

Positional Release Techniques

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Positional Release Techniques

With accompanying CD-ROM

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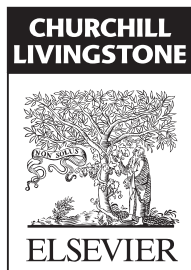
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T H I R D E D I T I O N



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Abbreviations

A

ACh:	acetylcholine
AIIS:	anterior inferior iliac spine
AK:	applied kinesiology
AS	anterior, superior
ASIS:	anterior superior iliac spine

C

CCP:	common compensatory pattern
CMRT:	chiropractic manipulative reflex technique
CNS:	central nervous system
CRI:	cranial rhythmic impulse
CSRM:	cranial-sacral respiratory mechanism
CT:	cervicothoracic

E

EMG:	electromyographic
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F

FMS:	fibromyalgia syndrome
FPR:	facilitated positional release

G

GAS:	general adaptation syndrome
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H

HVLA:	high-velocity low amplitude
HVT:	high-velocity thrust

I

INIT:	integrated neuromuscular inhibition technique
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L

LAS:	local adaptation syndrome
LS:	lumbosacral

M

MET:	muscle energy technique
MFR:	myofascial release

MPS:	myofascial pain syndrome
MRI:	magnetic resonance imaging
MWM:	mobilization with movement

N

NAGs:	natural apophyseal glides
NMT:	neuromuscular technique

O

OA:	occipito-atlantal
OMT:	osteopathic manipulative therapy

P

PI:	posterior, inferior
PNF:	proprioceptive neuromuscular facilitation
PRT:	positional release technique
PSIS:	posterior superior iliac spine

Q

QL:	quadratus lumborum
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S

SBIS:	silicone breast implant syndrome
SCS:	strain and counterstrain
SE:	scanning evaluation
SIJ:	sacroiliac joint
SMWLM:	spinal mobilization with limb movement
SNAGs:	sustained natural apophyseal glides
SOT:	sacro-occipital technique
SRC:	static resisted contraction

T

TART:	texture, asymmetry, range of motion, tenderness
TFL:	tensor fascia lata
TL:	thoracolumbar
TMJ:	temporomandibular joint
TP:	tender point
TPPS:	tender point palpation scale

W

WDR:	wide dynamic range
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Foreword

With this 3rd edition of *Positional Release Techniques*, Leon Chaitow forges along a path established by Lawrence H. Jones, DO, FAAO. Larry Jones assembled ideas from his teachers Bill Sutherland, Harold Hoover, and Fred Mitchell, culminating in the Strain-Counterstrain technique. Similarly, Chaitow's genius is synthesis—he puts together ideas from an ecumenical panoply of practitioners, including DOs, DCs, PTs, NDs, and MDs. With his fresh eye, he extracts pearls from articles that I had read but misunderstood. Re-reading this literature has imbued me with new enthusiasm.

Positional Release Techniques is more than a techniques manual. The book also delves into biomechanics and pathophysiology (making it an excellent textbook), and probes many of our clinical hypotheses that remain unproven. At the new School of Osteopathy at Unitec in New Zealand, the 2nd Edition served as a foundation text for our research programme. I'd like to highlight some of that work. What are tenderpoints and triggerpoints? Our research suggested everyone has tenderpoints, but some have more than others. Tenderpoints are indicators of body-mind-spirit fatigue. When the bodycount of tenderpoints becomes excessive, we diagnosis "fibromyalgia". This label, however, is labile; Dunnett (2006) tested a population of healthy young women, and a significant percentage of subjects "changed" fibromyalgia diagnosis during the course of a menstrual cycle, fulfilling the criterion (≤ 4 kg pressure at ≥ 11 points) during the luteal phase or menstrual phase, but never during the follicular phase. Thus the perception of endogenous pain may be modulated by cyclical hormonal changes, as well as the hypothalamic-pituitary-adrenal (HPA) axis. HPA axis dysfunction may blunt endogenous pain modulation pathways, such as the endorphin and endocannabinoid systems. As noted by Chaitow, the bodywork treatment of tenderpoints may not involve the endorphin system. We researched the endocannabinoid system. Anandamide, the best-known endocannabinoid, is associated with pain relief; serum levels of anandamide double after the administration of osteopathic treatment (McPartland et al., 2005). If

tenderpoints truly represent a "sum of stress," their treatment truly requires a holistic approach. Walker (2003) used the methods outlined in this book to treat patients with forearm tenderpoints, a common and recalcitrant problem. Walker's holistic approach proved successful. Notably, forearm pain is shared by many bodyworkers (Peat, 2004), so you, the reader, are directed to the self-treatment guide in this book.

