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bpd@home

Bodywork Professional Development / +44 (0)7526 925734

Active Isolated Stretching: Empowerment through Flexibility

by Marjorie Brook LMT CIMI

Massage therapists are expected to alleviate stress, help with relaxation, and relieve pain caused by injuries, repetitive use and physical limitations. A therapist's success in doing so often leads clients to view their massage therapist as a "cure-all." Sooner or later, however, a massage therapist might be faced with questions from their clients such as: "Why does the pain keep coming back?" or "I feel better, but I am afraid to do anything that might start the pain again."

If you would like to empower your clients to take an active part in their own health, consider incorporating Active Isolated Stretching (AIS) in your treatment protocol. While AIS is not the only tool I use, it is my favorite hammer, so to speak. One of the best things about using AIS is that you can teach your clients alternate ways of doing some of the stretches themselves at home while you are working with them.

AIS is a scientifically designed flexibility system that works with the body to create and maintain balance. The method was pioneered and developed by Aaron Mattes, MS, RKT, LMT more than 30 years ago. AIS helps the body to function more efficiently by increasing the range of motion (ROM) of the joint and aiding in neuromuscular re-education. With AIS you isolate each muscle and perform a series of stretches that target the fibers at every angle. Due to the isolation of the muscles, the body is unable to engage any compensatory muscles to perform the stretches. It quickly becomes clear how different muscles have been compensating for pain and injury to direct you right to the problem area(s).

How AIS Works

There are two primary principles that provide the basis for how AIS works. The first is the mechanism of reciprocal inhibition and innervations working together. If you want to lift

your arm, your nervous system has to shut off the muscles that bring your arm down (inhibition) while turning on the ones that lift it up (innervations). AIS works with your nervous system and in the process, re-educates the muscles how to function properly and how to utilize and maintain full ROM.

The second principle is to hold the stretch for 2 seconds. Holding a stretch for longer than 2.5 to 3 seconds triggers a protective stretch reflex in the muscle fibers, and the muscle you are trying to stretch contracts. By not tripping the stretch reflex, you are able to get a gentle stretch without having the body work against itself. The stretch is repeated eight to 10 times in a set. The repeated "pumping" action of the muscle allows for increased circulation to the area. By targeting very specific angles of the muscle and promoting full ROM of the joint, the results are a highly efficient and effective stretch, affecting the muscles from origin to insertion. It reaches areas our fingers and hands cannot go. With AIS, you can address injuries such as sprained ankles and pulled muscles as well as physical disorders such as sciatica, multiple sclerosis, scleroderma, scoliosis, and paralysis. Most important, you give your clients the ability to fend off the multitude of physiological and psychological effects their disease or reoccurring injury is causing.

Client Success Stories

I have used AIS with success for clients ranging from children to seniors and presenting a broad range of problems. Below are the stories of two clients who experienced dramatic results with AIS.

Client Story 1: "Tom," 49, suffers from multiple sclerosis (MS). When physical therapy and pain management no longer yielded results, his insurance company stopped coverage, leaving him house-bound without any means of therapy or aid. As a former college



athlete, Tom was utterly frustrated at his loss of control over his own body. When I met Tom, he was 60 lbs overweight, wheelchair-bound and depressed. I explained how AIS works and that I needed his help if the therapy was going to be successful. He looked doubtful but said he would do whatever he could. Since Tom was starting to experience drop foot and his ankles were very swollen, I started there. After showing Tom how to use the stretching strap to assist himself, I asked him to concentrate on lifting up his foot and giving a light pull on the strap at the end of the move. While we worked together, his edema went down, and Tom started to get excited. The motor functionality in his feet started to improve, and Tom's enthusiasm increased. As we progressed on to other areas of his body, I explained how he could perform the stretch on his own, and I also showed his wife how she could assist him. After two sessions, Tom insisted on coming to my office instead of having house calls. After six visits, Tom amazed and thrilled me by coming up the walkway to my office using his walker. His wife informed me with a big smile that he had been doing his exercises every day and his whole attitude had changed. Today, Tom has lost 40 lbs, goes out with friends again and seems to have a new lease on life. He still has bad days and setbacks because of MS, but with the help of AIS, he has the ability to slow down its progression and take some control back over his life.

