For a number of months the Organizing Committee has been planning the **Big Bash** for this September 13th. We’ve created a relaxed and fun event that will allow you to re-connect with classmates and instructors. Christine Sutherland will be coming, as will Andrew Noble and Rhona Birenbaum. We’ve also heard that Joe Smolders and Michael Bard might be attending...

We have worked very hard with the Toronto Marriott Eaton Centre staff to ensure that we can provide a fantastic evening. Tickets for the **Big Bash** will be $50.00 (unheard of for a downtown Toronto event), including a buffet dinner and dancing to follow. Please note that we have had a food tasting and it’s going to be yummy… something for everyone!

The next step is yours. **Big Bash** tickets are now on sale. Included as an insert in this issue is a Ticket Order Form. Your ticket(s) must be purchased by September 2, 2008. We’re expecting hundreds of grads, so make sure you make arrangements soon!

*continued on page 2...*
Where Are They Now?

CHRISTINE SUTHERLAND  Co-Founder

I left Ontario for British Columbia in the early 1990s to take care of family. I provided palliative care massage to my parents, which gave me the opportunity to use my professional experience as a massage therapist to help them. This turned out to be one of the most important experiences of my life. I even taught my daughter to massage her grandparents! I did have to leave Sutherland-Chan behind, however, and leaving Grace and the school after our 10-year relationship was like losing a sister.

In 1998 I started touring with Loreena McKennitt as her massage therapist. This has been a great experience. I have also been involved with developing the work of massage therapy in spinal cord injury recovery. I have produced and directed two films on the subject; currently I am shooting a film called, “Stand Because You Can.”

My biggest project is a television series pitch called, “Hands On with Christine Sutherland.” This series is designed to promote greater health and a balanced lifestyle.

On a more personal note, I have been struggling with an eating disorder most of my adult life and this has inspired me to produce another film called, “It’s Not About Food.” The film integrates the significant role touch and massage play in recovery.

For me, Sutherland-Chan was a first-born dream come true and Grace was the perfect partner for conceiving this wonderful family of therapists who are changing the world one massage at a time!

Also on Saturday, September 13th, we will be holding a ‘family friendly’ Open House from 10:00 am to noon. Alumni, friends and family members are welcome to re-visit the school location at 330 Dupont or see it for the first time. There will be displays of memorabilia and refreshments. Join us on the morning before the Big Bash!

Additionally, this September there will be a commemoration of the 30th Anniversary held at the school. At 10:30 a.m. on Tuesday, September 9th we will officially recognize our thirty years of massage therapy education by inviting students, faculty, staff, neighbours, suppliers, media and local politicians to a ceremony at 330 Dupont St. Alumni are welcome to join us! There will be speeches and photos, reflections and memories, and then we’ll cut the cake and raise our cups to salute the school!

If you haven’t yet heard from your Year Captain, it may be that there have been difficulties getting in touch with you. Check the updated Year Captain List insert in this issue – and be in touch!
Highlights from the past 30 years...

