

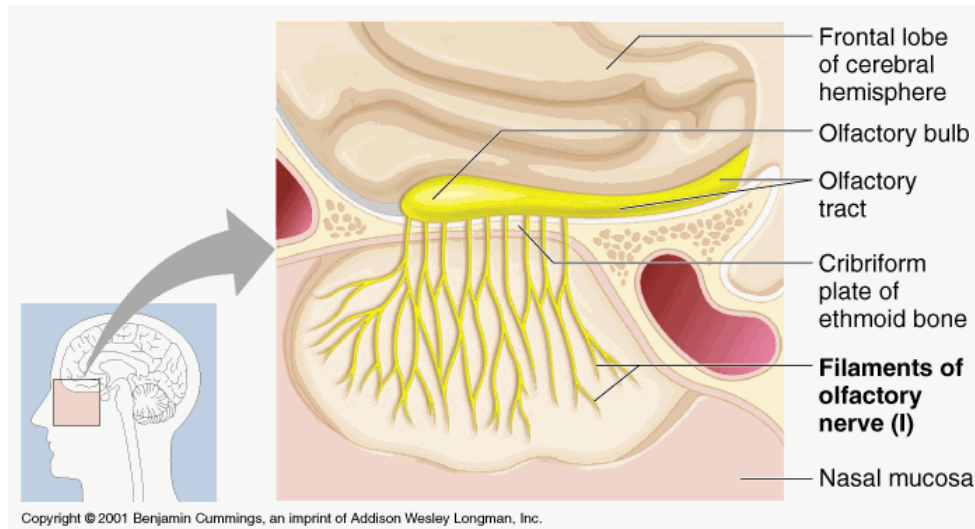


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## *Cranial Nerve I: The Olfactory Nerve* by Maggie Brooks-Carter DO RGN SMTD



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So how is your sense of smell? Us ordinary mortals can probably only sense eight or nine thousand smells. Those who practice the art of smelling wines and perfumes will far exceed us – I think I saw a figure of over 10,000 different smells. This sense is vital to life and safety, warning us to take action, for example, if we smell smoke. Diseases can be recognised by their smell e.g. the smell of the diabetic coma is described as 'newly mown hay'. In the past, doctors used their sense of smell to note the health of their patient. The sense of smell does diminish with age and females tend to have a better sense of smell.

Clinical Aromatherapy is the therapy that really utilises the knowledge gained over many, many years that inhaled scents can have incredible effects. Clinical Aromatherapy has been used in weight loss when the study used smells of foods in a nasal inhaler. This worked as Dr Hirsch explained, 'Odours have a direct effect on the satiety centre in the brain which is the area that tells your body when you've had enough to eat. Continual exposure to pleasant food aromas indicates to the brain that the body is satisfied and does not need to eat'. (*Aromatherapy: Health benefits of the Science of Scent*). Aromatherapy is another area that I cannot hope to cover here - suffice to say I think we all feel even better if our relaxing massage included our favourite smells. Certain oils stimulate the thalamus to secrete enkephalins e.g. clary sage. Other oils act as aphrodisiacs. Others are used as antibacterial, antiviral, antifungal - the list is endless.

The rhinencephalon is the part of the Central Nervous System involved in olfaction – 'the nose brain' and is associated with a person's emotional tone. Smell can evoke happiness, fear and sexuality.

The olfactory nerve is solely a sensory nerve and is the one cranial nerve that doesn't go through the thalamus (the relay centre) for the actual sense of smell. Only, when memories are involved, will this happen. The olfactory tracts don't cross. Taste and smell cells are the only cells in the nervous system that are replaced when they become old or damaged.

### **Olfactory Epithelium**

The chemicals (assuming they are small enough to be volatile and dissolve in the mucus) diffuse across the mucus membrane, to the cilia stimulating the olfactory receptor neurone. Thus, it is a chemosensing nerve – the actual chemicals creating the smell are involved (a bit like taste). Taste and smell senses are intricately related. Try holding your nose while eating chocolate! It will make it more difficult to say more than it is a sweet flavour.

The mucus is constantly replaced allowing new odours to be smelt. If the mucus becomes thick, the sense of taste is affected. This is why things do not taste as good when we have a cold.

Each of the neurones manufactures a specific olfactory receptor protein, this allows our sense of smell to be very specific. Humans can detect seven primary odours. The different smells we differentiate are floral, minty, camphoric, musky, ethereal, pungent and putrid.

Thus, the sense of smell involves the olfactory nerve endings in the upper part of the interior of the nose. Aromas can reach these nerves either directly through the nostrils, as in breathing, or indirectly up the back passageway from the mouth – these are the best ways to stimulate the olfactory nerve endings. There are 50 millions sensory receptor cells in the olfactory epithelium with about 10 - 20 cilia for each neurone.

The olfactory nerves enter the nares where they divide into two groups:

- i. inner group over the upper third of the septum
- ii. outer group over the superior turbinate and surface of the ethmoid in front of it. The filaments then descend to form a complex network.

Fibres of the olfactory nerve originate as primary, central processes of olfactory receptor nerve cells in the mucous membranes of the upper part of the nose (above the superior concha). Bundles of these fibres pierce the cribriform plate of the ethmoid and end in the olfactory bulb in the anterior cranial fossa.

**The olfactory bulb** contains the nerve cell bodies of the secondary sensory neurones which are involved in the relay of olfaction to the brain. This is where the smell is recognized. Each smell molecule fits into a nerve cell like a lock and key. The olfactory bulb is part of the limbic system which links our sense of smell with behaviour, memory, motivation and mood.

The olfactory bulb lies on the cribriform plate of ethmoid bone which protects it. It is perforated by olfactory nerve axons. The bulb is divided into the main olfactory bulb and the accessory olfactory bulb.

