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Thermal Stones for Remedial Therapists by Greg Morling

While the overall qualities of warmth and heat have long been associated with comfort and relaxation, heat therapy goes a step further and can provide both pain relief and healing benefits for many types of musculoskeletal pain and injury. (Mooney, 2011)

In addition, heat therapy in the form of thermal stones is arguably the most efficient and successful way to apply heat to ease a client's pain. With the correct training this method can be both an invaluable therapeutic clinical tool as well as providing a way of relieving the 'overuse' strain and pain experienced in the hands of many massage therapists.

This article provides an examination of how heat therapy interacts with the skin and body to alleviate pain. It also focuses on what I would describe as the 'gold standard' in therapeutic heat application; thermal stones. I have been arguing that the application of thermal stones to relay heat to the body for therapeutic benefit should be a standard procedure, recognized as an essential part of a good massage college curriculum. Thermal stone massage can be much more than a Spa treatment and this piece is the first, as far as I know, to offer sound evidence on how and why thermal stones can be a therapeutic massage tool in the hands of a qualified remedial therapist.

Physiological Effects of Heat

Many episodes of pain and musculoskeletal dysfunction result from strains and over-exertions, creating tension in the muscles, fascia and associated soft tissues. As a result, this restricts proper circulation and sends pain signals to the brain.

Muscle spasm can create sensations that may range from mild discomfort to excruciating pain. Heat therapy through the use of thermal stones can help relieve pain caused by muscle spasm and dysfunction.

The length of a heat treatment influences the body's response to the temperature therapy: short applications tend to be stimulating and longer treatments are usually sedative. Remedial massage therapist need to be clear about their therapeutic aims when using heated stones. *Warm* includes treatments that raise the target tissue temperature to between 33 degrees Celsius and 38 degrees Celsius. *Hot* is over 38 degrees Celsius. Caution must be taken with prolonged heat applications because of the large increase in metabolism they can cause. Of course, it is not *illegal* to combine a warm and hot

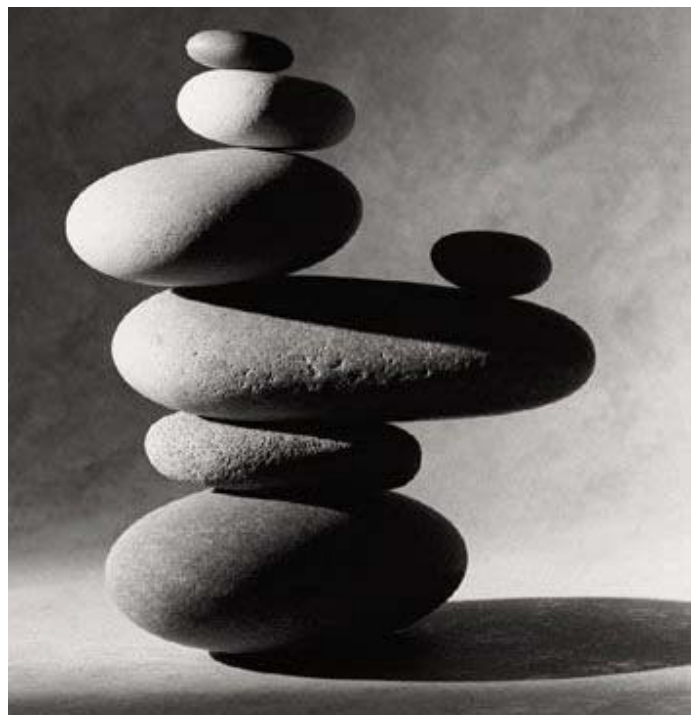
sequence in your clinical practice. I will from time to time, use the trigger/reflex point stone from my thermal stone set to work in the cervical area with direct friction and then follow up with gliding working stones over the same area.

Remedial massage treatment using thermal stones are considered to be superficial. The stone, in most cases would be *warm*, not *hot*.

More sedative thermal stones massage sequence are usually found in Spa and Wellness retreats and sessions may range from one to three hours in duration.

Superficial treatments tend not to penetrate more than about 3 centimetres. As a remedial therapist the local effects of your treatment using thermal stones can sometimes be enhanced by passive ROM and/or stretching. Stretching without using heated stones first will not be as successful as if thermal stones were used. Further, I would argue that when large scale or multiple heat applications are used, the body can experience systemic effects, not just local ones.

Surface thermotherapy causes superficial vasodilatation, which draws fluid out of a deeper area of congestion. This is very much the case with thermal stones. There will be a little less success in heat conduction when working with clients who may have greater amounts of subcutaneous adipose tissue, as fatty tissue acts as a thermal insulator that reduces the transfer of heat to deeper tissues.