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1978</td>
<td>School opens at 402 Spadina with 14 students; curriculum is 1040 hours</td>
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<tr>
<td>1979</td>
<td>School moves to 732 Spadina</td>
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<td>1980</td>
<td>Grace begins publishing Bodywork, a small publication for the general public</td>
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<tr>
<td>1981</td>
<td>Curriculum increases to 1560 hours; first Clinical Outreach sites are incorporated into the program</td>
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<tr>
<td>1986</td>
<td>Curriculum increases to 2200 hours</td>
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<td>1987</td>
<td>Grace attends the World Junior Track and Field Championships in Greece as a team therapist; becomes a leader in sports massage therapy</td>
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<td>1988</td>
<td>10th Anniversary is celebrated on Toronto Island</td>
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<td>1990</td>
<td>The school relocates to 330 Dupont Street</td>
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<tr>
<td>1991</td>
<td>First hospital setting Outreach is established at Guelph General Hospital</td>
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<tr>
<td>1992</td>
<td>Grace receives OMTA Meritorious Service Award</td>
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<td>1994</td>
<td>New legislation governing massage therapy: the Regulated Health Practitioners Act</td>
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<tr>
<td>1995</td>
<td>Our largest annual intake of students at 150</td>
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<tr>
<td>1997</td>
<td>Debra receives OMTA Meritorious Service Award; our largest graduating class at 141</td>
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<tr>
<td>1998</td>
<td>20th Anniversary is celebrated with an Open House; Debra joins Grace as an owner; first issue of FingerPrint</td>
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<td>1999</td>
<td>Curties Overzet Publications incorporates — first textbooks are Breast Massage and Massage Therapy &amp; Cancer; Sutherland-Chan wins the AMTA award for best awareness promotion for the 1998 Open House</td>
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<tr>
<td>2001</td>
<td>Job Search Support Service is initiated — total number of job opportunities quickly rises to 279!</td>
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<td>2002</td>
<td>100% pass rate on the written portion of the CMTO provincial registration exams</td>
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<tr>
<td>2003</td>
<td>Breast Massage Term 4 specialty clinic opens at the school — a North American first!</td>
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<tr>
<td>2004</td>
<td>Multiple Sclerosis research study is conducted onsite</td>
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<td>2006</td>
<td>First issue of the Clinic newsletter Keeping in Touch</td>
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<tr>
<td>2007</td>
<td>Chronic Pelvic Pain Term 4 specialty clinic opens — another North American first!</td>
</tr>
<tr>
<td>2008</td>
<td>Sutherland-Chan celebrates 30th Anniversary</td>
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In Memory of Erlan Albert O’Neil (1938-2008)

In addition to being a much respected colleague and member of the Sutherland-Chan community, Erl was a massage therapy pioneer. He contributed in many ways to advancing our fledgling practice knowledge base. Erl was an integrative practitioner before that term was being used. He was also a fundamentally kind and decent human being who generously shared his time and expertise with students and fellow instructors. He was hardworking and dedicated. We are very grateful for his contribution to the school and often still miss his unique vision and scholarly input at meetings. Grace Chan & Debra Curties

I came to Toronto at 18 years of age. Dad was doing what he loved best, learning massage. He was first a student, then quickly a teacher. I remember sitting and waiting for him to finish his work. Everyone was dressed in white and wearing Birkenstocks then, it seemed to me. If you knew him, you probably met me in the waiting room. Now that he has passed away, I wonder what he would say? If you asked him something he would do his best to give you a good answer. He gave me super massages — some deep, where you only felt better two days later, others were just touch-ups. He just liked helping others. It was that, that made him happiest; helping you, me, and everyone he could. I want you to know, his days at Sutherland-Chan, before he started losing his health, were his best days for sure. Warren O’Neil
by Debra Curties, ’84

I have been reading a lot of studies about massage and cancer lately. Initially, I was unsurprised to see massage therapy being recognized as highly effective in reducing cancer patients’ anxiety, much the way I would react to reading that massage had been proven relaxing. But as a recurring theme it started to attract more of my conscious interest. In fact, anxiety reduction was usually found to be the strongest, most consistent massage therapy effect, along with correlated benefits such as reduced symptom distress, improved sleep and better ability to cope. Some authors were postulating that massage therapy’s efficacy in reducing pain and nausea is largely achieved indirectly through reducing anxiety and promoting neurochemical homeostasis. I began to realize that I wasn’t properly differentiating between anxiety and stress. It started to dawn on me that we are, maybe a tidge accidentally, very good at something we’ve learned next to nothing about.

What is Anxiety?

Anxiety is a component of fear, a common reaction to stressors like test-taking, being in unfamiliar situations, or concern about a new health symptom. As a short-term situation-specific response, anxiety’s purpose is to make the person more alert, focused or careful, and to trigger the ‘fight or flight’ response if needed. Anxiety affects individuals both physically and emotionally. Common manifestations include sweating, heart palpations, dry mouth, trembling, lightheadedness, numbness/tingling, chills or hot flashes, frequent urination, nausea, diarrhea, muscle tension, chest constriction, shortness of breath, restlessness, irritability and limited concentration.