The olfactory tract lies in the olfactory sulcus on the undersurface of the frontal lobe and splits into two roots:

- i. Outer root passes across outer part to the nucleus amygdala and the anterior part of the hippocampus
- ii. Inner root turns sharply inwards and ends partly in Broca's area and partly in the callosal convolution

**The olfactory tract** is a white band which emerges from the posterior aspect of the olfactory bulb and consists of post synaptic fibres of the secondary sensory neurones, passing backwards to attach to the cerebrum in the region of the anterior perforated substance. It ends by dividing into medial and lateral olfactory striae which enter the frontal lobes of the brain. It then travels posteriorly through the substance of the brain to the hippocampal areas. Associated fibres link these areas with the tegmentum, the pons, and the thalamus. There is also a reflex relationship with the trigeminal nuclei, the glossopharyngeal nerve, the vagus and hypoglossal nerves.

The brain interprets the good or bad smell but this is also closely connected to our memory. Spraying cinnamon around a house that is up for sale helps the prospective buyer think of home and oven baked cookies, baked in the good old days! He or she is then far more tempted to buy. Realtors and estate agents use this trick! Try it yourself. Again, this involves the limbic system and it is only after this relay has occurred that the information is passed to higher cortical brain regions for perception and interpretation. Smell is unique as it goes direct to the subconscious.

### Lesions

The olfactory nerve is not protected in its entirety. It is vulnerable in the face so can be damaged when there is a nose fracture. Exposure to harsh chemicals, strong odours, and certain types of infections can also cause damage.

Lesions to the olfactory nerve can occur because of blunt trauma, meningitis, and tumors of the frontal lobe. They often lead to a reduced ability to taste and smell.

Fractures parallel to the sagittal suture of the skull can cause tearing of the olfactory fibres that cross the cribriform plate and can cause unilateral anosmia.

Hitting one's head on concrete is another way to damage olfactory fibres which can be torn from the cribriform plate. These fractures can also result in leakage of cerebrospinal fluid into the nasal cavity as a result of leakage from the subarachnoid space. Obviously, germs can then enter the cranial cavity with devastating effects.

However, lesions of the olfactory nerve do not lead to a reduced ability to sense pain from the nasal epithelium. This is because pain from the nasal epithelium is not carried to the central nervous system by the olfactory nerve; rather, it is carried to the central nervous system by the trigeminal nerve (cranial nerve V). (See previous article on the trigeminal nerve.)

### Potentials for problems that will hopefully respond to Craniofacial work

On reaching the roof to the nasal cavities, the sensory receptors in the nasal mucosa convert the chemical particles of odour into nerve impulses by mixing with the fluid secreted by the mucous membranes. This activates the receptors. Any change in the quantity or the quality of the fluid will result in limitation of the olfactory system i.e. runny nose, congestion, dryness.

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#### Upcoming workshops

8 January 2012 @ 8pm GMT

Advanced Fascial Articulatory

Techniques (details to follow)

with Ralph Stephens &

Maggie Brooks-Carter

Online webinar LIVE from Scotland

£10

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14-15 January 2012

Advanced Fascial Articulatory

Techniques:

Cranio-fascial & Sacro-fascial

with Ralph Stephens &

Maggie Brooks-Carter

Aberdeen

£200 (pre 30/11/11)

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5-6 May 2012

Advanced Fascial Articulatory

Techniques:

Spino-fascial (2 days)

with Ralph Stephens &

Maggie Brooks-Carter

Cedar Rapids, Iowa

POA

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19-20 May 2012

Advanced Fascial Articulatory

Techniques:

Cranio-fascial & Sacro-fascial

with Ralph Stephens &

Maggie Brooks-Carter

Albuquerque, New Mexico

POA

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Each bundle of sensory fibres is ensheathed in dura/pia mater membranes which are continuous with the periosteum of the nasal bones, therefore any disturbance in either the nasal bones or surrounding membranes will result in abnormal tension of the dural membrane and vice versa.

Abnormal tension can also arise if the mobility of the ethmoid or frontal bones is impaired. Medial compression, unilaterally or bilaterally can interrupt nerve function and cause loss of smell.

Narrowing of the ethmoid notch causes compression to the ethmoidal and frontal sinuses thereby causing congestion and/or nasal drip. Due to the attachments with the sphenoid and vomer to the ethmoid, any pressure, congestion or malfunction in the mobility of these bones can also interfere with the proper function of the olfactory nerve.

Mollanji et al 2002 Silver et al 2002 This study showed that 50% of cerebrospinal fluid clearance is via the lymphatic system in dogs. This occurs via the olfactory nerve and around the cribriform plate to connect to the nasal lymphatics and then to the cervical lymphatics. Working on the cranium to enable the ethmoid to be free to move will have profound effects on drainage.

The ethmoid does become swollen in sinus conditions. Gentle rhythmic pulses can be applied to the frontal bone and maxillae affecting the sutures involved with the ethmoid. The ethmoid articulates with the frontal bone, crest of nasals, septal cartilage, superior anterior border of vomer, crest of sphenoid, superior and inferior nasal conchae, orbital plate of palatine (thus it helps form orbit), frontal process of maxilla and the posterior border of lacrimal. Thus work on the temporomandibular area and working to release sphenoid will all effect ethmoid function.

Septal deviations are referred to the ethmoid. This may be due to facial development not being by the book. The ethmoid is always considered

with the sphenoid, frontal, zygomatic and maxillary bones - all of which benefit from craniofacial work

The connections with the olfactory system with other centres of the brain, which receives input from the senses of smell, sight, hearing and balance and because the limbic system connects with the thalamus, hypothalamus and pituitary gland, emotional problems may arise with dysfunction in any of these areas.

The olfactory fibres which reach the hippocampus are important in helping us to remember smells and to be aware of when they have been encountered previously.

