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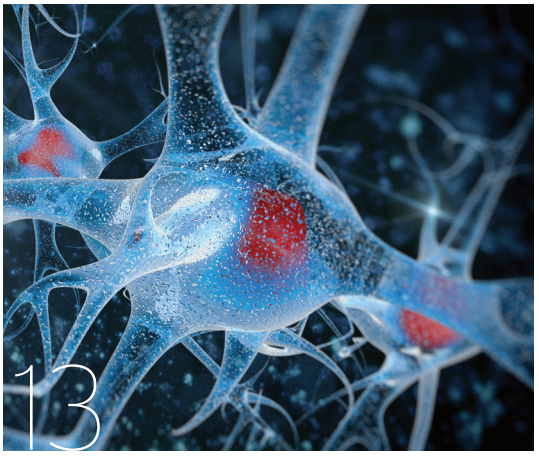

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As we develop future issues, we want your input. We want to hear about the great things you're doing and about the things you'd like to learn about through this magazine. Tell us what you have been doing or simply email us your ideas for future articles and features. We'd love to hear from you!

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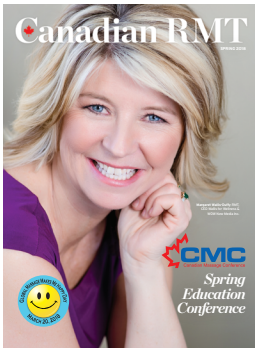

As CEO and founder of Wallis for Wellness and WOW New Media, Margaret Wallis-Duffy RMT continues to inspire, motivate and educate health care professionals and the public.

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MARGARET WALLIS-DUFFY, RMT

When Margaret started back in 1992 as a single RMT practitioner, she had a much bigger vision. Her goal was to create an integrative wellness clinic that would provide holistic health (mental, physical, emotional, spiritual and even financial) treatments for people of all stages of their lives. Today, Wallis for Wellness has blossomed into a well-respected, integrative wellness clinic with a compliment of registered massage therapists, physiotherapist, naturopathic doctors, registered dietician, pedorthist, occupational therapist/mindfulness practitioner, certified reflexologist, cranialsacral therapist, osteopath, clinical aromatherapist, reiki master, acupuncturist, life coach, family/marriage councilor, midwives and a Doctor's Breastfeeding Clinic. Margaret is currently in the process of expanding her wellness centre with an addition of a Pain Management Clinic. Her innovative thinking and a passion to educate, empower and inspire people to live well led her to go beyond the clinic and establish WOW New Media, a comprehensive media team producing online video and online radio programming that educates the public about health and wellness. **wallisforwellness.com**

MICHELLE FRANCIS SMITH, RMT & NICOLE NIFO, RMT

Michelle and Nicole created Perinatal Massage Therapy Education to inspire, empower and educate RMTs with tools to more effectively and confidently work with perinatal patients. By providing exclusive live or online continuing education courses in pregnancy, postpartum and infant massage, they will help you build your toolkit making your practice more marketable, increasing your confidence to transform your perinatal massage practice and business. **perinatalmassagetherapyeducation.com**

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Dr. Elorriaga is the founding Director of the McMaster University Contemporary Medical Acupuncture Program and the creator of the science-based Neurofunctional Electroacupuncture method for the treatment. Dr. Elorriaga has also developed an Advanced Neurofunctional Treatment of Sports Injuries using a precise manual technique. Dr. Elorriaga has taught hundreds of postgraduate courses related to these topics in Canada, the USA, and 14 other countries. **mcmasteracupuncture.com**

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Renowned myoskeletal therapist, Erik Dalton, shares a broad therapeutic background in massage, Rolfing® and manipulative osteopathy in his entertaining and innovative pain-management workshops, books and videos. Dalton is executive director of the Freedom From Pain Institute® and developer of the Myoskeletal Alignment Techniques® and is the author of *Dynamic Body: Exploring Form, Expanding Function*. Visit **ErikDalton.com** to read internationally published articles and subscribe to free monthly "Technique" e-newsletters.