Anxiety falls into two categories: state anxiety and trait anxiety. State anxiety is experienced as part of a stressful circumstance, for example, going into hospital. Trait anxiety involves having an anxiety-prone personality, being consistently more inclined to worry and to express high levels of anxiety in everyday situations. Trait anxiety intensifies state anxiety and makes it harder to modify.

Problem Anxiety

Continued anxiety morphs into apprehension, nervousness and worry. Anxiety becomes problematic when these states are prolonged or out of proportion and the feelings of anxiety become detached from specific causes. The person is often aware of the irrationality but unable to change it. Adverse effects show up in day-to-day function, work and relationships. The anxiety symptoms can become progressively in any number of directions from headaches to chest pain. Sleep disturbance often leads to a sense of exhaustion and/or being unable to cope. Prolonged anxiety also lowers immune resilience and predisposes towards illness. Massage therapists probably only have an inkling of the extent to which anxiety underpins our clients’ symptoms and reasons for seeking massage treatment.

Prolonged problem anxiety can lead to increasingly dysfunctional states such as hypervigilance, avoidance, panic, obsession, emotional unreality (‘fugue’ state) and violent/suicidal ideation. Protracted anxiety is closely associated with clinical depression, self medication (anxiety is frequently the unacknowledged origin of tobacco, alcohol, drug and food addictions), and activation of mental illnesses called anxiety disorders.

Although problem anxiety is not fully understood, some aspects of neurofunction are known to be involved. The amygdala and hippocampus, both limbic centres, often manifest detectable transmission abnormalities, especially in anxiety disorders. The amygdala, which is believed to alert the rest of the brain when a threat is present, may help create associations between emotions, memories and dysfunctional anxiety reactions. The hippocampus, which encodes painful or threatening events into memories, can become hyperactive and is probably responsible for phenomena such as memory fragmentation and flashbacks.

The other key concern is altered neurochemistry. Prolonged anxiety is associated with neurotransmitter imbalances. Of particular interest are serotonin (believed to be a key mediator of anxiety, memory and sleep), dopamine and GABA, as well as chemical pathways involved in sympathetic activation and endorphin dynamics.

The most successful treatment protocols for problem anxiety combine psychotherapy and medication, and incorporate relaxation practices, breathing awareness, regular moderate exercise, seeking life ‘balance’ and avoidance of stimulants. This suggests that multi-faceted limbic transmission pattern changes and neurochemical supports are needed to address root causes.

Anxiety Disorders

Anxiety disorders are a group of conditions characterized by prolonged states of irrational anxiety. They manifest in episodic, recurrent and chronic forms, affecting about 18% of the North American population. They often onset before age 20 and can be more active in transitional states such as adolescence and menopause. Women have a higher overall incidence than men, although it varies by condition.
Common Anxiety Disorders

Each of the common anxiety disorders is a mental illness with anxiety as the foundation from which the specificities of the disorder develop. There isn’t space in this format to describe their truly interesting complexities, but brief summaries are offered below:

► Generalized Anxiety Disorder (GAD)
Chronic distressing anxiety without clear root cause (excessive, threat-filled worry about everyday occurrences/ issues); can lead to avoidance of routine responsibilities and activities; often co-exists with other anxiety disorders.

► Phobias
Intense, irrational fears of things that pose little or no threat; resulting avoidance behaviours can impair daily life; can be specific phobias such as dogs, heights, elevators, water, blood; social phobia: disabling social setting anxiety; agoraphobia: intense anxiety causing avoidance of many or all public situations – person is often restricted to home.

► Panic Disorder
Recurrent terrifying panic attacks (the person’s body has a ‘facilitated pathway’ for fight or flight activation); intense avoidance of people, places or circumstances associated with past/future attacks; hypervigilance about physical health; GAD; can progress to agoraphobia

► Post-Traumatic Stress Disorder (PTSD)
Caused by extremely traumatic events or chronic stressor exposure beyond tolerance: persistent anxiety, flashbacks, reliving of event(s); hypervigilance, insomnia/nightmares, panic, emotional dysfunction, avoidance behaviours.