Biomechanically, a tenderpoint is a bad intersection, a collision of fascial cleavage planes and nociceptors, with poor circulation (McPartland, 2004). In this 3rd Edition, Chaitow highlights research by Langevin et al. (2006), who came to the same conclusion. Langevin associated tenderpoints with acupuncture points. Indeed Jones's tenderpoint charts show a substantial overlap with acupuncture maps. However, Johns (2004) showed that comparisons of point locations based on two-dimensional (2-D) charts may overestimate correlations. Johns compared Jones's tenderpoints with Chapman's reflexes. Chapman was an osteopath who described a series of neurolymphatic points as markers of visceral dysfunctions. Thirty years later the chiropractor George Goodheart discovered Chapman's reflexes also served as indicators of conditionally inhibited muscles, leading to the development of Applied Kinesiology. In a comparison of charts, 87% of Chapman's reflexes correlated with the location of at least one Jones tenderpoint, but when Chapman's and Jones's points were mapped upon a person, their 3-D locations correlated only 21% (Johns, 2004).

Triggerpoints, unlike tenderpoints, are palpable nodules located in a taut band of muscle. They give rise to referred pain, motor dysfunction, and autonomic phenomena. Simons et al. (1999) associated trigger points with an excessive release of acetylcholine (ACh) at the motor endplate. We expanded this molecular etiology to include presynaptic, synaptic, and postsynaptic mechanisms, such as excessive release of ACh, defects of acetylcholinesterase, and upregulation of nicotinic ACh receptors, respectively (McPartland and Simons, 2006). This theory has altered our treatment of triggerpoints. Heavy ischemic

compression upon triggerpoints is out. Positional release is in! We need to think molecularly, and use techniques that modulate gene regulation and gene expression. Our research suggests "...the formative and regenerative forces that organize embryological development are present throughout our life span... In other words, the forces of embryogenesis become the forces of healing after birth" (McPartland and Skinner, 2005). Gene regulation and regenerative forces arise when we modulate sensory afferents and autonomic efferents, and this may be the mechanism by which cranial biodynamic treatment works (Cardy, 2004).

Positional Release Techniques is filled with concrete examples, fine line drawings, and careful guidelines, which make the techniques easy to learn and apply. The text illustrates a plethora of tutorial exercises. The methods described in this book are powerful. The diagnostic techniques are accurate. Leon Chaitow is to be congratulated, once again, for combining his tireless scholarship and seamless composition into an outstanding book of pearls.

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Preface

The ideas that permeate positional release technique (PRT) methodology can be equated with non-invasive, non-interventionist, passive and gentle approaches that 'allow' change to emerge, rather than forcing it to do so. Despite the apparently general nature of PRT methods, clinical experience within the osteopathic profession shows that they can be intensely practical and specific.

Two main themes emerge from PRT in its original form. The strain/counterstrain approach derives from the original work of osteopathic physician Lawrence Jones. It uses a pain monitor to find optimal positioning (i.e. when pain is no longer felt at the monitoring point). Functional technique also emerged out of osteopathic medicine; this PRT approach is based on positioning whilst sensing/palpating the tissues involved, so that they achieve their greatest degree of comfort or ease, without using pain as a guide.

In order to gain a sense of the underlying concepts involved in PRT application it is necessary to accept that the self-regulating mechanisms of the body are always the final determinants as to what happens following any form of intervention. For example, a high velocity, low amplitude thrust adjustment (HVLA), or application of a muscle energy technique (MET) or myofascial release (MFR), or almost any other procedure, acts as a catalyst for change. If the treatment is appropriate the body produces an adaptive response that will allow enhanced function and therapeutic benefit. The adaptive response is the key to whether or not benefit follows treatment. Excessive adaptive demands simply load the system more heavily, and symptoms are likely to worsen, while if there is inadequate therapeutic stimulus little value emerges from the exercise. The methods mentioned above (HVLA, MET and MFR) are all 'direct', that is to say, a barrier (or several barriers) will have been identified, and the therapeutic objective will be to push the barrier(s) back, in order to mobilise a restricted joint, or to lengthen shortened myofascial structure (for example).

Consider another way of addressing the restriction problem – an indirect one: reflect on whether, if the

barrier is 'disengaged', the inherent tendency towards normality, demonstrated in the natural propensity for dysfunction to normalise (broken bones mend, tissues heal), is capable of restoring functionality to the types of dysfunction to which HVLA MET and MFR (as examples) are being applied.

