HOW THE BOOK WORKS!

A client presents with a right shoulder pain problem. To give you a clearer idea of how the entire body alignment may be involved, Chapter 1 of **MultiDimensional Healing** has a clear explanation of how to evaluate the client's posture with an eye to myofascial restrictions. Emphasis is placed on alignment because even though the client might not be complaining of lower body symptoms, a crooked pelvis can't help but play into strain of the shoulder girdle muscles. Frequently symptoms appear places other than the source! This is particularly true for clients that have experienced many treatments and therapies to only the shoulder that have not helped.

Sample page from the evaluation section of **MultiDimensional Healing.**

ONE SIDE OF THE PELVIS HIGH, THE OPPOSITE SHOULDER HIGH

This literally causes a wedging of one side of the body, the torso and its contents are compressed on the shorter side. This not only has ramifications for the muscles and fascia that end up compensating, but could also compromise functions of structures under compression – nerves, intervertebral disks, the organs themselves. (Figure 1-5)

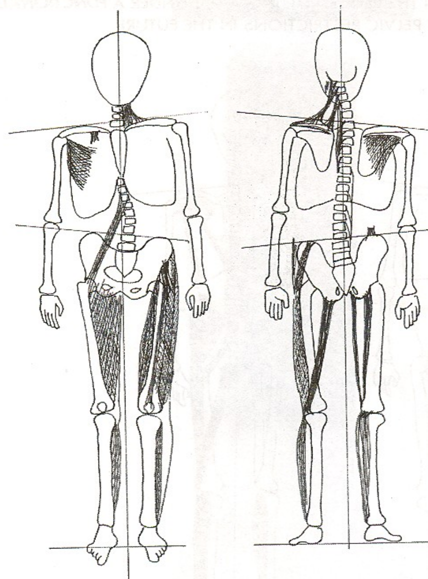

Figure 1-5

Figure 1-5: One side of the pelvis high, opposite shoulder high . When both the shoulders and the pelvis are unlevel, the compensation scenario gets more complicated. If the right shoulder is low and the right pelvis is high, there is a wedging of the right side. Anteriorly, the restricted areas will include the pectoralis major and minor, serratus anterior, psoas major, anterior adductors, and vastus medialis on the right, and the sternocleidomastoideous, supra and infra hyoids, and scaleneus anterior, medial, and posterior, the sartorius, rectus femoris, vastus lateralis, and peroneals on the left. Posteriorly, assess the right infraspinatus, iliocostalis thorasis, erector spinae, internal obliques, quadratus lumborum, medial hamstrings, adductor magnus, and medial gastronemius on the right, and the suboccipitals, upper trapezius, levator scapulae, supraspinatus, erector spinae, quadratus lumborum, gluteus minimus, tensor fascia latae, and lateral hamstrings and lateral gastrocnemius on the left.

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Myofascial treatments may include release of the superficial fascia, cervical musculature, and scapular mobilization as shown on these **sample pages from Chapter 1**.

FLAT HAND TECHNIQUE

One of the techniques for assessing and releasing the superficial fascia is to place the flat of the hand over the skin and try moving the skin around. It should move freely over the underlying tissue. If the skin moves more freely in one direction than another, there are restrictions. Place the flat of the hand or fingers over the restricted area with a firm but gentle pressure, as if to move the skin in the direction it feels stuck. Moving into the restriction in this way feels like 'taking up the slack'. (Figure 1-8) Wait until your hand(s) becomes quite warm and you begin to feel the skin move. This may take as little as 90 seconds, but often takes as much as three minutes.

Figure 1-8: Flat hand release of superficial fascial layer being performed on scapular region.