Direct Effects of Heat

- Increased metabolism of affected tissues
One of the key physiological effects of using thermal stones is increased metabolic activity. The chemical reactions in the body (the primary work of the cells) occur more rapidly with elevated temperature. Van Hoff's law states that chemical reactions increase two or three times for every 10 degrees Celsius temperature increase. With sufficient, well tolerated heat, an increase in chemical activity increases oxygen and nutrient uptake in tissues, enhancing tissue health and performance.

- Altered cardiovascular dynamics
Dilated blood vessels increase the rate of blood flow. The increase in metabolism boosts the demand placed on the heart to deliver more nutrient-filled blood to active tissues. This is far more relevant for those performing a full body Spa treatment, however it is important to understand that the effect of large application of heat to the body will at first raise the blood pressure and then over time the individual usually relaxes under the influence of the stone thermotherapy and the sympathetic nervous system activity decreases, resulting in a slower, deeper heart beat.

Despite the potential for ultimately beneficial effects, these initial changes in cardiovascular dynamics caused by large-scale heat may not

be well tolerated if the individual's heart is not completely healthy. As mentioned, this may not be such an important issue for those therapists employing remedial thermal stones over selected areas of the body.

- Altered blood dilution
Diaphoresis (excess sweating) can cause fluid to leave the body during thermal stone treatment. This process necessitates replacement by water, so it is important to have water available during and after a treatment so your client does not become dehydrated.
- Detoxification
Perspiration increases the use of the skin as an elimination organ. This means that thermal stone treatment can have beneficial effects in reducing toxicity and supporting the other organs of elimination, especially the kidneys, lungs and liver.
- Direct effect on soft tissue structures
Other than reflex effects, the impact of superficial heat on skeletal muscle is minimal. However, when thermal stones are used in conjunction with stretching and exercise it is possible to create a more positive therapeutic change and improve overall mobility.

Thermal stones have a loosening effect on connective tissue

(fascia). Fascia is not a very elastic tissue, so it has limited capacity to stretch and it can adhere to neighbouring structures, including muscle. Thermal stones can help loosen the fascia's ground substance, making its fibre network more pliable and assist it to 'unstick' from surrounding structures. I would contend that those massage therapists who use myofascial release protocols in clinical practice could double therapeutic results if their techniques were used in conjunction with thermal stones.

Thermal stones can be used very successfully on scar tissue to improve their fibre alignment and to reduce their tendency to adhere to tissue around them. (Fowlie, 2006)

Reflex Effects on Heat

Brief applications of thermal stone do not tend to result in significant reflex effect. The massage practitioner is advised to work slowly, evenly and accurately when directing thermal stone to a dysfunctional area of tissue in order to enhance the benefits of heat therapy. The longer the point (or area) is worked on, the greater affect the thermal stones will have therapeutically.

Below are some possible reflex effects on viscera;

- Longer treatment to the abdomen reduces the blood flow to the intestines, slowing the digestive process. Such a treatment may be effective in addressing intestinal cramping and diarrhoea.

Upcoming Workshops

14 Jan 2012

Understanding the Iliopsoas

with Greg Morling

London

£150

15 Jan 2012

Arthritis: Advanced Techniques and Treatment Plans for

Bodyworkers

with Greg Morling

London

£150

21 Jan 2012

Understanding the Iliopsoas

with Greg Morling

Edinburgh

£150

22 Jan 2012

Thermal Stones for Remedial Therapists

with Greg Morling

Edinburgh

£150

** Discounts for attendance at both days

- Longer thermal stone treatments on the chest relieve respiratory congestion by relaxing the smooth muscles of the bronchioles, improving ease of breathing.
 - Menstrual cramping may be eased by extended thermal stone work on the pelvis.
 - The kidneys benefit from a prolonged heat application to the lower back or lower abdomen. As metabolism increases more filtration of the kidneys occurs and production of urine increases.
 - Longer heat treatment on the trunk also relaxes the bile ducts, which helps to relieve gall bladder conditions.
 - Prolonged heat to one limb induces vasodilatations in the contra-lateral limb.
- decreases the afferent (sensory) nerve firing the muscle spindle which causes a reduction in spasm and/or cramp.