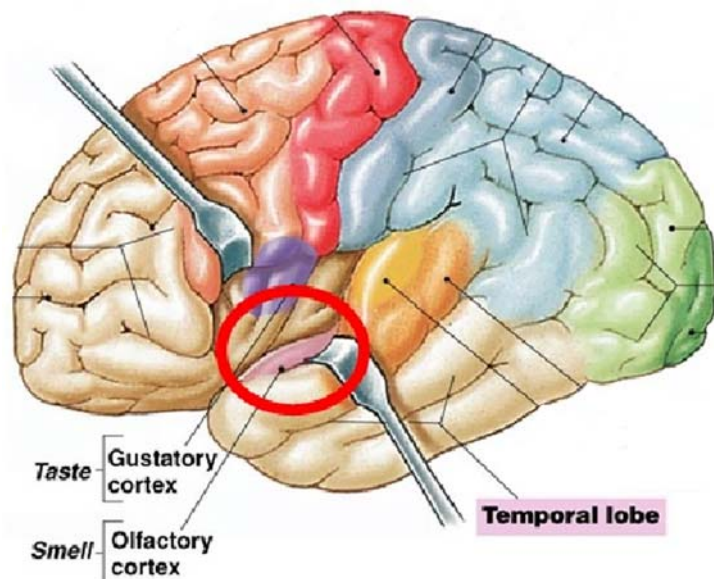
Olfactory sensory stimuli can also affect endocrine function by virtue of its relationship with the thalamus, hypothalamus and the pituitary gland. The olfactory system also provides sensory input to the pons which interconnects between the cerebrum and the two halves of the cerebellum. It is believed to help control breathing, REM sleep and the onset of dreaming via the reticular system.

There has even been research linking anosmia to Alzheimer's disease and memory loss.

Cranial manipulation, massage and of course, Advanced Fascial Articulatory Techniques (AFAT) can be helpful for cranial problems and conditions. Ralph and I will be presenting ways of releasing the facial fascia so that the olfactory nerve can work to its optimum. With the strong link to the endocrine system and emotions, work on the head and face is usually very much appreciated. In fact, I find clients are totally amazed at the improvements that occur as a result of these techniques that will be part of our Craniofacial workshop.

In regard to the olfactory nerve, I think all our senses our heightened after a face massage so doing that bit more to bring the cranium into balance is exciting. Working on and in the nose itself has far reaching effects not only on sinus problems but also on the cranium as a whole.

*See back page for details on Maggie Brooks-Carter.*



*Olfactory cortex located in the uncus on the ventral surface of the temporal lobe*

*q&art* by Art Riggs**DISTAL VS. PROXIMAL WORK**

DEAR WHICH WAY,

Early in my education, I learned that any test question that used the word *always* was most likely a red light to mark the answer false or to choose another option. Your question illustrates a common theme that arises in this column. I will address the tendency of unquestioning adherence to inflexible rules in a future column, but will say now that we all need to constantly examine our techniques and belief systems in light of new information, or we risk stagnation, boredom, and less effective work.

The common knowledge you mention is due to the emphasis early Swedish massage had on moving superficial venous blood and lymph in its normal direction of flow. Although this is indeed a good reason, some teachers imply that working in the other direction is harmful, thereby scaring their students from doing any distal work. Yet, working distally is very beneficial in implementing the goals of other bodywork systems, such as therapeutic/medical massage, structural work for posture or improved joint function, and even in subtle work to help the flow of energy outward from the core. What's necessary is a clear understanding of your therapeutic goals. An excellent bodyworker will take the best of many different philosophies and apply them in varying degrees with each client, as the need arises.



DEAR ART,

You and several other writers in *Massage & Bodywork* often demonstrate strokes moving in a direction away from the heart. I was taught to always work toward the heart and don't feel comfortable working in the opposite direction. Can you please explain your rationale? Is your direction really safe?

~ WHICH WAY TO GO?

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*Upcoming workshops*

Jan/Feb 2012 @ 8pm GMT

*Deep Tissue Massage &  
Myofascial Techniques*  
with Art Riggs

Online webinar LIVE from California  
FREE

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9-11 March 2012

*Deep Tissue Massage &  
Myofascial Techniques for Hip,  
Knee & Foot*  
with Art Riggs

London

£275 (pre 31/12/11)

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Here's a passage from one of my favourite anatomy teachers, Gil Hedley, that reinforces what I've heard from every medical and anatomy expert I've checked with regarding the safety of working distally: "From an anatomical perspective, you can do damage in any direction with bad work, and you can do good in any direction with appropriate contact. If you are a machine programmed to touch, like one of those massage chairs, that might be a case where it would be best to set the program in a particular direction, as the power to discriminate is absent.

But in a conscious practitioner, working with a generally healthy client, the direction that's best to work in is the direction that gets results."<sup>1</sup>

Although there are, indeed, many reasons for working in a proximal direction, there are many other benefits when it comes to not limiting yourself with hard and fast rules. It's really pretty simple: I often get excellent results working distally. Most of the problems that our clients present with are a result of short and tight muscles that cause pain or prevent proper movement. It just doesn't make sense to bunch these muscles by always pushing them into further shortening. Especially for deep work, it just plain feels better to work in a distal direction.

Here are some of the advantages of thoughtful, distal stroke direction:

- Since most muscles attach proximally in order to exert force proximally, working distally lengthens short muscle fibres and fascia for lasting relief from contraction which limits joint function and causes discomfort.
- It frees and lengthens nerves that have shortened along with the muscles.

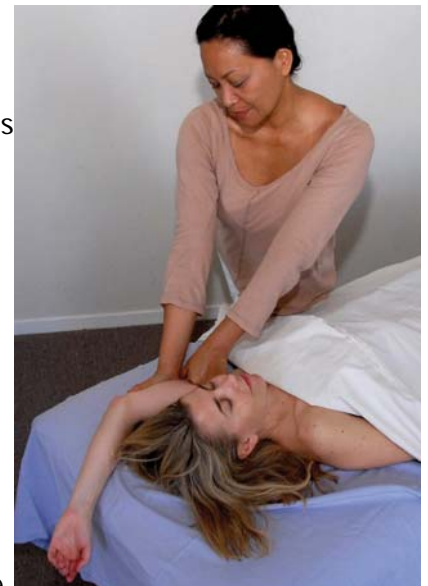


*Both practitioners and clients love this technique because it lengthens the entire leg and decompresses the hip. Very little effort is used to sink deeply into the hamstrings by leaning with your body weight (it also works fine for quadriceps and the iliotibial band). After sinking, all the energy is directed by pushing of the right leg in a distal direction, while the left hand applies force downstream at the ankle or lower leg. This affords a great stretch all the way down from the quadratus lumborum to the ankle, while decompressing the hip, knee, and ankle*

- It decompresses joints and releases tight ligaments for better osseous function.
- Possibly the most important benefit is that working distally helps train our clients to override protective holding and reprograms movement patterns as they release in the direction of lengthening and relaxation.