If the tissue doesn't warm and soften, ease the pressure a little. Restrictions will not change if the body feels 'threatened', so the patient should be as relaxed and the technique as painless as possible. Remember that accomplishing change with as little pressure as possible is the best for both the practitioner and the patient. Be careful not to slide your hand on the skin. You must wait until the skin actually moves on the underlying tissue. The movement of the hand with the skin will continue along the path of the restriction, a sensation not unlike water moving downstream. When the movement stops, that particular tissue has changed. The temperature under the practitioner's hand will change and the skin will feel quiet. Upon re-assessment the skin should move freely into that direction. If change is minimal or this technique too painful, moving the hand in

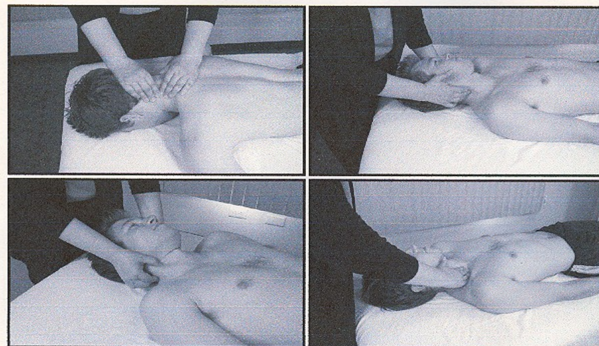


Figure 1-19: Pressure or lifting/pinching technique used to release A. the suboccipital, B. the scalene, C. the sternocliedomastoideus and D. the subclavius muscles.

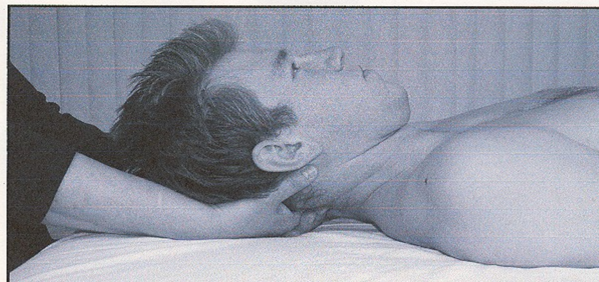


Figure1-19E: Gently cradling the occiput with crossed hands until the lengthening occurs.

Mobilization of the Scapulae

In sidelying, the lateral scapular muscles are easily accessed, especially into the axillar region. Deep restrictions of the teres major and minor, subscapularis are shown here being released with the lifting/pinching technique. (Figure 1-20A) Often, when the patient positions in prone propped on the elbows, the lower scapula is easier to loosen. For example, this hold will release the middle/lower trapezius. (Figure 1-20B)

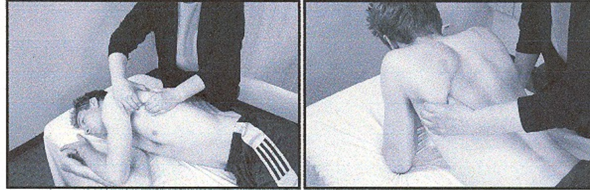


Figure 1-20: Patient positions for releases of A. the teres major/minor and subscapularis muscles and B. the middle/lower trapezius muscles.

With the patient on his side, (pillow between his knees and lumbars supported with towel roll for comfort), the top scapula may be further addressed by gradually having him roll his top shoulder posteriorly. The rhomboids and levator scapula can be released with the stretch and pressure applied appropriately, (Figure 1-21A) followed by the pectoral releases (Figure 1-21B). This is also an ideal time to release any residual paraspinal restrictions and encourage full rotation of each thoracic vertebrae (Figure 1-21C).

Figure 1-21: Patient in sidelying position for releases of the right scapula. Suggested techniques applied to A. rhomboids and levator scapula muscles, B. pectoralis major and minor muscles, and (C), ensuring full rotation of each thoracic vertebra.

With the patient prone grasp the scapula firmly and lift away from the posterior ribcage to complete the process. (Figure 1-22)

Chapter 2 gets into cranial sacral assessment and therapy. Perhaps this client requires some cranial re-alignment to fully overcome his shoulder pain. This is a **sample page of a cranial technique.**