► Obsessive-Compulsive Disorder (OCD)
Anxiety-driven obsessions about fearful consequences or risks; leads to development of talismanic rituals designed to avoid, counteract or safeguard against threat; ritual has a consuming, driven quality that interferes with everyday life.

Scientists think that, much like heart disease or cancer, anxiety disorders are complex illnesses that result from an individualized interplay of inherited predisposition (>50% incidence), personality type, childhood factors such as neglectful or over-protective parenting, and individual experiences such as bullying, trauma or abuse. Anxiety disorders can also be an intrinsic component of conditions such as multiple sclerosis and asthma, and can be triggered by reactions to some drugs and stimulants.

Massage Therapy and Anxiety

Doing a literature search using “massage and anxiety” gleans hundreds of citations. Most relate to state anxiety, in other words, massage therapy’s effectiveness in helping people manage anxiety-inducing situations. The large body of studies in the cancer literature reflects on treatments offered in hospital, hospice and community settings at all stages of the cancer journey. These include a retrospective review (Cassileth, 2004) of 1290 massage treatments at a cancer hospital in New York, which found that after one treatment the average anxiety reduction was 52%, 60% for patients rating their pre-treatment anxiety as moderate or severe. A Cochrane systematic review (Fellowes, 2004) found that the most consistent effect of massage treatment for cancer patients was anxiety reduction. Another (Smith, 2002) exemplifies several studies that reflect on massage’s ability to disrupt the anxiety, symptom-related distress and poor sleep connection. Numerous studies have found light back stroking or hand/foot massage very effective in lessening anxiety and nausea during chemotherapy.

Pain experience, a complex mix of physiological and psychoemotional factors, is greatly intensified by anxiety. Although we tend to see massage therapy as effective insofar as it can address soft tissue sources of pain, the evidence suggests that, like morphine, massage’s effects may be strongest in alleviating the distress side of the equation. There are several studies on the subject of post-surgical pain, anxiety and massage. It has been found to moderate pain/anxiety during labour and delivery. A very interesting study (Mok, 2004) demonstrated that ten minutes of light “slow-stroke back massage” was highly successful in decreasing shoulder pain, relieving anxiety and promoting sleep in elderly patients in the week following a stroke. Chronic pain reduction from massage may in part be a result of restorative sleep promotion.

There are fewer references about trait anxiety, although a well-regarded meta-analysis (Moyer, 2004) suggests that a massage therapy treatment series can effect significant improvement in anxiety-proneness. There are currently only a small number of studies that address massage and anxiety disorders, but their results invite more study. In one example (Collinge, 2005), long-term psychotherapy patients with anxiety disorders were referred for massage therapy, from which they reported improvements in sense of personal safety, interpersonal boundary-setting, body shame and bodily sensation. Massage for PTSD sufferers has received more study, revealing interesting possibilities in decreasing dissociation, reducing physical symptoms and supporting multi-level healing.

Anxiety creates a hyperactive sympathetic state, which, when prolonged, has ramifications on physical functions as diverse as blood pressure, breathing, muscle tension, appetite, sleep, thought processing and immunity. Massage therapy appears to be remarkably effective in helping normalize anxiety-based responses and modifying the distressed, unable-to-cope state central to problem anxiety. Are these effects at the core of how massage therapy works? Can we create them more consciously and efficaciously? If we were more focused on anxiety as a fundamental issue, would we design treatments differently for many of our clients? Do we know enough about this subject?

For detailed sources/references, contact: robert@sutherland-chan.com
Hedley’s style is somewhat unconventional. Rather than approach the topic of anatomy via the traditional ‘regional’ method, he shows us complete, whole-body expressions of major systems. His purpose as stated in his introductory remarks is “to investigate relationships... to increase our awareness of continuities.” In my nearly eighteen years as a massage therapist and teacher, I have been privileged to participate in human anatomy dissection and I’ve also been lucky enough to visit dissection labs on numerous occasions. I have always found these experiences illuminating. But I have to admit, I have never before experienced anything quite like what these three DVDs have to offer!