Is it possible for self-regulating, homeostatic mechanisms to be encouraged to act when the load on dysfunctional tissues is temporarily eased?

- Can a restricted joint release without force?
- Can an excessively tight, muscular condition release spontaneously?
- And can pain sometimes be relieved instantaneously, merely by holding the painful tissues in an 'eased' position?

Clinical PRT evidence shows that all these questions can be answered affirmatively, at times. If restriction – whether of joint or soft tissue – involves hypertonicity and relative circulatory deficit (ischaemia, etc.), then is it possible that an opportunity for spontaneous change may occur by holding these same restricted tissues in a way that reduces the tone and allows (albeit temporarily) enhanced circulation through the tissues, and a chance for neural resetting (involving proprioceptors and nociceptors), to take place?

PRT methodology suggests that this is the case and a number of variations have evolved that incorporate the concept of 'offering an opportunity for change', as distinct from 'forcing a change', as is the case with HVT and MET for example.

There are particular settings and contexts in which PRT is probably the treatment method of first choice – as in extreme pain, recent trauma (for example whiplash, or immediately following a sporting or everyday strain), post surgery, extreme fragility (for example advanced osteoporosis). In addition, PRT is sufficiently versatile, with numerous variations, to be useful as a part of a sequence involving other interventions, for example before or following HVLA application, or as part of a sequence involving MET and neuromuscular technique, in trigger point deactiva-

tion, or as a means of easing hypertonicity during a massage therapy treatment.

The ideas that underpin PRT are also to be found in craniosacral methodology, in which disengagement of restrictions, moving away from restriction barriers, is a common approach.

Positional release variations, based on traditional osteopathic methodology are detailed in Chapters 1 through 7 inclusive, and are demonstrated on the accompanying DVD.

Of particular interest in this third edition is the inclusion of chapters that discuss a number of physiotherapy-derived systems, (Mulligan's Mobilisation with Movement, Unloading taping, and McKenzie-type exercises) as well as from chiropractic methodology (Sacro-occipital Technique - SOT) that have strong links to the underlying concepts of PRT.

Robert Cooperstein has outlined and illustrated the useful 'positional release' concepts and methods used in sacro-occipital technique (SOT), in Chapter 8. SOT derives from the work of Major deJarnette, whose early work with cranial osteopathic pioneer Sutherland demonstrates how osteopathic and chiropractic ideas and methods that evolved in the early to mid-20th century, had a great deal in common.

Anthony Lisi has presented some of the core McKenzie methods in Chapter 9. The concepts of exercises being employed guided by 'preferred directions of movement', is pure positional release, although used in quite distinctive and original ways.

In Chapter 10 Ed Wilson presents a description of those aspects of the work of Brian Mulligan, the inno-

vative New Zealand physiotherapist, whose mobilisation with movement (MWM) concepts have been so widely adopted in physiotherapy settings. There are specific variations within MWM that have close similarities with PRT ideas and Wilson has performed the invaluable task of moving beyond descriptions of methods to evaluation of underlying mechanisms.

The elegant approach that 'proprioceptively unloads' dysfunctional joints and tissues and then tapes the structures into their 'ease' state, for hours or days, in contrast to the minutes of 'ease' used in osteopathic PRT methodology is described by Dylan Morrissey in Chapter 11.

Finally in Chapter 12 Julia Brooks and Anthony Pusey illustrate the remarkably successful use of osteopathic positional release in treatment of animals, including dogs and horses. No clearer examples can be offered of the true breadth of usefulness of these most gentle of methods.

The cross-fertilisation and interdisciplinary possibilities that are exemplified by the coming together of osteopathic, chiropractic and physiotherapeutic methods and ideas, highlight the potential for the future, as barriers and rivalries give way to cooperation, collaboration and ultimately integration, for the benefit of all.

Leon Chaitow
Corfu, Greece 2007

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The authors of various chapters illustrating different settings in which positional release methods are employed deserve my profound thanks :

Julia Brooks DO, Robert Cooperstein DC, Anthony J Lisi DC, Dylan Morrissey PT, Anthony G . Pusey DO and Ed Wilson PT, for contributing their specialised

knowledge to this book. Sadly, Anthony Pusey DO passed away before publication of this book. His pioneering work with animals, and his influence on his profession, are major elements of his legacy. Chapter 12, which Anthony, (together with his wife Julia Brooks DO) coauthored, offers a glimpse of his remarkable work.

My sincere thanks also to John McPartland DO for his help over the years in expanding my perceptions, and for his Foreword to this book.