PARIETAL LIFT

Using only enough pressure to engage the parietal bones bilaterally as shown, a light pressure is applied to slightly compress the parietals into the frontal, temporal, and occipital sutures. (Figure 2-6A and B) Upledger refers to this as indirect technique and is the equivalent of pushing a screen door closed tighter to allow the latch to be undone without friction. Gentle unwinding of the parietals may occur during this procedure. When all is quiet, a slight distraction force is applied to disengage the sutures. (Figure 2-7A) As with the myofascial techniques, several barriers will release to this distraction before all is quiet. Upledger differentiates between the feel of freeing the sutures (a more firm resistance) and the membranes (a more elastic resistance). Waiting for all possible changes takes several minutes. Paul St. John teaches a technique using the hair as a handle as an alternative to the fingers touching the skull.[4] (Figure 2-7B)

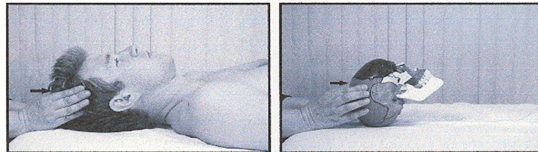


Figure 2-6A: Compression applied to the parietal bones (indirect technique), B. Skeletal representation.

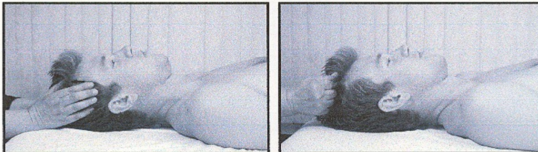


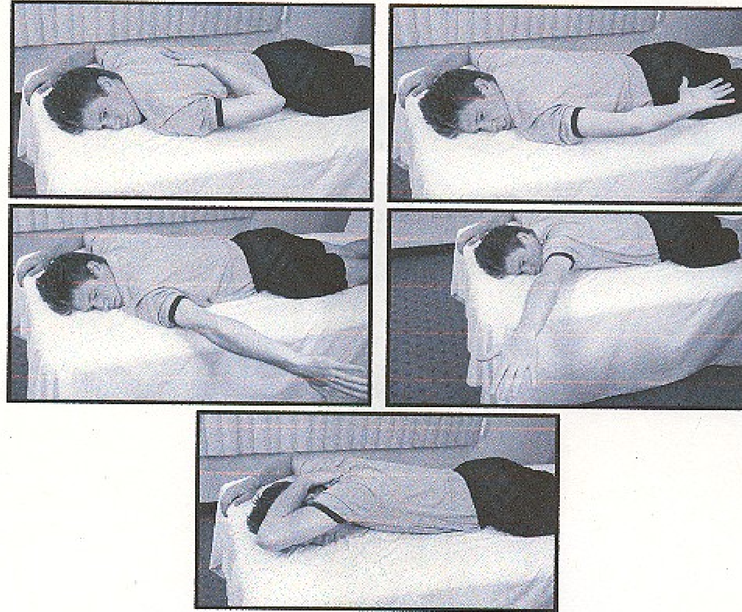
Figure 2-7A: Distraction of the parietal bones (direct technique), B. Using the hair to decompress the parietal bones.

> ** THE MAIN POINT TO REMEMBER IS THAT *LESS FORCE* IS MORE CONDUCIVE TO CHANGE. IF THE BODY FEELS AT ALL THREATENED, IT WILL TENSE AND PREVENT CHANGE. IF EVER IN DOUBT WHETHER YOU ARE BEING EFFECTIVE, ***LIGHTEN THE TOUCH.***

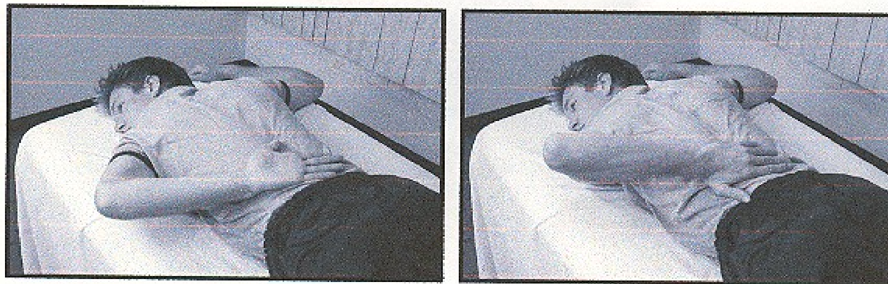
If there are memories/emotions embedded in the tissues requiring release, **Chapter 3** explains how to help the client through this – it is often necessary for the wholistic solution to his pain. Knowing when to make appropriate referrals is vital.