Indications of Thermal Stone Application

Before applying heated stones you must take a full client history and check for any contraindications for using heat on your client. Many conditions benefit greatly from the application of thermal stones, both in the remedial and Swedish massage environment. The following list is a very good guide:

- promote injury/wound healing (following acute stage) following removal of stiches and/or bandaging
- non-inflammatory muscle pain and muscle spasm
- myofascial trigger points; these points respond particularly well to directed thermal stone. There are suitable reflex/trigger stones in most thermal stone sets.
- Delayed onset muscle soreness (DOMS) also known as 'muscle fever'
- Conditions involving spasticity. (people with multiple sclerosis do not tolerate heat well)
- Chronic tendonitis or tendonosis
- Chronic bursitis
- Scar tissue
- Soft tissue contracture; Joint contractures can occur primarily or most of the time secondary to neuromuscular imbalance. The knee joint is the most commonly involved followed by the ankle joint.
- Non-inflammatory joint pain
- Adhesive capsulitis
- Poor mobility in general. Working with thermal stones may increase ROM
- Osteoarthritis; particularly beneficial around hips and knees.
- Rheumatoid arthritis (not in flare-up stage)
- Anxiety
- Wry neck and other cervical conditions

(Morling G. 2003)

Skin; The Elephant in the Room – and on the Table!

'Although the skin has constantly occupied the forefront of human consciousness, it's strange that it should have elicited so little attention.' Montagu (1986)

When we discuss thermal stone massage and for that matter, massage therapy in general, we should recognise that it is the skin we touch and not the muscle. We affect the muscle but we touch the skin. We touch with our hands and we may also touch with warm stones. Touch from hand or stone stimulate several sensory receptors; (cutaneous receptors) and are generally of the mechanoreceptor, nociceptor, and thermoreceptor types. Mechanoreceptors sense pressure (such as touch) and vibrations and for example include Meissner corpuscles, Merkel disks, Ruffini corpuscles and Pacinian corpuscles. Nociceptors sense pain caused by damage and thermoreceptors convey feelings of heat or cold.

The safe stimulation of these receptors on the skin by the correct use of the thermal stones is a critical issue. Every skin is different and the skin sensitivity of individual clients will always vary. Caution must be exercised when applying heat from the thermal stones and of course thermal stones should not be used on inflamed tissue or when they are too hot for the client's skin. The magnitude and duration of application is a critical consideration when using thermal stones.

How heat administration through the use of thermal stone reduces pain has not really been studied or explained. Perhaps it is by altering pain nerve fibre conduction speeds, or raising nerve pain thresholds. Pain, secondary to muscle spasm can be alleviated by direct heat application to tender spastic muscle areas. Beneficial effects of increased blood flow to the tissues include facilitation of drainage and a "wash-out" effect, purging the tissues of debris and by-products of tissue injury.

Thermal stones are such a valuable tool for the massage therapist in clinical practice. They offer a new way to perform an inexpensive and effective pain reducing massage procedure for so many musculoskeletal injuries.

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The Nervous System, Guarding, Pain Reduction & Cramp

The effects of heat induced by thermal stone are not fully understood. We know that heat can have an *analgesic* effect. Theories range from placebo effect from the application of nurturing stones and hands to the idea that heat blocks the nerve impulses travelling to pain centres higher in the nervous system. Irrespective of the cause, it is obvious that thermal stone application not only diminishes pain, it can also reduce muscle guarding. It is believed that thermal stone elevates an individual's pain threshold, alters nerve conductivity, and decreases the firing rates of muscle spindles, which are the stretch receptors in muscles responsible for initiating protective reflex muscle contractions.

Reduction of efferent (motor) activity through the application of thermal stones in turn

Cranial Nerve II: The Optic Nerve by Maggie Brooks-Carter DO RGN SMTA

The optic nerve is sensory only and is around 4cm long. It leaves the orbital cavity by passing through the optic canal or foramen in the sella turcica of the sphenoid along with the ophthalmic artery into the cranial cavity. The optic nerve is surrounded by meningeal sheaths and these membranes fuse with the sclera on the posterior of the eyeball. The nerve is well cushioned by the orbital fat, but is still vulnerable to chemical or trophic disturbances in the cerebrospinal fluid around it.

The optic nerve is actually a central nervous system tract and therefore its axons are subject to CNS diseases such as MS and tumours. The blood supply can be affected, for example, in diabetes, blood vessels in the retina can become damaged.

Where the nerve passes through the **optic foramen**, at either side are the sphenoidal air sinuses. If there is congestion within these sinuses, pressure can build onto the nerve resulting in visual disturbances. The nerve is fixated at the superior surface of the fusing together, and with the periosteum covering the bones. This serves to stabilise the nerve and reduce movement in the orbit. By virtue of this fixation, the nerve is affected by the disturbances in the mobility of the sphenoid, its sinuses and also the ethmoid sinuses.