Volume I: Skin and Superficial Fascia (1 hr, 40 min) begins with a global exploration of ‘skin.’ In dissection, this is the stuff we typically want to get rid of in order to see what lies beneath. Hedley’s approach is to first observe (even massage!) and then carefully remove the entire skin of the cadaver to reveal “superficial fascia man” beneath. His demonstration shows the skin as an organ of considerable volume and scope. A summary of the functions of skin is included as review, as well as an appealing philosophical digression about its significance. He then employs the same sequential method for the superficial fascia: first observation, then palpation (sound familiar?). Then the process of ‘differentiation.’ In the opening section, this differentiation was to separate the skin from the underlying superficial fascia. In this second section, he differentiates the superficial fascia from the deep – the images are truly remarkable. Background life history material on Hedley reveals interests in divinity and philosophy, and his concluding ruminations on the ‘role’ of the superficial fascia are indeed intriguing.

In Volume II: Deep Fascia and Muscle (1 hr, 50 min), we are given a brief review of the previous DVD as a reminder of how we got to the deep fascia. This also serves to remind us of the ‘integral’ nature of his approach. Time-lapse photography takes us from the skin, through the superficial fascia, to the layer of deep fascia. Once again, Hedley’s approach is directed to the unified whole, rather than ‘dis-integrated’ regional parts. He points out regional differences in the continuous fascial matrix. The images are stunning, especially of the fibres of the fascia lata, which is seldom depicted with such clarity and detail. In the spirit of his opening remarks regarding wanting to “increase our awareness of continuities,” Hedley offers unusual insights into the interrelationships of muscle groups of the upper and lower extremities. His so-called “deltopectoralis” falls into this ‘functional’ category. He laments traditional anatomy that draws lines or divides structure for convenience, rather than honouring the functional significance and the unity of the whole.

Volume II ends with a bonus track on “The Fuzz,” but you have to wait for the credits to find it. The “fuzz” is what Hedley refers to as the connecting fibres between various layers of tissue.

In the introduction to Volume III: Cranial and Visceral Fascia (1 hr, 53 min), Hedley states, “The human form is an integrated whole. There are no parts to the living form [my italics]. Parts are merely renderings of the enquiring mind and the artefacts of the anatomist’s scalpel, which reduce the form to its bare bones in the quest for understanding...”

I like his words. I find them an amusing juxtaposition to what is to come since in this DVD the cranial and visceral continuities (parts) are laid bare. There are four main sections: thoracic fasciae, abdominal fasciae, cardiac fasciae and cranial fasciae. All are wonderfully crafted. Before I watched this DVD, I had always wondered what the endothoracic fascia, something I have perceived, really looked like – now I know. If you’ve ever wanted to view the thorax without the bones, this is for you! The footage of the pleural/diaphragmatic/abdominal continuity is unique. In the cranial section, his method of opening of the skull seems directed more to convenience than anatomical convention, but it works. The images are clear. In demonstrating the lambdoid suture, he even goes so far as to speak of sutural “movement” and includes mention of craniosacral or energetic perceptive palpation – “phenomena which are surely under-described in conventional literature.”

I have to say I found this DVD series engaging and informative. If there is one drawback, it is a lack of indexing. There is also no scene menu, which makes hunting for things a little time-consuming. That being said, it remains that those lacking parts are but small detriments in the overall continuity of a structurally sound whole.
The Fingerprint Research Page

by Paul Finch, Ph.D., Director of Education

The origin of evidence-informed practice (EIP), or evidence-based medicine, can be traced to McMaster University, where in 1992 a model reflecting this approach to practice was consolidated and named. EIP has since become the norm for health care professionals. In an EIP model, practitioners base treatment decisions on a blend of information from best research evidence, the unique characteristics of the patient/client, and clinical expertise (encompassing experience and skills).