Chapter 4 explains a slightly different slant on exercise than traditionally taught - incorporating elements of neuromuscular re-education and Feldenkrais. This **sample page is an exercise for shoulder and scapular muscle re-training.**

PRONE SCAPULAR RANGE OF MOTION EXERCISES



1) Lie on your stomach, start with your hand in a position behind your back, up as high as it will go comfortably. Move your arm in a large arc up to over your head, and then down behind your head. Reach your hand down your back as far as it will go comfortably. Reverse the procedure to return the arm to the starting position ('angels in the snow' face down!). Do this several times, keeping the arm level with your body as much as possible. Start with teh arm that moves the easiest, then repeat with the other arm.



2) Same position as exercise 1, with your hand as far as it will go up your back, practice turning your hand palm towards and then away from your back several times. Repeat with the other hand.

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Chapter 5 addresses the energetic component of treatment. Whether we are aware of it or not, **we are all inter-relating on an energetic level**. Hopefully this chapter will provide some insights for making those interactions therapeutic.

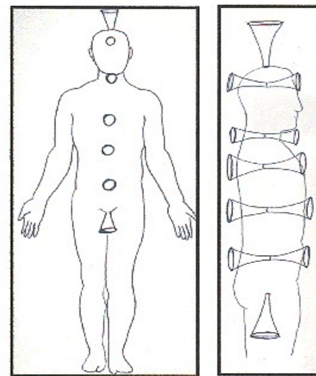

Figure 5-4A: Normal chakra alignment from the front, B. and from the side.

Emotional/psychological issues also enter into how the energy is flowing, and therefore how efficiently the physical systems are operating. To help heal a physical disease, the individual may have to retrieve energy that is being lost to negative emotions, and with counseling/therapy begin to overcome those emotional issues. As the energy of the chakras improves, the patient's posture improves, and the patient's health improves. And according to Myss and Wolfe, the person's ability to benefit from allotropic medical intervention will also improve.

Other, more esoteric aspects of the energy anatomy are being described everyday, and modalities for energy treatments are starting to be studied and verified by scientists. No matter how the system of energy in the body is described, however, the essence of it is this: **Free flowing, well-balanced energy is a key to health and wholeness. Facilitating energy balance, both within an individual and between individuals, is therapeutic.**

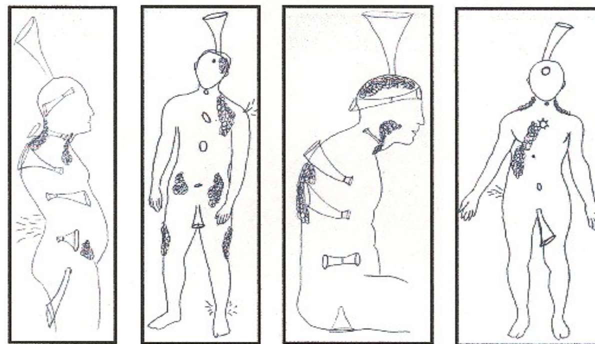

Figure 5-5A-D: Possible chakra misalignment with postural asymmetries.

In **Chapter 6** find a discussion of how the client's belief system effect's his ability to heal, **thus the heavy emphasis throughout the book on education – being present to explain the treatment in language the client can understand and taking the time to answer questions.** You'll find it helpful to have a clearer understanding of how the client's spiritual beliefs may effect your interaction with him as well.

Finally, **in the Conclusion**, is **an experiential exercise** that will help you as a practitioner develop a better understanding of **how energy feels**, how energetic interaction happens, and how all this can be therapeutic not only to you and your client, but to the world…

Discovering how all these factors play into the wholistic healing of your clients is the emphasis of this book. If as a practitioner you do not choose to train in all these areas, **MultiDimensional Healing** will be invaluable for knowing when and where to make the appropriate referrals.