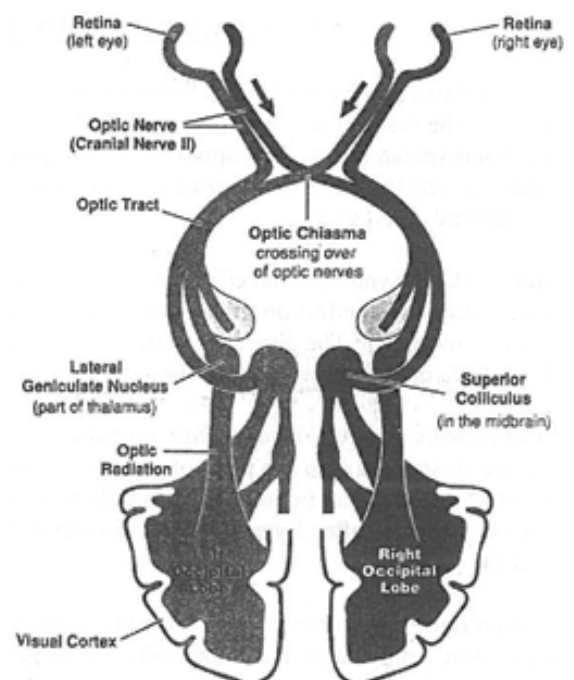
With any change in the position of the sphenoid i.e. side-bed, torsion etc., then difficulties with visual field will occur. If the sphenoid is fixed in flexion then this will tend to shorten the orbital cavities, thereby changing the focal point. This may result in long-sightedness (hyperopia). If the sphenoid is fixed in extension this may result in short sightedness. The same can be said with a derangement of any of the bones of the orbit i.e. frontal, sphenoid, maxilla, zygoma, palatine, ethmoid and lacrimal. Fixation of any of these bones may result in venous stasis or dural tension, therefore compression with resultant pain behind the eyeballs. By virtue of the relationship of the occiput, temporals and sphenoid, the venous sinuses, (particularly the cavernous and petrosal), may become congested, unable to drain adequately through the jugular foramina and this causes back pressure in the orbits.

If one greater ring of sphenoid moves anteriorly and the other posteriorly then one eyeball will be prominent and the other recessive, resulting in double vision (diplopia).

The torsions and shifts in position of the cranial bones can be caused by bony fixations or membranous strains.

The two optic nerves, having passed through the optic foramen, join up to form the **optic chiasma**. Here the nerves arise from the nasal side of the retina cross over to the other side. Fibres from the optic chiasma are attached to the 'lamina terminalis' of the brain and diaphragma sellae. The third ventricle is above and the diaphragm sellae overlies the **pituitary gland**. Thus, enlargement of the pituitary gland can cause visual disturbances such as tunnel vision. The carotid artery is lateral and the anterior cerebral artery crosses above the nerve just before forming the optic chiasma. Any pressure on the nerve from aneurysm of these vessels present very early as visual dysfunction.

The infundibulum of the hypothalamus is directly behind the optic chiasma and links the hypothalamus to the pituitary. Sphenoidal dysfunction therefore can lead to a variety of problems – visual, endocrine, temperature regulation and/or a loss/excessive appetite.



Upcoming workshops

14-15 January 2012

*Advanced Fascial Articular
Techniques:*

Cranio-fascial & Sacro-fascial

with Ralph Stephens &

Maggie Brooks-Carter

Aberdeen

£200 (pre 30/11/11)

The optic tracts emerge from the posterolateral angle of the optic chiasma. Because some of the fibres have crossed over at the optic chiasma, the optic tracts each contain fibres from both eyes; therefore input from both eyes will still reach the cerebral cortex even if one of the optic tracts is damaged. The optic tracts pass backwards around the lateral side of the midbrain to reach the lateral geniculate body of the hypothalamus. A small number of fibres, papillary and ocular reflexes, bypass the lateral geniculate body and go directly to the pretectal nucleus and the superior colliculus.

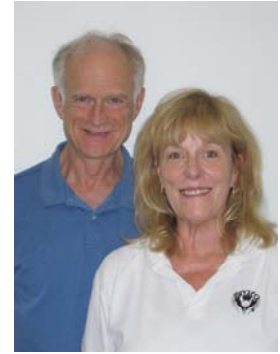
From the lateral geniculate the optic radiation curves backwards to the occipital visual cortex. By way of central connections, the optic nerve is in relationship to the oculomotor nucleus, accessory nucleus and the trochlear nucleus.

The medial root of the optic nerve supplies fibres, which synapse within the superior colliculus and send projections to the reticula formation (alertness to visual images) and pons (helping to retain posture). Projections from the lateral root of the nerve travel via the lateral geniculate body of the thalamus to the occipital visual cortex of the cerebrum. Due to the numerous tracts between the visual cortex and the cerebrum, vision is

important in interpretation, reading and visual memories. The periosteal lining of the orbital cavity is continuous with the dura mater of the cranial cavity therefore abnormal tension of the dura at any of its points of attachment i.e. frontal, temporal, occipital, foramen magnum, C2, C3 and S2 will all need to be examined when examining visual disturbances.