So, by all means, continue working proximally with clear goals, but rest assured that you can also safely work in the opposite direction to achieve additional benefits. As with all of our work, the key to effective therapy - and the fun of creative thinking - is to let the needs of our clients dictate our therapeutic practice.

*Art Riggs teaches at the San Francisco School of Massage and is the author of Deep Tissue Massage: A Visual Guide to Techniques (North Atlantic Books, 2007), which has been translated into seven languages and the seven-volume DVD series Deep Tissue Massage and Myofascial Release: A Video Guide to Techniques. Visit his website at [www.deeptissuemassage.com](http://www.deeptissuemassage.com)*



*Extending the arm above the head while lengthening the triceps away from its origin can provide decompression of the shoulder, as well as free abduction. If joint mobility is limited, you can support the arm with a pillow.*

#### NOTE

*1 Gil Hedley presented the most exciting anatomy class I've ever experienced, and I highly recommend his teaching and DVDs. Check out [www.gilhedley.com](http://www.gilhedley.com)*

## *The Back: Anatomy, Energy & Fulcrums* by David Lauterstein

### **THERE IS NO BACK**

Strictly speaking there is no back. No more is there really a "back" of the body than we would talk about the back of an orange or a banana. The human torso is a slightly flattened cylinder with the spine running right through our centre.

Though we can feel the so-called "backbones," these are just the little bony tails, the tips of the spinous processes, projecting posteriorly from the vertebral bodies. The main structural, weight-bearing elements of the spine are the vertebral bodies which lie in our centre.

I remember years ago in Chicago I had a lawyer client who appreciated my excitement for learning anatomy and mentioned that she could get me into the Cook County morgue...as a spectator of course!

So one day we headed on down, and it felt like *down*, to the underworld of the Cook County Morgue. I saw for the first time many recently deceased bodies. I saw a number of people who had been reported on the previous night's TV news. They looked like they could jump up and say hello.

One young man who'd recently passed was lying there. Where his stomach ordinarily would have been, there was this reddish column. At first I had no idea what it was. But soon I realized -it was the front of his vertebral column in the lumbar region! At that point, his spine was closer to the front of the body than to the back.

Since then I've never forgotten it -the spine is not mostly posterior in our bodies, it is in our centre.

### Anatomy

Skeletally the back consists of the vertebrae and the ribs. It is important to remember that in so far as the spine is back's centre, the back continues well down between the two halves, the ilia, of the pelvis. If you draw a line between the two iliac crests, that would be at the level of the third lumbar vertebrae. Beneath that level are two more lumbar vertebrae and the five-fused vertebrae that constitute the sacrum and the five-fused vertebrae constituting the coccyx.

In its upper region, the back doesn't end at the top of the ribcage but extends up through the seven cervical vertebrae to the occipital bone at the base of the head. So "the back" is considerably longer than we generally envision it.

Muscularly the back is composed of a number of major layers:

- The first is latissimus dorsi and the trapezius. Interestingly these are basically shoulder girdle muscles, latissimus inserting on the front of the humerus and trapezius inserting on the clavicle and scapula.
- The next layer, the rhomboids, is also shoulder girdle muscles, inserting on the scapula.
- The third main muscle layer is the erector spinae, the first layer of back muscles proper. The erector spinae are three strands of muscle on either side of the spine. Like vines climbing up a trellis these three muscles climb up the back. Laterally you have the iliocostalis attaching to the pelvis and ribs; intermediate, the longissimus, attaching to the pelvis, ribs and the vertebral transverse processes; and medially, right next to the spinous processes, the spinalis.
- The fourth main layer is composed of the multifidus and rotatores running from transverse processes up to spinous processes
- The fifth layer is the quadratus lumborum running from the "inner lip" of the iliac crest up to the transverse processes of the lumbar vertebrae and the undersurface of the 12<sup>th</sup> rib

### Structural Considerations

Over time, stress and the pull of gravity tend to result in a more compressed spine. Eventually that can lead to back pain even to slipped discs, sprained ligaments, straining muscles. So the most important thing you can do for a back is to decompress it.

In addition we spend too much of our time leaning forward rather than back. So our back muscles are pulled forward with us. Thus, the muscles here need decompression and they need to be pulled "back".

### Energetics

Energetically the back represents many levels of potential existential meaning. Hippocrates himself said tellingly, "Get thee knowledge of the spine, for it is the source of many diseases."

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#### *Upcoming Workshops*

19/20 May 2012

*Deep Massage: The Lauterstein Method – Back and Neck*

*with David Lauterstein*

London

£225 Early bird £200 (by 31/01/12)

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Equally it is the source of many virtues.

From the back, we acquire self-support especially through the lumbar region. This can translate into the feeling of supporting oneself emotionally and/or economically. I remember in 1988 I learned I was to be audited by the IRS. My back immediately went into spasm. I thought, "Oh this is too textbook – challenged support = back spasm."

Other possible energetic issues have clearly been grasped by the wisdom imbedded in everyday expressions:

"Have a backbone!" recognizes the back as a primary source of strength and steadfastness.

Since the back and front are somewhat fictitious – us being slightly flattened cylinders – it is also relevant to look at the back as well the intestines as related to having "guts". Courage is essential to a healthy back. The tonus of the back and abdominal muscles, in turn, helps sustain courage!

"Don't get your back up!" implying don't get angry – usually relates to the mid and upper back and trapezius (derived evidently from what cats do when they're angry).

The thoracic spine is related more to the realm of the heart. Chronic kyphosis or mid-scapular pain may relate to emotional issues such as holding back or holding in one's feelings, not speaking from the heart, or excessive protection of the heart.