Client Story 2: "Brad," 14, has pectus excavatum (also known as sunken or funnel chest). Brad's mother is a client who came to me for scar tissue release therapy.



"With AIS, you can address injuries such as sprained ankles and pulled muscles as well as physical disorders such as sciatica, multiple sclerosis, scleroderma, scoliosis, and paralysis"

Upcoming workshops

30/31 Jan 2010

*Scar Tissue & Active Isolated Stretching with Marjorie Brook
Belfast
£200*

2 Feb 2010

*Scar Tissue Release Therapy with Marjorie Brook
London
Early Bird £100*

She asked if I thought I could do something for her son's fingers, which had been broken two years prior and had not healed properly. As soon as I met Brad, I knew that his fingers were the least of his problems. Despite standing slouched forward, typical of many 14-year-old boys, I could clearly see that his right shoulder was internally rotated and basically stuck to his chest. The left side was rounded forward in compensation with the right. His arms were rotated outward, giving him the appearance of normal function. His head also jutted forward. As far as his fingers were concerned, the phalanges of the two middle fingers were truly sticking out. The fingers had never received any rehabilitation. After a few stretches, I showed Brad specific AIS exercises and gave him a hand-exercise ball to take home.

Once his fingers were taken care of, I asked his mother to explain what was going on with his shoulder. Apparently Brad had broken his collarbone coming through the birth canal. He was put in a sling and that was it. Over the years, she had asked the doctors if there was a problem with the way Brad's shoulder was developing and the reply was always the same: "No that is just the way he is growing." So with her and Brad's permission, I started to work on his shoulder. I gently went through the protocols for the shoulder and neck while explaining to him what I was doing and why. I made sure that he was actively involved in every aspect of the session. Within 20 minutes, Brad's shoulder was no longer pressed against his chest and was already gravitating to its proper functional position. I

gave him a homework assignment of stretch and strength exercises and went to work on his mom. While I was working on her, I could see Brad moving his shoulders around. When I asked him how they felt, he replied: "Weird, but in a good way."

On Brad's second visit, he told me that baseball practice was awkward at first because he kept overthrowing the ball until he got used to the way his shoulder was moving. On his third visit, he told me that his endurance was better. I asked him if he was able to take deeper breaths and get more oxygen into his lungs, and he said yes. His mother was happy that she no longer had to tell Brad to stand up straight. On his fourth visit, his mother told me with tears in her eyes how Brad was doing so well in basketball now that the other night he and his father would not come in out of the rain; they just kept shooting basket after basket. Brad continues to come once a week for stretching and strength training. All of his atrophied/undeveloped muscles are coming back to life, and he is learning how to use his body more effectively. Recently, he asked if we could start stretching his legs since soccer season was starting up.

Incorporating AIS in Your Practice

It is always a challenge to introduce any new technique to your clients. People usually prefer the security of your established routine and are wary of anything new. It is slightly more so with AIS since it requires the patient to be an active participant. If a client is hesitant, you can start by introducing small sets of stretching at the

beginning of the session before you start to massage. The cervical and wrist stretches can be performed with the client already undressed and on the table. You can also offer to stretch an area of injury or discomfort, like sciatica, before the client gets undressed as a free demonstration. Eventually, you can offer a half-and-half session where the client can be stretched first and then receive a massage. Once your clients experience the results of the stretching, they will be more inclined to book whole stretching sessions.

AIS is a simple and effective technique that helps to enhance performance, decrease the likelihood of injury and reduce muscle soreness. It helps to increase blood supply and lymphatic flow and the delivery of nutrients on a cellular level. AIS improves ROM of the joints and aids in neuromuscular re-education. Used therapeutically, AIS works with the body, not against it, and empowers clients to take an active role in their own well-being. Furthermore, it works hand-in-hand with massage and other bodywork techniques. Inspiring your clients to be active participants in their own healing process and maintaining their health is the most powerful effect of all.