For the eyes to work to their optimum, drainage is essential so we will be working to ease off any restrictions while at the same time, balancing the orbit. We have to consider all the diameters of the orbit, as they will influence muscle action. We have to consider the frontal bone (inferior border), zygoma (orbital border) and maxilla (superior border). Usually, our techniques will include widening the orbit as well as working the muscles that operate the eye. Work on the sphenoid and palatine bones will be included in our treatment. We will also work to increase the drainage via the lacrimal glands. We can assist patients with glaucoma, astigmatism, nystagmus, cataract and diplopia.

As ever a full assessment of the cranium will be done prior to treatment and best results occur when the whole person is treated. This is, after all, a holistic therapy.



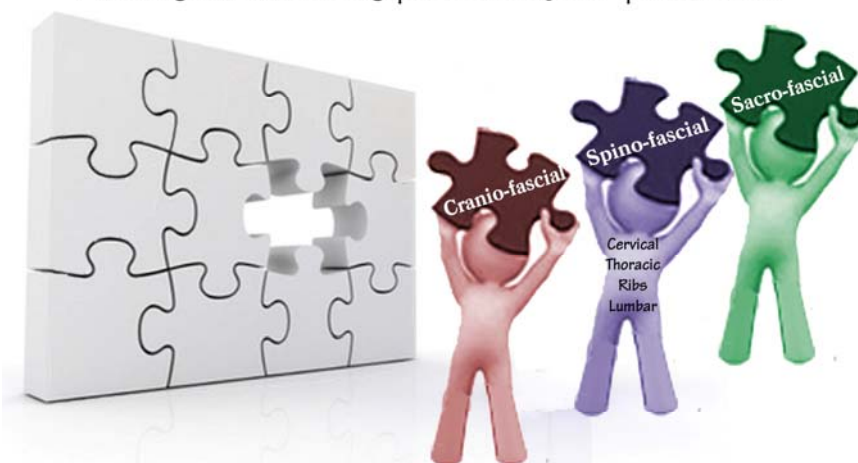
Ralph Stephens [2008 Inductee - Massage Therapy Hall of Fame!] is an internationally recognized instructor, therapist and author who has been practising massage since 1986. One of a few master instructors in the profession, Ralph clearly presents what you need to know to help people in a way that you can take it home and use it immediately. He is known for making complex anatomical concepts easy to understand and fun to learn.

Ralph has worked with many world class athletes and was Sports Massage Team leader for the 1990 World Disabled Skiing Championships. He has produced 16 training videos, a textbook [Therapeutic Chair Massage (LWW-2006)], and many articles. He presents advanced continuing education seminars in Sports, Medical and Chair Massage, helping people like you help more people. In 1997 he was awarded the AMTA National Meritorious Award for commitment and dedication to the profession.

Maggie Brooks-Carter qualified as a Registered General Nurse in 1972 and then as a result of nursing induced back pain discovered Osteopathy and then Massage Therapy!

On the path to this discovery Maggie taught exercise classes, aerobic classes, instructed instructors in the USA, jogged many a kilometre and taught weight training in various gyms in the USA (including President and First Lady) and Aberdeen (Credo, Nautilus and Warehouse). Maggie trained in Swedish Massage, Remedial Massage, Manipulative Therapy and then Osteopathy where she met Nick Carter who was already teaching. They combined forces to form the Brooks-Carter Clinic, Scottish Massage Schools and the Scottish Massage Therapists Organisation. Scottish Massage Schools started in 1992 as Grampian School of Massage in Aberdeen. In these days, massage was not commonplace and promotion and education were essential. Now Maggie has sold Scottish Massage Schools but her teaching qualifications will not all go to waste as she is launching a new series of Advanced Fascial Articular techniques workshops with Ralph!

Finding the missing piece for your practice...



Advanced Fascial Articular Techniques
with Ralph Stephens & Maggie Brooks-Carter

Getting to the source of the Pain

Some thoughts by Paul Lewis

Are your clients coming to you with the same issues over and over again. Maybe I will try this or that next time---Are we really getting to the source of the client's issues or are we only addressing the referred pain and giving a temporary solution to an ongoing issue. For example, if a client comes to you with stiff neck and shoulders, or reports numbness in the hand or lower leg. what would you do next? Pause for a moment and ask yourself , "what do I usually do in each of these situations?" Do you say to yourself, "I have seen this before. I know what to do." Do you ask the client to go directly on the table or chair so you can test out your new modality.