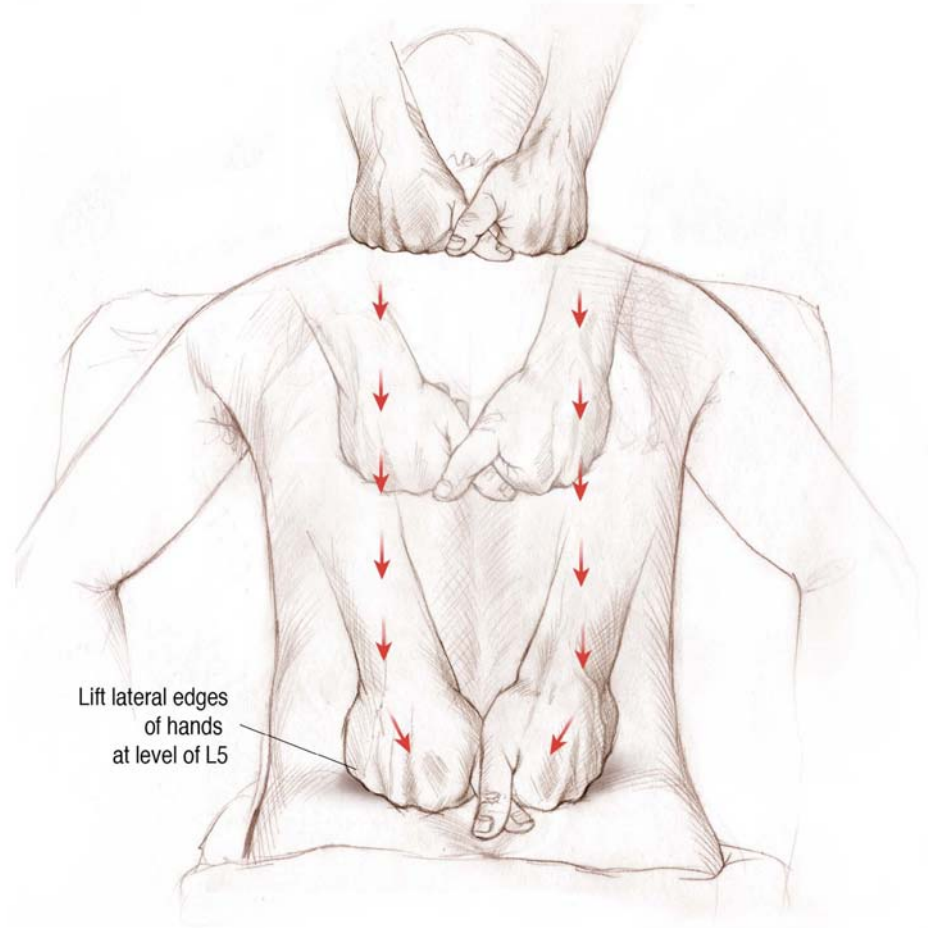
Wilhelm Reich, the father of body-centred psychotherapy, said all neurosis manifests as a restriction of breath. And the health of the thorax is linked fundamentally with the full excursion of the breath. So then deeply almost all thoracic back pain can also be seen as a restriction of breath, which may stem from or end up causing emotional tension.

### Fists Down the Erectors

This simple yet powerful and wonderful feeling fulcrum is essential to back health. Most people have a self-image that their back begins at the top of the pelvis and runs up to the shoulders. This one fulcrum dramatically gives the client the experience that their spine runs rather from the base of the skull to the bottom of the sacrum; the back is nearly a foot longer than most people visualize it!

Therapist: Standing at the head of the table

Client: Face down (ideally with head in face cradle)



**Figure 1**

You will do this fulcrum in the beginning of the session at least three times. The first time will be short in duration and with fairly little pressure – this will be your first exploration of the territory. Successive fulcrums can be deeper and slower.

Centre yourself before putting your hands on. Be in a comfortable position, breathing relaxed, and gently yet clearly focused. A note on hand and wrist placement – for most people's bodies your most aligned position will be with the first finger sides of the fists almost touching, and with the little finger sides of your fists about 2" apart – so your hands are at about a 45° angle to each other. My extended thumbs usually overlap making an "X". Your working surface is the proximal phalanges of your fingers, especially the fourth and fifth.

Place your loose fists, finger pads against your palms, at the top of the ribcage in the belly of the trapezius muscle.

Take out the looseness, making good contact.

Then take up the slack by stretching the tissue inferiorly. This is before you begin sliding down the back. The initial inferior-ward traction gives the nervous system an indication, "This is the direction in which we are going to go." Also this traction gently engages and stretches the neck muscles lying above – helping the client feel how truly long their spine is.

Now add additional vectors by slowly proceeding down the back with the first fingers of your hands almost touching. Of course, avoid going over the spinous processes.

Along your way, feel for the natural curves of the spine and for any particularly tense places. Continue slowly down the back going all the way to the level of the third or fourth sacral segment. However, lighten up on pressure when you are gliding on the sacrum.

This fulcrum is one of the longest of all that you'll do. As you move down the back, pay attention to sustaining the stroke so that it is one long deeply relaxing, lengthening experience. Note the duration -you want to go slow enough so that you can feel tension and so that the client can release it from inside out. Yet you don't want to go so slowly as to provoke the client's impatience.

Monitor for change to sense how well this fulcrum is working. Note changes of breath – particularly look for the movement of the lower back as the person may breathe in and out more fully.

Near the bottom of the sacrum clearly disengage. End clearly on a note of length.

Reminder: All of this should feel good – ideally *really* good. It doesn't take much pressure to do this well, it takes skill and care.

In the beginning of a session you will most likely repeat this fulcrum three times – each time a bit deeper and slower. It helps organize the person around their center and integrate the other freedoms you will be facilitating. During the session, when the client is prone, it is fine to repeat it anytime you feel it will be helpful.

### "Nine Points"

The lower back muscles are interestingly not very available from the back. They have many layers each lying deeper than the last. Therefore, coming in from the side is the most direct way to access and address the lower back.

Therapist: Standing alongside at the level of the thighs.

Client: Face down (ideally with head in face cradle)

You will work into one side and then build the next fulcrum ("Ironing Up the Erectors") before going to the other side of the lower back.