It is interesting to note that the developers of the modern evidence-informed model suggest that its origins can be traced to much earlier times. For example, following the French revolution, physicians began to reject the assertions of authorities, and sought evidence in the systematic observation of patients. A case in point is physician Pierre Louis’s evidence-based rejection of blood letting in cases of cholera.

The ultimate goal of an evidence-informed approach to practice is to improve clinical outcomes. This is not to say that outcomes are necessarily poor to begin with. It suggests health care providers always strive to do better as our base of professional knowledge and understanding evolves. Although the EIP process is linked to the world of research, it is a reflective approach in which information is gathered from a number of sources, including clinical experiences, to best serve the interests of the patient/client. Researchers generate evidence that practitioners must then make sense of, and decide whether it is important to consider during therapeutic decision-making, in other words, whether it is “good” evidence.

A number of authors have argued that the evidence hierarchy (prioritizing meta-analyses, systematic reviews and randomized controlled trials) is not always well aligned with the needs of CAM (complementary and alternative medicine) disciplines, which adopt a holistic or wellness-oriented approach to care. They have proposed that there is no intrinsically superior design, suggesting that most designs have equal weight and should be chosen according to their best fit with the question at hand. I recently proposed an elaboration on these arguments called the Evidence Funnel (see diagram).

In this model, as in the clinical reality of the practitioner, the clinician receives evidence gained through different research designs and from different sources. In the Funnel, such information enters the Relevant Evidence section. Informed assessment of the evidence, integrated with clinical expertise and consideration of the unique characteristics of the client, results in optimal therapeutic decisions and outcomes.

As massage therapists, you are committed to achieving the best outcomes for your clients. Evidence informed practice is an approach that need not be applied to every client encountered, but, with challenging or unique cases, it is simply another tool that can be used to enhance client care. It you have not already, I would encourage you to give EIP a try when you encounter such cases.

References

Seeking Client Referrals
If you know of anyone who would be a good referral to our Term 4 Chronic Pelvic Pain or Sports Clinics, we are looking for new clients for these specialty clinics.

CPP: Tues & Thurs @ 1:00 pm April 29–June 19
Sports: Tues @ 1:00 & 2:30 pm April 29–June 17

Find an S-C Grad!
If you haven’t already signed up for our grad locator website service, you really should! It’s very effective for steering new clients your way, and great when old classmates are trying to find you!
Contact Virginia @ EXT. 15.

Help Keep Our OSAP Default Rate Among the Lowest in the Province
Repay your student loan promptly. It’s good for your credit rating and the financial standing of your practice. It also helps make sure S-C students have access to loans in the future.

Thank You!
For books donated to the School Library
Anne Chu ’90

Alumni Weddings In Hong Kong
Sher Martelle ’04 married Jonathan Climas on March 1, 2008
Jenny Woolsey ’98 married Stewart Harris on September 22, 2007

Student Referral Raffle
May 5, 2008
Alumni support the school in many ways - recommending students is just one example. Each year we collect from new T1 students the names of alumni who directed them to the school. Then we draw four names from that list and award prizes to the winners.

A very special thank you to all alumni who regularly refer new students to the school.

This year’s prizes are:
First Prize
$400 Future Shop Gift Card
Second Prize
$250 Canadian Tire Gift Certificate
Third Prize
$200 Sutherland-Chan Con-Ed Gift Certificate
Fourth Prize
$50 Indigo Gift Card

Welcome To New Staff
Jessica Markoff ’07
T1 Body Awareness
T1 Intro to Clinic
T2 Techniques
T2 Theory & Practice (Musculoskeletal)
Jes is the first person to be hired in our new role of Teaching Assistant.

Newsletter Committee
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Debra Curties ’84
Alumni Representative
Jes Markoff ’07
Faculty Representative
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Admin Representatives
Mike Nurse
Marion Bishop
Robert Rodbourne
We are all very interested in your feedback and ideas about the newsletter. Please contact us.

Robert Rodbourne
416-924-1107 ext. 19