Marjorie Brook has been a nationally certified, New York State LMT since 1997. She is an advanced AIS practitioner/instructor who teaches nationwide, as well as in Canada and Europe. Marjorie offers CPD courses in Active Isolated Stretching and Strengthening, Scar Tissue Release, and Body Mechanics.

It's Not All About the Piriformis by Marty Ryan

Considering the Abdominal Viscera in Low Back and Pelvic Pain

Different health care and manual therapy modalities see low back and pelvis pain differently. Admittedly, the low back region is a difficult area to define. Just ask your clients to touch their own low back pain and see what I mean. You may see answers anywhere from the tip of the coccyx to T8.

The low back and pelvis is a complicated confluence of the weight-bearing bony skeleton and related soft tissues. This includes the large postural muscles and related fascia, the digestive, eliminative, and reproductive system viscera, as well as large amounts of blood / lymph / nerve tissues.

Chiropractors, acupuncturists, physiotherapists, orthopedic surgeons, medical doctors, movement therapists, and massage therapists all have different ideas about how to optimize function and decrease pain here. Is it a joint issue? Is it a soft tissue problem? Is there a nerve being impingement? Does the gut play a role? What pharmaceutical interventions should be used? Is surgery a possible answer? How do we get right with gravity and the low back? How do patients maintain body awareness, proper nervous system messaging, and fluid dynamics to this region when they leave our office? All of these are terrific questions.

This short article proposes that manual therapists also consider the abdominal viscera and pelvic floor

when assessing and treating low back and pelvic pain.

Here are some reasons to consider the guts when working with low back and pelvic pain –

1. The abdominal viscera are bulky and substantial. This tissue includes the fascial architecture and suspensory tissues + fluids + fat + the abdominal and pelvic organs themselves.
2. This weight is managed by the fascial suspension of the parietal peritoneum hanging from the respiratory diaphragm, the spine, and the rest of the abdominal "container." This container also holds back the expansion of the hollow abdominal organs which is quite a tricky balancing act.
3. Improperly managing this weight may contribute to some of the "usual suspects" of low back and pelvic pain - lumbar lordosis, low back muscle spasm, disk and facet issues, pelvic floor weakness, and anterior / posterior skeletal muscle imbalance.
4. The pelvic floor skeletal muscles and related fascia is suspended between the coccyx, pubis, and ischial tuberosities, and plays a large role in gait, posture, and erect weight bearing responsibilities. This area should not be missed!
5. The quadratus lumborum, spinal rotators, erector group, hip rotators (piriformis and its neighbors), and gluteals are only part

of the LB pain equation. This is where most manual therapists stop looking. At this point, only posterior tissues have been considered. Braver therapists will also treat the iliopsoas muscle, which at least considers the other side of the spine.

6. Myriad other factors can compromise the function of the low back and pelvis including pregnancy and labour, high velocity impact injuries, post-surgical adhesion syndromes, scar tissue, inflammation, and fluid return challenges – just to name a few.

If working with the abdominal viscera and pelvic floor is not a place of fluency for you, and your low back and pelvis pain clients are not getting better; it may be time to increase your treatment skill sets.

Marty is teaching a 2-day class in February 2010 called **Applications to Fascia, Fluid, and Energy** in Edinburgh, Scotland; and a 3-day class called **Applications to the Pelvis** in London. Register for classes at www.bodyworkcpd.co.uk

Marty Ryan, LMP is a massage therapist at the **Tummy Temple** in Seattle, WA / USA. His practice specializes in optimizing the digestive and reproductive systems. He is also the founder and director of **Love Your Guts Seminars**, currently a 3 weekend training series teaching palpatory anatomy and treatment techniques for the abdomen and pelvis.