Centre yourself, remembering to stay as relaxed as you can during this fulcrum. In the beginning please do not press in hard and work with effort.

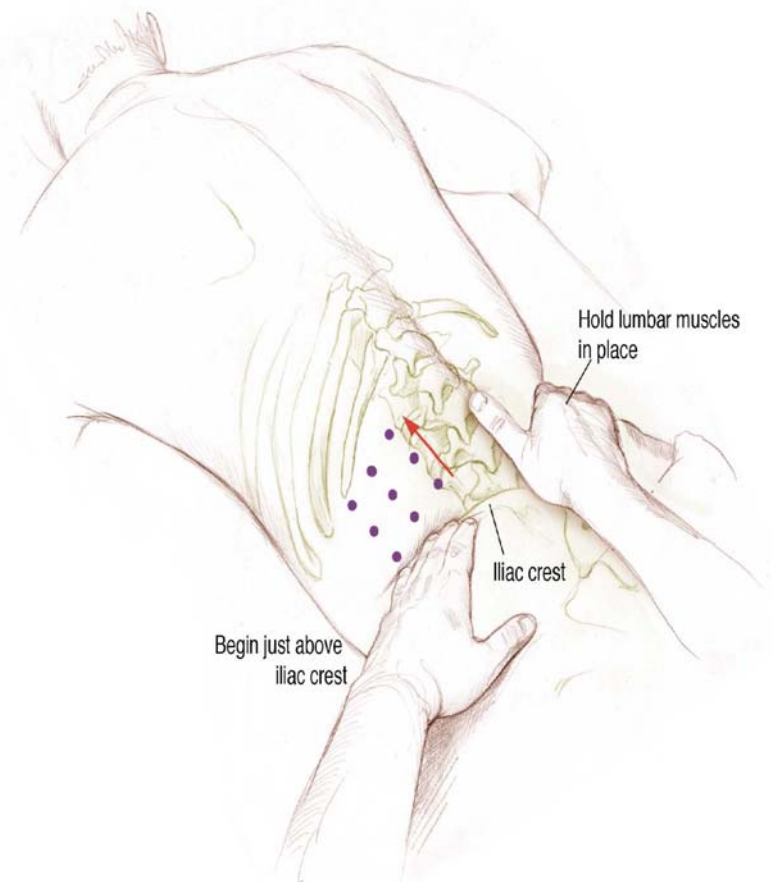


Figure 2

Excess pressure can be painful to your client and hurt your own wrists, fingers or back. *Never substitute force for intelligence!*

Starting on the right side, place your left foot on the floor at the level of the client's thigh and your right foot more at the level of the pelvis. Take your left hand across the body to the left side of the lower back. Find the bony landmarks – the iliac crest and a few inches above it the 12<sup>th</sup> rib. Between them lies the lumbar musculature.

Position the fingers of your left hand at 90° to your palm. Place the fingers, particularly the thumb-side of the first finger, snugly up against the lateral margin of the lumbar muscles. This hand will hold the left side of the lumbar muscles in place, creating stability, while your more active right hand will press into the right side of the lumbar muscles.

Now with gently curved fingers of the right hand, press in just above the iliac crest and into the side of the erector spinae. You are pressing into the lateral margin of these muscles about two inches lateral to the spinous processes. Take out the looseness. Now with just a little more pressure take up the slack – it should feel good or at least neutral for your client. Your pressure is medial-ward, toward the centre.

You may find no tension or particular sensitivity -if so, great! Just clearly disengage. However, if you do feel some tension or the client reports you're on a relevant spot, then rest into the area, sinking in, creating a fulcrum. Then the client relaxes his or her own tension from inside out.

You often will not notice any change. Or you may feel a melting, a hard place rather suddenly feeling softer. Just hold the fulcrum and allow the client to release from inside out. Monitor for any overt signs of letting go on the client's part.

In any given point here, usually 3 seconds is quite enough time. Better to err on the side of leaving the client wanting more, rather than feeling overworked, forced to change, or wanting less. Again if you find no tension, you will know that within about one second and can clearly disengage without building the fulcrum.

Clearly disengage with the right hand. Allow the client a breath or two, and then press into the next of the nine points. This will be halfway between the iliac crest and the 12<sup>th</sup> rib, again into the side of the erector group. Note these points are not anatomically landmarked – we have just chosen to address this fairly small but crucial area in detail, sampling for and addressing low back tension just above the iliac crest, halfway between it and the twelfth rib, and just underneath the twelfth rib.

Proceed as before -if you feel tension, rest in and build the fulcrum -if not, move on.

The third point is just below the 12<sup>th</sup> rib into the side of the erectors.

The 4<sup>th</sup> point is at the same level as the first, just above the iliac crest. But it goes into a deeper muscle layer, the multifidus. To assure your entry into the deeper layer, begin exploring with your right hand placed more laterally. Then, when you press in, you will be one layer deeper.

Again note these muscle layers are not anatomically distinct to palpation. The lower back muscles are like a 3" thick filet mignon. So use our illustration and these verbal directions to give you a good sense of the layers you are addressing.

As above, in this 4<sup>th</sup> area, build a fulcrum if needed. Then again explore halfway between the iliac crests and 12<sup>th</sup> rib; and finally just below the 12<sup>th</sup> rib. These then are points 4-6.

The deepest layer of the lower back is the quadratus lumborum. To position yourself to access it, start yet more lateral. Looking from the side, you are starting about a third of the way toward the front of the body.

Again press into the three points building fulcrums as called for, just over the iliac crest, halfway between it and the 12<sup>th</sup> rib and then just below the 12<sup>th</sup> rib

I was once working on a man, working slowly up his mid-back with my forearm.

He asked, "What are you working on?"

I said, "I'm just working up your ribcage."

He said, "I didn't know I had ribs in my back!"

I wonder what he thought was there? So many people suffer from a lack of self-knowledge. The philosopher/bodyworker, Thomas Hanna, called it "sensori-motor amnesia".

The broad surface of the back is mostly ribs surrounded by soft tissue and housing the heart and lungs. So to address the back we certainly need

a fulcrum that will free the ribs and their associated tissues.