Do you find yourself bypassing the fundamental and important pre and post assessment of the client which should be as natural to therapists as a reflex response. Void of assessment, how do you know you are actually helping and not adding fuel to the fire. I believe our assessment and palpation of client issues are fundamental which (we)therapists need to use each and every time a client come to see us.

Implementation of these skills not only help to give you a base line from which to measure the efficacy of the treatment, but more importantly, the assessment will give you a better idea as to which structures to address. Assessment helps support your reasoning and rational behind the modalities and techniques used. I believe that assessment is vital to the planning of the treatment plan and supports the basis for applying various modalities. Applying joint mobilizations to the AC joint, Myofascial work to the abdominal area or segmental stretching to the SCM just for the sake of it in hopes of relieving the clients issues is like guess work.

They say word or mouth is one of the best forms of advertising. Every time a client comes to see us, we are promoting the profession and the professionalism and experience experienced by one can go a long way. Is the assessment part of your treatment?

For more information on Paul Lewis visit: www.paullewis.ca

Advanced Treatment Techniques for the Upper Body using Dynamic Angular Petrissage (DAP)

This workshop will be taught primarily through therapist hands-on participation, demonstrations and group discussion. Focus will be Neck, Arms and Shoulder Girdle. Therapists will learn and practice regional advanced treatment techniques to be more efficient and effective in accessing and treating functionally problematic muscles and fascia in selected upper body regions such as the neck and shoulder girdle.

This workshop will start with a common case presentation of a client to effectively look at the symptomatic presentation in order to support the clinical reasoning and rational for techniques, modalities, treatment positions and structures addressed. The introduction of Dynamic Angular Petrissage (DAP) will be used to augment the treatment and reduce treatment stresses on the therapist. Therapists will be introduced to and practice the various Swedish techniques, modalities and treatment positions based on the evaluation of the case presented. Postural positioning for safe application of techniques along with self care exercises will be introduced and practiced. The course will wrap up with an assessment of the participants and problem solving within the group setting.

Learning objective

At the end of the course the learner will have:

- Demonstrate proficiency in Accessing, Activating and treating various muscles in the upper body
- Demonstrate the ability to apply the concepts of DAP to augment massage treatment
- Identify and demonstrate postural positioning for safe application of techniques
- Learn and practice upper body treatment techniques to reduce stress on the therapist
- Reliably demonstrate the ability to determine through reasoning which structures to address

Course structure / running order:

- Case Study, Appropriate anatomy review
- Introduction of Hand saving techniques
- Body Mechanics, Advanced techniques
- Problem solving and reasoning
- Client comfort

28 page course booklet provided.

Presenter: Paul Lewis

Date: 21 October 2011; 9.30am - 6pm

Venue: London School of Osteopathy, 12 Grange Road (off Tower Bridge Road), **London** SE1 3BE

Cost: ~~Normal price £150~~ **Special price £95** *thanks to the sponsorship of Massage Table Store, Oakworks & Bodywork Professional Development*

To book: 07526 925734 or info@bodyworkcpd.co.uk *Payments accepted by cheque, bank transfer or credit/debit card.*

Paul Lewis is also lecturing and demonstrating on **Post-surgical Therapy for Mastectomy & Implants** from 6pm to 9pm on Friday 14 October 2011 at the British School of Osteopathy, London. Cost £37



Post-surgical Therapy for Mastectomy & Implants

This three hour lecture by Paul Lewis (Canada) will be taught with lecture and some demonstrations. The aim is to bring together learned assessment and techniques to address post surgical issues. Upper body treatment techniques with a focus on engagement techniques using Dynamic Angular Petrissage (DAP) will be introduced.

Topics discussed and techniques demonstrated include: Client comfort and care, assessment techniques, use... of hydrotherapy, segmental stretching, Myofascial treatment techniques, Joint Mobilizations and draping for client comfort.

A case study will be used to look at the client symptoms in order to support the clinical reasoning and rational for the techniques and modalities utilized. Therapists will be introduced to techniques that reduce stress on the therapist. In addition self-care exercises will be covered for ongoing client treatment and recovery. An overview of breast massage techniques/scar treatment will be discussed.