For more info on this work / www.loveyourguts.net



Upcoming workshops

13&14 Feb 2010
Palpatory Anatomy of the Belly: Fascial Architecture & Applications to Fascia, Fluid & Energy
 with Marty Ryan
 Edinburgh
 Early Bird £190

19-21 Feb 2010
Palpatory Anatomy of the Belly: Pelvis & Applications to the Pelvis
 with Marty Ryan
 London
 Early Bird £250

Sciatica Approach by Steven Goldstein

BASIC PREMISE.

Integrative Fascial Release functions upon the basic premise, that "all soft-tissue release is based upon how the autonomic nervous system is discharging its impulses" (Michael Shea 1995). Accordingly, from this myofascial perspective, the autonomic nervous system is the primary mechanism that allows for the release of fascia.

CONNECTIVE TISSUE PROPERTIES

In addition to the autonomic nervous system premise we add therapeutic methods that affect the sol-gel relationship of the connective tissue ground substance. Utilizing thixotropic effect (fascia becomes for fluid when it is stirred up, and more solid when it sits without being disturbed (Juhan 1987) & piezoelectric events (changing a mechanical force to electrical energy (Mark Barnes 1997), we have the basis for integrative and interactive change in the physiology and structure of the myofascial connective tissue.

PROPRIOCEPTION, PAIN RECEPTORS & THE AUTONOMIC NERVOUS SYSTEM.

Maintaining the premise of the autonomic nervous system-soft-tissue relationship; then pain is considered an autonomic nervous system phenomenon. Pain triggers the neuromuscular system to maintain a sympathetic response. Shea postulates this as sympathetic tone.

Nociceptors register pain that become sensitised when chronically stimulated, leading to a drop in their threshold (Chaitow-DeLany 2000). With acute or chronic pain,

soft-tissue dysfunction maintained by the ANS maintains high sympathetic tone. Once you intervene in the decrease of pain, even marginally, then soft-tissue will respond to manual pressure.

Fascia not only holds nociceptors but a host of other receptors. As excerpted from Clinical Application of Neuromuscular Techniques Volume One, (Chaitow-DeLany, Churchill-Livingston 2000); Bonica (1990) suggests that fascia is critically involved in proprioception, and that, after joint and muscle spindle input is taken into account, the majority of remaining proprioception occurs in fascial sheaths (Chaitow-Delany 2000).

These receptors hold the key for stimulation of the autonomic nervous system. Once reflexively stimulated by manual pressure engaging superficial fascia, the receptors register within the ANS, thus relaxing and lowering sympathetic tone.

Parasympathetic response creates autonomic phenomenon that is visually discernible by manual engagement of the myofascia. It is in the threshold of parasympathetic that we can use indirect methods of myofascial release to lower pain, and neuromuscular and emotional holding patterns that facilitate soft-tissue response.

MYOFASCIAL RELEASING METHODS.

By employing three broad myofascial methods both directly, as manual pressure and movement, and indirectly, by nervous system response, we can affect soft-tissue dysfunction profoundly.

This is the basis for how Integrative Fascial Release treats clinical soft-tissue dysfunction.

TWO-POINTING TECHNIQUE WITH THE TREATMENT OF SCIATICA.

With regard to treatment of sciatica, we have a variety of sciatic nerve dysfunctions; nerve root compression, disc protrusion and nerve by impingement usually by contracted musculature (piriformis syndrome). Depending upon the severity of the symptoms, our first approach is the reduction of pain.

Integrative Fascial Release uses manual pressure engaging superficial fascia in the form of two-pointing. Two-pointing refers to the placement of hands usually beginning within the visceral seat of parasympathetic response, the abdomen and the pelvis.

By placing hands superiorly upon the abdomen and inferiorly on or around the sacrum, along with the engagement of the superficial layer of fascia, the autonomic nervous system responds with various autonomic phenomena to lower sympathetic tone and create a parasympathetic response.