At the end of a challenging day, it is common to feel one's back having born the stress of the day perhaps leaving you feeling a bit bent out of the shape.

When I think of addressing the mid-back, I recall my Godmother, Millie Barry, showing me how to iron as a little boy. There was something so comforting and restorative about using heat and pressure and care and watching the disorganized fabric acquire a lovely new smoothness.

In deep massage we work with clearer, stronger force fields than those which currently exists in the body. Like ironing a shirt, we notice how clearer, stronger fields override disorganized structure and energy. A touch which knows anatomy and engages the person with utmost clarity, through the steps of the fulcrum, reawakens the body part and the whole person to a clearer, stronger experience of themselves.

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*"And the hands go and go,  
the sacred surfaces are  
smoothed"  
Pablo Neruda*

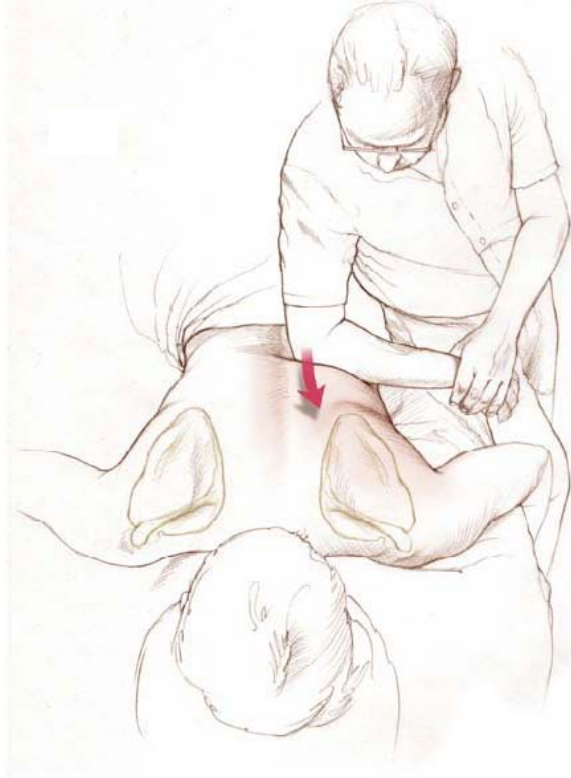
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This fulcrum follows the nine points on the right side and is followed by nine points on the left and ironing up on the left.

Therapist: standing, facing headward, with legs alongside the pelvis  
Client: prone

Your working tool here will initially be your forearm with elbow well bent, so that your hand is almost pointed at your own waist. Your forearm then will be generally perpendicular to the spine.

Starting on the right side, place your forearm near the bottom of the ribcage around T11. Do not put pressure in but just take out the looseness settling into the ribs and tissues here.



**Figure 3**



**Figure 4**

Now take up the slack initiating a pulling of the tissues superiorly, without yet moving through the tissue.

Add additional vectors, ascending up the back slowly. Proceed with care and curiosity. Feel for the shape, tensions, movements in the person's body. Especially go slowly enough that you can feel the movement of breath between the ribs or lack thereof. In places when you sense more tension or less freedom, feel free to slow down, or to rest in and melt away the tension. Slowly, patiently iron out the tension and help restore the natural, free excursion of ribs and soft tissues. Ultimately you are helping free the diaphragm, heart and lungs as you create more spaciousness and better organization in their surrounding environment.

When you reach the level of the scapula, at about T7 or 8, your forearm will run up against the bottom of the scapula. I have found continuing to work with the forearm or elbow between the scapulae to be problematic and have had at least one occasion where a student injured a client by working with the elbow near the base of the neck.

So between the scapulae, gracefully change positions. Let your right hand disengage and cup the front of the shoulder. From this position, you can gently traction the front of the shoulder girdle open, pulling laterally, adding an even greater three-dimensionality to this fulcrum. Position your left hand, fingers gently spread, in the area between the scapula and the spine. Take out the looseness around T 8. Take up the slack, initiating an upward pull. Then add additional vectors slowly working up with your finger pads from T 8 to T 1.

It is irresistible to finish this fulcrum with the fingers of the left hand hooking into then pulling laterally through the trapezius and supraspinatus lying in the supraspinous fossa.

There is often so much tension between and above the scapulae that I may repeat this fulcrum 2-3 times. See what you and your client feel is called for.

*See back page for more about David Lauterstein*

# Addressing common musculo-skeletal conditions with Thermal Stone



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)

Thermal stones are the *gold standard* for massage therapists to use to encourage these healing benefits - Greg Morling

## What we will cover:

### Thermal stone review

- The broad scope of thermal stone use
- The unique quality of metamorphic/sedimentary thermal stones
- Taxonomy and working protocols
- 'Marrying' heat to protect the client's skin

Addressing musculo-skeletal conditions;

- sciatica
- plantar fasciitis
- pectinius/inguinal dysfunction and
- respiratory conditions



## The scope and benefits of thermal stone

- most conditions that are not in the inflammatory stage
- myofascial release + thermal stones =the gift!



ROM and the perfect partner to stretching - of all kinds



- Such a kinder way to work for you and for them!



## Sciatica

### Working prone

- Trigger point / gluteals
- Manual vibration with and without stone
- Access to deeper hip flexors, extensors with stone and vibration
- Ishium direct triggers
- 3 triggers on hamstrings
- thermal stone.....
- the next gift...ITB



# Plantar fasciitis

- Replacing your working hands and 'trigger thumbs' with thermal stone
- fibrous collagen tissue responds to heat – and pressure



While your there.....

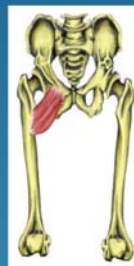
- calcaneus
- achilles
- metatarsals



- Can we mention the pure bliss of this on the feet?

