

## FASCIAL RELEASE

The continued study and practice of fascial release techniques is an important aspect of CPD and the orthopathic professional development programme.

Myofascial Release can restore renewed mobility to a painful or restricted area by a specific repertoire of FDM techniques. We can use the analogy of mobilising a jammed drawer by pulling it out completely before pushing it back in again. In living matter, this often called is the "indirect technique".

The trauma history of how that drawer became stuck in the first place may however suggest pushing it back in all the way in order to free it. In therapy, this is referred to as the "direct" technique because the forces are targeted into the joint barriers compressing the osseous-ligamentous attachments.

Although osteopathic and chiropractic textbooks occasionally mention this important distinction, schools and colleges generally do not teach it. My own training college looked only at one side of the coin: the indirect technique of using articulation and mobilization under traction, a treatment approach that is sometimes detrimental to the instable or hypermobile joint.

During last year's CPD seminar, we focussed for two practice days on this model by examining and treating distorted fascia (FDM). This is stuff to be experienced; a whole gaggle of textbooks will not teach you it. It was refreshing for many of us to hear again that the orthopath's efforts to recreate in his/her mind the initial circumstances of the trauma or the injury, will provide the correct clues of which technique to apply - the indirect (unfolding) or the direct (refolding), coil and recoil. The aim is to

recreate the memory of the trauma and the forces active at the time so that spontaneous release can take place by orthopathically applying the correct FDM technique.

Which techniques are used more appropriately than others depends on the anatomical nature of the joint and the way it is used. The proportion for shoulders, wrists and fingers, injured by fascial over-compression and therefore in need of refolding intervention, seems higher than for other joints. This also appears to be the case for spinal facet opening restrictions that are sometimes tectonically fixed. You may occasionally find it in ankles and knees that were subjected to sudden loading compression trauma by jumping from a high place.

If the patient does not remember the trauma event, the lesioned part gives the necessary clues when carefully challenged by a traction or compression test.

Another refinement of this test is recreating a body posture that eases the pain perception, created by palpation or trigger point stimulation. Many of these points are areas of myofascial tissue tautness, ligamentous or capsular transition zones or excessive muscular or fascial contractions that might become tectonically fixated by adhesions. When the pain-free or analgetically neutral position is re-created as at the time of the trauma, the posture of the patient might look odd, but this is often when the involved muscle groups can promptly and gracefully relax. This phenomenon is "Spontaneous Release by Positioning".

Myofascial release techniques are like psychotherapy. You retrace the precise sequence of steps and events as if looking for lost car keys. **Siggi Trefzer**