AUTONOMIC NERVOUS SYSTEM RESPONSE

This response usually takes the form of fasciculation activity (trembling or twitch response), shaking, jerking, skin colour changes, clamminess, laughing, peristalsis (tummy rumbles and gurgles) and glazing or glassiness of the eyes; these are all signs of autonomic discharge. (Shea 1995)

"Integrative Fascial Release functions upon the basic premise, that 'all soft-tissue release is based upon how the autonomic nervous system is discharging its impulses' (Shea 1995)"

Sciatic Approach cont.

TRANSVERSE FASCIAL PLANES

Simultaneously two-pointing the abdomen allows reflexive relaxation to the deeper transverse fascial planes known as diaphragms. Relaxing deeper transverse planes allows for more consistent re-organization of fascial restrictions.

LOW FORCE-LONG DURATION

Since fascia is continuous and ubiquitous, along with its' ability to respond to low-force and long duration stretch or compressive force (Leon Page 1950), it has the potential to alter the sol-gel relationship; thus relaxing and changing functional and structure dysfunction along with the reduction of pain.

PREPARING THE AREA INDIRECTLY

This greatly assists with any sciatica dysfunction. Thus preparing an area by the fascial use of two-pointing with upmost consideration given to autonomic phenomena, will allow for more rapid and speedy intervention with regard to a dysfunction like sciatica.

TWO-POINTING WITH LEVERAGE COMPRESSION.

Two-pointing is just the first in a series of fascial techniques employed to work with sciatic conditions. Essentially determine whether stretch or compressive force technique is desirable, and then used in conjunction with movement techniques (usually passive positional release); one can reflexively relax the whole gluteal structure, thus employing deeper and effective muscular intervention. By considering the myofascial

component, one can effectively treat sciatica-like dysfunction usually lowering pain significantly.

PREPARING THE AREA.

After parasympathetic response is achieved, the soft-tissue is ready to be cued and facilitated towards release and movement. This can be achieved by using either ischemic direct pressure, stretch or compressive methods. In IFR we will use compressive methods, if possible, over stretching technique. The viscoelastic-plastic nature of the tissue allows for the reflexive phenomena of unwinding. If one attempts to exaggerate a distortion pattern instead of attempting to elongate or stretch, the nervous system response proprioceptively will be to "let go", unwind and release. Thus achieving critical collagenous inter-fibre "space".

FASCIA AS A FUNCTIONAL JOINT.

Fascia is actually considered a "functional joint" (Oschman 1997). It allows for freedom of movement when properly relaxed. Creating space and support is the primary function of the fascia. Once a "slackening" is achieved within the "fascial sleeve", the ability to facilitate muscular change is increased.

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Steven Goldstein, an American émigré to Australia in 1999, resides in Melbourne, Australia, where he holds a Bachelor of Health Science in Musculoskeletal Therapy and Bachelor of Arts in Education. He is an innovative massage educator instructing his unique blend of direct myofascial, indirect osteopathic releasing methods and somatic approaches known as **Integrative Fascial Release** internationally since 1995.

www.fascialrelease.com

Steven has blended global lines of myofascial tension (Myers) (Schleip) (Paoletti), with articular receptor facilitation to unwrap and unwind soft-tissue with little or no force. He has drawn from the work of Micheal Shea for Autonomic Nervous System approach and expression as the foundation of any soft-tissue work, and Cranio-sacral therapy to facilitate change to transverse planes.

Techniques include the 'Two Point', the 'Fulcrum', Static & Leverage Compressions which are introduced simply and one dimensionally, then combined by 'osteopathic stacking' to introduce more complex releasing patterns with constant autonomic nervous system awareness, expression and response. Sound structural underpinning knowledge with an indirect approach, allows the practitioner to work more quietly and effectively.