# Pectineus/inguinal area

Pubis to lesser trochanter  
 Lymph nodes  
 Femoral pulse



Pectineus is positioned between the Iliopsoas and Adductor Longus muscles and is part of the short adductor group with adductors brevis and longus

Using thermal stones make this Such an easier area to address with palpation



# Respiratory conditions

Chronic bronchitis

Emphysema

Asthma



Thermal stones assisted by manual vibration may assist in loosening the external and internal intercostals which can have the effect of helping muscles to perform the breathing process



## Thermal stones for remedial therapists

- Save your hands
- Dramatically lower pain associated with deep friction massage
- 101 ways to use thermal stone in your practice
- What practitioners are saying...
  - \* *...so many new techniques. Thoroughly recommended. Joanne J.*
  - \* *...great hands – on, informative with fabulous techniques. Tia W.*
  - \* *I have been taught by many therapist/teachers over the past 12 years. I have found only 2 that really excel. Greg is one of them. Glenn R.*

14 Jan  
Understanding the Iliopsoas  
with Greg Morling  
London

15 Jan  
Arthritis: Advanced Techniques  
and Treatment Plans for  
Bodyworkers  
with Greg Morling  
London

21 Jan  
Understanding the Iliopsoas  
with Greg Morling  
Edinburgh

22 Jan  
Thermal Stones for Remedial  
Therapists  
with Greg Morling  
Edinburgh

\*\* Discounts for attendance  
at both days

**Greg Morling** is an international presenter at major Conferences in Australia and New Zealand who has been teaching for many years with over 24 years in clinical practice.

Greg is a past President of the Australian Association of Massage Therapists and is known for his work in massage for those with Parkinson's Disease. His recent research and clinical focus has been on developing new massage protocols to honour the enigmatic iliopsoas muscle by avoiding a reactive response during treatment.

#### **Watch again - webinars with Greg Morling...**

[Iliopsoas: its role in the evolution from quadruped to biped; & avoiding the fear reflex during palpation](#)

Listen again by clicking above. When you register you will be sent link to recording - please note there is a gap in sound at the cat slide due to broadband problem but it does come back (approx 45 minutes)

[Back Pain, Bio-tensegrity and Six \(6\) Stretches for the Iliopsoas](#)

Listen again by clicking above. When you register you will be sent link to recording (approx 1 hour)

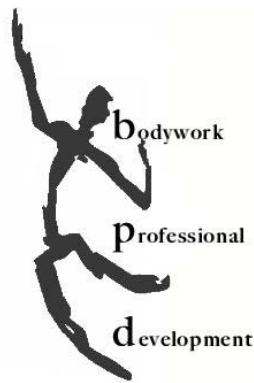
Also contact us for links to the recordings of the more recent webinars that Greg has done:

[Thermal Stone for Remedial Therapists: honouring our palpatory expertise with pressure, texture and heat](#)

And the webinar that these slides are from:

[Addressing common musculo-skeletal conditions with Thermal Stone](#)

**BPD has extended the Early Bird Discount for the workshops in London and Edinburgh until 31 December 2011. Bookings can be made by sending a cheque, bank transfer or by credit/debit card over the phone on +44 (0)7526 925734.**



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**E-Mail:**

[info@bodyworkcpd.co.uk](mailto:info@bodyworkcpd.co.uk)

*...extending your  
manual therapy  
skills*

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*We're on the Web!*

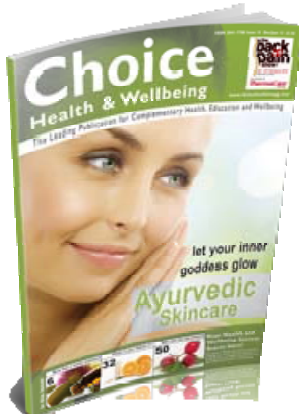
*See us at:*

[www.bodyworkcpd.co.uk](http://www.bodyworkcpd.co.uk)

*Check out our workshops,  
products and selection of  
articles*

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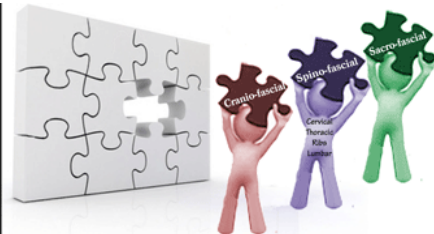
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## Advanced Fascial Articular Techniques

Ralph Stephens and Maggie Brooks-Carter introduce the missing piece to your practice



**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).

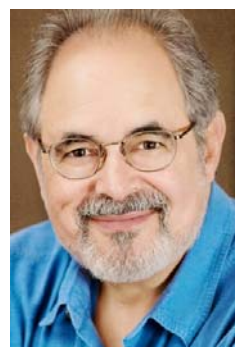
Maggie trained in Swedish Massage, Remedial Massage, Manipulative Therapy and then Osteopathy where she met Nick Carter who was already teaching. They combined forces to form the Brooks-Carter Clinic, Scottish Massage Schools and the Scottish Massage Therapists Organisation.

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 workshops with Ralph!

Maggie is a Registered Osteopath also trained in Remedial Massage, Clinical Aromatherapy and Reflexology. She has attended continuing professional development and attended workshops and seminars in the UK and USA .

She finds that her approach particularly to dealing with the pelvis as the foundation for all has been very effective over the years. She loves a challenge and doesn't like to give up. She is happy to be contacted to see if Osteopathy or another therapy can help.

Check out the new website [www.fascialtechniques.com](http://www.fascialtechniques.com)



**David Lauterstein BA LMT Cert.ZB MTI** has been in massage and bodywork practice since 1977 and is co-director of the Lauterstein-Conway Massage School in Austin, Texas. He is the founder of Deep Massage: The Lauterstein Method and has taught this in the UK and USA since 1982. He is one of the most respected educators in the massage therapy realm and was inducted in 2011 into the Massage Therapy Hall of Fame. He is author of the book, *Putting the Soul Back in the Body: A Manual of Imaginative Anatomy for Massage Therapists*, numerous articles on the philosophy and practice of massage and bodywork, and is the former editor of the national magazine, *Massage Therapy Journal*. He is also certified in Structural Bodywork and Zero Balancing and is a faculty member of the Zero Balancing Health Association. His background prior to massage therapy was in philosophy and music composition; he is composer of the Massage CD, "Roots and Branches"

BPD is delighted to welcome David, and his workshops, as a new addition to our CPD offerings in 2012.