Presenter: Paul Lewis

Date: 14 October 2011; 6pm - 9pm

Venue: British School of Osteopathy, 275 Borough High Street, **London** SE1 1JE

Cost: **Special price £37** thanks to the sponsorship of *Massage Table Store, Oakworks & Bodywork Professional Development*

To book: 07526 925734 or info@bodyworkcpd.co.uk *Payments accepted by cheque, bank transfer or credit/debit card.*

Don't Rub Your Eyes – Massage Them by Ralph R. Stephens BS Ed

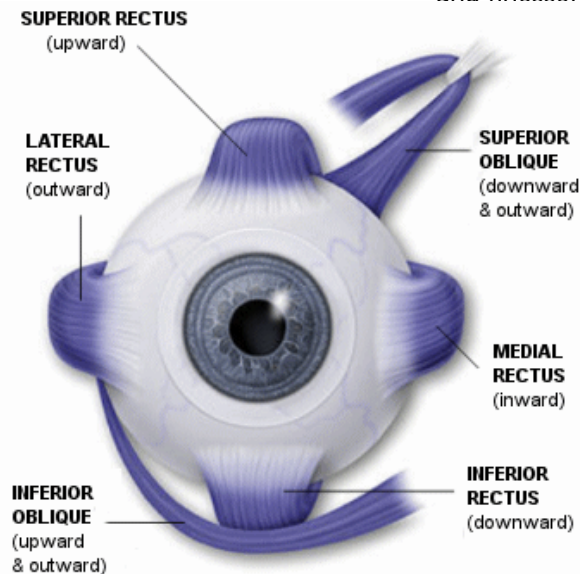
Just like muscles move and hold bones, they also move and hold the eye ball. These muscles can have the same dysfunctions as muscles anywhere else, but in addition can add pressure to the eyeball, adversely affecting vision and eye movement.

Orbital fascia forms the periosteum of the orbit but interestingly it is attached to the dura mater via the optic foramen and superior orbital fissure and also the optic nerve sheath. The orbital septum is formed from a branch of the elongation that connects to the anterior orbit. From the septum the fascia encloses the lacrimal gland and the superior oblique muscle.

Delicate and precise massage techniques can be utilized to examine and normalize the muscles of the eye and bring about positive vision improvements for many people. Conditions that have benefited from treating the muscles of the eye include, cross-eyes, lazy eye, close and distant focusing, as well as some headaches.

The muscles examined in the eye technique sequence of Advanced Fascial Articular Techniques seminars include:

- Corrugator
- Orbicularis Oculi
- Recti Superioris *superior rectus*
- Recti Inferioris *inferior rectus*
- Recti Medialis *medial rectus*
- Recti Lateralis *lateral rectus*



- Superior Oblique
- Inferior Oblique

The treatment will be working with the oculomotor and abducens Nerve (cranial nerves III & VI) loops as well as the zygomatic and temporal branches of the facial nerve.

The techniques for addressing these tissues are not particularly difficult or dangerous, but do require precision and finesse. We do not feel it is responsible to release them to therapists in an article such as this without initial supervision in their use. They will be presented as part of the new Advanced Fascial Articular Techniques (AFAT) workshop series by this author and Maggie Brooks-Carter.

I can't think of anyone who won't benefit from this natural form of eye care. Come study with us in Aberdeen, Scotland, January 14-15, or Cedar Rapids, IA April 14-15. Other dates and courses to be announced soon. We look forward to sharing this exciting, unique information with you.

These courses are being offered on a limited time basis.

For USA dates www.ralphstephens.com

See page 5 of this issue for more details about Ralph and Maggie.

Be the first to join
Ralph Stephens &
Maggie Brooks-Carter
as they launch their new
CPD opportunity in the
UK & USA



Put more AMPs into your sessions by Robert Schleip PhD

Advantages & Tips for Active Movement Participation (AMP) of the client during the hands-on myofascial work

Advantages:

- Generally any active motor output tends to decrease the **pain sensitivity** (even if the movement would be totally unrelated to the working area)
- Client feels **more involved** (and responsible) in the Rolfig process
- Slow and subtle body movements tend to trigger a more **trophotropic** state (relaxed, parasympathetic) and therefore a lower general muscle tonus in the whole body.
- Increases **body awareness** in the client (specifically in the moving body parts)
- The dynamic interplay of "stretch" and "slack" of the moving fascial or muscular fibers under your hands can allow you to reach deeper (to deeper fascial layers) through certain **"windows"** that you feel opening in the "river" of constant flow of the connective tissue fibers under your hands.
- Can be used in a specific way to have the client stretch (or lengthen) a particular fascial sheet against the pressure of your working elbow/knuckle/fingers (e.g. elbow to the side while you work on the pect. major). The effect of this specific application can be explained with the increased stretching force on the mechanoreceptors of this tissue.
- Can be used in a specific way to have the client contract a particular muscle while you work (push, lean, sink) on this muscle. This simultaneous contraction brings a very high degree of nervous system attention to the working area (e.g. especially via the Golgi receptors in the fascial envelope) and often results in a significant tonus deregulation

immediately after the Rolfer's hands are removed. Example: while working on upper pecs, you ask the client to pull this shoulder forward against your hand with different degrees of strengths (e.g. 50%, then decreasing slowly to 20%, increasing to 60%, then slowly letting go to 40%, 30 –20-10 and finally zero %).

