_____
_____

Relevant community or professional experience _____
_____
List AMTA Chapter (C) and Unit (U) Offices held with dates (include committees): _____
_____
_____
_____
Other Qualifications _____
_____
FOR THOSE SEEKING A BOARD OF DIRECTOR POSITION How many hours a week do you estimate will be required to perform the duties of this office?_____ Are you currently able to commit the appropriate time for the performance of your duties? YES NO
What are your reasons and objectives for seeking this office? _____
_____
_____
_____
At Board meetings, I understand that I must be present, focused and courteous; that I must put aside my private life for the duration of the function; that I will refrain from introducing distracting influences to other Board Members and that I will be prepared to transact the business of the Association.

_____ _____
Signature Date

Please submit Candidate and Volunteer Resume Form to **info@amta-ca.org.** If you have any questions about the position, please ask any of the current board members. Additional information on all roles can be found on the chapter website, **www.ca.amtamassage.org**. Thank you for your submission.

California Currents Contacts

Chapter Board

President
John Lambert
president@amta-ca.org

Secretary
Patricia Rusert Gillette
secretary@amta-ca.org

Financial Administrator
Michael Roberson
treasurer@amta-ca.org

Board Member
Liz DiGiulio
1stvp@amta-ca.org

Board Member
Bonni Kelley
2ndvp@amta-ca.org

Appointees

Northern Representative
Patricia Rusert Gillette
northernrep@amta-ca.org

Southern Representative
Michael Roberson
southernrep@amta-ca.org
949.292.9207

Government Relations Chair
Open
gr@amta-ca.org

Newsletter Editor
Michael Roberson
editor@amta-ca.org

Appointee to CAMTC
Mark Dixon
mdixon@camtc.org

Educational Coordinators
Northern: Ryia Suising
Central: Megan Martin
Southern: Sarah Berkke

Northern Regions

East Bay Unit
Golden Gate Unit
Redwood Empire Unit
Silicon Valley Unit
Far North Region
Greater Sacramento Area
Monterey Bay Region
Napa Valley Region

Southern Regions

Orange County Unit
Los Angeles-South Bay Unit
San Diego Unit
Desert Resorts Region
Gold Coast Region
Inland Empire Unit
Mid State Region

Chapter Administrator
Jeff Milde
Calma Association Management, LLC

Chapter Website
www.ca.amtamassage.org

Elected Delegates
1) Rio Safford
2) Patricia Rusert Gillette

****NOTE****
California Chapter's Phone Number
916-382-8542
and EMAIL ADDRESS
info@amta-ca.org

Follow Us on Facebook
Amta-CA-American-Massage-Therapy-Association-California-Chapter

And National:
American Massage Therapy Association - AMTA

2018 AMTA California Chapter Calendar

January 2018

Sunday, 25, Chapter Board Meeting, Novato
Sunday, 28, SVU, Meeting/Workshop with
Carole Osborne

February 2018

Friday, 2, Unit Service Awards are Due
Tuesday, 13, Chapter Board Meeting, Call In
Sunday, 25, SDU Meeting/Workshop with
Brian Utting, 8CE
Saturday, 28, SVU, Workshop, Cadaver Lab

March 2018

Friday, 16, Chapter Board Meeting, Irvine
17-18, AMTA CA Chapter's Annual Massage &
Bodywork Educational Conference, Irvine

April 2018

Saturday, 7, California IRONMAN®, Oceanside
Tuesday, 10, Board Meeting, Conference Call
Saturday, 21, Sea Otter Classic, Monterey

May 2018

Sunday, 6, OCU Meeting/Workshop with
Cynthia Ribeiro, 6CE
Sunday, 20, SDU Meeting/Workshop with
Nicola McGill, 8 CE

June 2017

Sunday, 3, Board Meeting, Novato
Friday, June 29-July 1, Stand Down San Diego
(Kevin Whitfield, resettherapyfitness@gmail.com)

July 2018

Tuesday, 21, Board Meeting, Conference Call

August 2018

8-11, American Massage Therapy Association
National Convention, Washington, DC

September 2018

Tuesday, 4, Board Meeting, Conference Call
Saturday, 8 Camp Pendleton Family Day,
Del Mar Beach, San Diego
(Kevin Whitfield resettherapyfitness@gmail.com)
Saturday, 8, Best Buddies Challenge, Hearst Castle,
San Simeon
(Cynthia Sykes, cynsykes46@gmail.com)
Sunday, 16, SuperFrog® IRONMAN®,
Imperial Beach, San Diego
(Michael Roberson, southernrep@amta-ca.org)

October 2018

Thursday, 25, Sports Massage with John Combe, 8.5hCE
Chapter Member Meeting, Santa Ana
Saturday, 27, Sports Massage with John Combe, 8.5 CE,
NHI Emeryville
21-27 National Massage Therapy Awareness Week

November 2018

Sunday, 25, Board Meeting, Location, TBA

December 2018

Sunday, 31, Chapter Scholarships Awards Due
It's the holidays!
Enjoy the time with your family, loved ones and friends.

January 2019

Tuesday, 8, Board Meeting, Conference Call

February 2019

Tuesday, 12, Board Meeting, Conference Call

Keep Current with our Education Opportunities and Community Outreach Events by checking often the Chapter Website www.ca.amta-ca.org