Upcoming workshops

18-20 Jun 2010

Integrative Fascial Release (IFR) Foundations

with Steven Goldstein
Edinburgh

Early Bird £250

25-27 Jun 2010

Integrative Fascial Release (IFR) Foundations

with Steven Goldstein
Edinburgh

London

Early Bird £250

26-27 Mar 2011

Fibromyalgia: Clinical Approaches for the Manual Therapist

with Steven Goldstein
Edinburgh

Early Bird £225

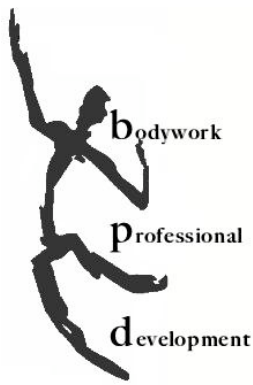
1-3 Apr 2011

Integrative Fascial Release (IFR) Intermediate

with Steven Goldstein
Edinburgh

London

Early Bird £250



10 Beechvale Road
Killinchy
Co Down
BT23 6PH

Phone:
+44 (0)7526 925734

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info@bodyworkcpd.co.uk

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Postural Assessment and Correction

Most people live from day to day with poor posture without ever knowing it and it isn't until they start to feel vague aches and pains they can't put their finger on, that they know something is not quite right.

As a sports therapist I know that an athlete cannot perform at his or her best unless the posture is correct and balanced but, we are not just talking about athletes here, we are talking about EVERYONE!

The majority of people will never compete at anything – all they will ever want to do is simply live. Throughout the course of a person's working life, especially since computers came into the fray, due to the nature of the work, we are finding that bad backs, stiff necks, tiredness and depression (to name just a few) are now a common occurrence so, as a therapist, we have to know what to look for that is physically causing the problem.

There are a number of muscles in the body that act as postural muscles and there are a number of muscles that are phasic and some that double up as both postural and phasic. Over all there is a wonderful exquisite orchestrated balancing of torsions and correcting happening throughout the time you are out of bed and, even whilst you are in bed. Problems occur when some muscles dominate others where there should be an even torsion, then this starts to affect the joints the muscles and the joint starts to mal-track and, pain is the result. After shortened muscles have been lengthened to their original and normal functional length, it changes the matrix of the muscle from Gel to Sol enabling the muscles to function better. Then there is a longer lasting effect and a decrease in pain.

Postural assessment is an extremely powerful procedure and an essential one in every case you take on. It

identifies the root cause of the problem and a host more that, with the right tools and knowledge, is easily treated. Postural assessment training gives the practitioner the tools to identify where the problem is and therefore a good idea of the cause. Learning techniques to correct those problems and in the right sequence is vital and the effects are outstanding and dramatic. From the patient's point of view, they are at last out of pain and, from a therapist's point of view; he or she feels empowered from knowing that they have helped a person out of pain.

Graham Blakeley, a physical training instructor and sports therapist, will be presenting his '**Postural Assessment & Correction**' workshop in Edinburgh (May), London (October) and Belfast (November) in 2010. This workshop is suitable for all bodyworkers and those whose profession is to have hands on their clients in order to treat.

Upcoming CPD events in 2010

- 30/31 Jan ~ Scar Tissue Release Therapy & Active Isolated Stretching (AIS) ~ Marjorie Brook ~ Belfast [Only 2 places left]
- 2 Feb ~ Scar Tissue Release Therapy ~ Marjorie Brook ~ London
- 13/14 Feb ~ Palpatory Anatomy of the Belly: Fascial Architecture & Applications to Fascia, Fluid & Energy ~ Marty Ryan ~ Edinburgh
- 19-21 Feb ~ Palpatory Anatomy of the Pelvis & Applications to the Pelvis ~ Marty Ryan ~ London
- 20/21 Mar ~ Medical Massage for the Lumbar-Pelvis & Cervical Spine ~ Ralph Stephens ~ London
- 27/28 Mar ~ Medical Massage for the Abdominal Wall & Shoulder Girdle ~ Ralph Stephens ~ Edinburgh
- 9-11 Apr & 6-8 Aug ~ CORE Myofascial Therapy Certification ~ George Kousaleos ~ Edinburgh
- 17/18 Apr ~ Sports & Performance Bodywork: A 4-system approach ~ George Kousaleos ~ London