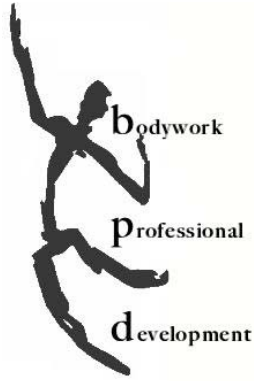
- As an **educational tool** to include the functional change of the work, e.g. teaching a movement quality that is initiated by lengthening rather than contraction).
- To break habitual and limiting movement patterns by showing **new options** (e.g. if the pelvis always goes into an anterior pelvic tilt in any hip flexion, have the client explore the opposite pattern (knee and tailbone forward simultaneously).
- Leading from undifferentiated to **differentiated** movements (e.g. if pelvis and whole ribcage tend to behave like one block, you can teach differentiated rotations in the sidelying position (first pelvis, then ribcage, or only pelvis, etc.)
- Generally: **Active motor learning** is the fastest and most effective way of learning of our nervous system (Sherrington: *'The motor act is the cradle of the mind.'*)

Tips:

- **Describe movement directions** in a language that relates to the client's body as reference point, instead of to the outside room (e.g. "*knee forward*" instead of "*knee up*" in supine position). Yet the first couple a times you might use dual context descriptions with the body reference first and the outside room reference second (e.g. *'Let your tailbones come forwards, towards the ceiling'*);

changing it later gradually to the body reference descriptions only.

- Include so called **right brain oriented** descriptions and images
E.g.: *flower opening its petals, wings opening, growing a long heel all the way to the end of the room, a string pulling on your nose to the left, a deer rubbing its back at a tree, spanning a sail between your elbow and your back;* etc.
- Ask for **subtle** movements. The smaller the movement, the more effective the new information is for the central nervous system (Weber-Fechner Law)
- When using **language** to describe a movement, be aware that our cortex organizes movements in SKELELTAL (and not muscular) terms and thinks always in directions. It also prefers to organize the DISTAL elements of a movement. Therefore use a language that describes the direction of the most distal skeletal part (e.g. instead of "*Lengthen your deltoid*" say "*Let your elbow float away from your shoulder down towards your right foot*")
- Stay in constant **verbal contact** with the client ("*yes ...very slowly... yes ...that's nice, now, slowly backwards...even slower...yes ...just a tiny smidgen ... yes! ... that's it .. hmm ... and now let your...*" etc.)
- Move from simple movements to more complex and sophisticated ones, finally leading to very differentiated movements that are new and **non-habitual** to the client (and of course related to the work of this particular session).



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An optimal use of AMPs could include the following elements:

- **Finding out** where the client has limited choices of movements that are related to the main goal(s) of this session in this particular client
- Asking for his most familiar movement pattern related to this complex (e.g. hip flexion together with lumbar shortening). Then breaking that up in **minor steps** towards a new and unfamiliar option.
- **Example** for a person with habitual anterior pelvic tilt during most knee forward motions (application here in the sidelying 3rd or 4th hour position):
A) Separate motions: having client move only the knee forward/back couple a times. Then only tilting the pelvis a couple a times.

B) Habitual combination: Then anterior pelvic tilt ('sitbones backwards') and knee forward at the same time. First with the initiation of the this combined movement at the knee, then at the sitbones.

C) Interspersed second joint motion: Tilting pelvis with sitbones forwards. In this position sliding the knee forwards once and then backwards again. Then tilting the pelvis with the sitbones backwards. In this position slide the knee forwards once and then backwards. Repeating this cycle until it becomes fluent and familiar (usually 3-6 times).

D) New combination: Finally the new & unfamiliar combination pattern: 'Start by tilting your sitbones forward, then slide your knee forward too. Then bring the sitbones back and let the knee follow backwards too. And let's start again: your sitbones float forwards as your lower back lengthen, then your knee slides forward to continue that motion,' etc. When fluent, let the client gradually change from a sequential movement (first sitbones, then knee) to a more smooth simultaneous one.

During all these steps (takes 2-5 minutes the first time) you continue to work on the connecting fascia between knee and pelvis, e.g. in 3rd or 4th hour.

- **Closing** the session with having the client feel their new mobility - and comparing it with the old pattern - in the gravitational field (e.g. legs swinging from LDH in walking) and combining it with some specific "home work" or movement cues.

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