WALT FRITZ, PT

Walt Fritz, physical therapist since 1985 and has been practicing myofascial release since 1992. After training and working with well-regarded pioneers of the MFR field, he began to move the traditional myofascial release narrative from it's historical past into more modern and accepted narratives of neurological explanation. **waltfritzseminars.com**

Postpartum Massage Therapy: Key For Pelvic Floor Rehabilitation

BY MICHELLE FRANCIS-SMITH, B.A., RMT
& NICOLE NIFO, RMT

Our passion for pregnancy, birth and beyond brought us together in 2015 to form Perinatal Massage Therapy Education. As Perinatal focused Massage Therapists and Educators, we have over 30 years of combined experience with providing massage therapy support during the stages of pregnancy, birth, postpartum and for infants. All of it is fulfilling and brings great rewards in our massage practices, but of all the areas of this work, generally, postpartum patients have been the most underserved in their recovery after birth in Canada. This trend is now changing and Massage Therapists have a unique role in those quiet one-on-one massage treatments to shine by providing specialized support, which assists in healing the pelvic floor and supporting structures. Ultimately, setting our patients up to take on new parenting activities of daily living and return slowly to many of their previous ones more successfully.

What Is The Postpartum Period And How Can Massage Therapy Help? The postpartum period is typically thought of as the period that immediately follows birth. Specifically, it is the first year after birth and includes the puerperium (the 4-6 week period of extensive adjustments). Minimally, it includes the period of time until the uterus involutes (to decrease normally) to its pre-pregnant state. The extensive adjustments typically include physical, emotional and psychological. All areas which can be aided by Massage Therapy. The postpartum patient who is recovering from birth may have had a vaginal or cesarean delivery, have experienced birth trauma and may now be experiencing mood disorders, depression or even psychosis. Therefore, it is necessary to understand the full symptom picture and how to physically and emotionally support the patient through positioning, techniques, and communication. With a deeper understanding, an effective treatment plan can be created utilizing our skills to meet the client goals.

What is the Pelvic Floor and Why is Massage Therapy Relevant? The Pelvic Floor is a collection of muscles, nerves, tendons, blood vessels, ligaments and connective tissue interwoven in the pelvis. It extends from the pubic bone to the coccyx and the ischial tuberosities. During respiration, it rises and lowers in synergy with the diaphragm. The pelvic floor muscles function to support: internal organs, sphincters, stability and control of the pelvis and spine and more.

While it is not in our scope of practice to treat internal structures of the pelvic floor, we do have access externally to the musculature of key target areas in the lumbar, gluteal, inner thigh, hip flexor, and the abdominal regions. Massage Therapists are already equipped with the knowledge to treat these areas but often lack the education to integrate the specifics of how the pelvic floor and surrounding anatomy work together to aid in the rehabilitation of postpartum patients. With increased awareness and education, patients can now benefit more than before and Massage Therapists can now better serve the postpartum community more effectively.

Learn more by visiting: **www.pregnancymassagetherapy.com**

Better Together... An Evolved Vision for Healthcare

MARGARET WALLIS-DUFFY, RMT

As RMT's we are fortunate to be a part of an amazing profession that can have a positive impact on the mental, physical and even spiritual wellbeing of the people that we have the honour of treating.

Why is it then, that so many of us struggle to link arms with other healthcare professionals and truly work together to improve the health and wellbeing of those that we have the honour of treating?

How do we begin to shift the way we view our profession and find ways to inject us right into the middle of this integrative model of healthcare?

Well, it beings with challenging our perspectives and uncovering our own limiting beliefs. Are we listening to the stories that lie within our subconscious minds that tells us on a daily basis that we are not worthy of playing a vital role in our healthcare system? Perhaps you haven't truly examined why you are holding yourself back from reaching out to other healthcare professionals and finding ways to work with them.

This is a crucial exercise that all of us must do if we are going to elevate our profession and become a vital part of a more integrative healthcare system.

Here is the good news! We, as a profession have the opportunity or more importantly the responsibility of changing this limited paradigm of thinking!

In our 24/7 society, at a time when many people suffer with stress and perhaps live in fear (losing their job, getting sick etc), we as Massage Therapists have a unique value proposition.

It's not JUST about the physical benefits of massage! We are changing and transforming lives through the laying on of hands and the connection we make of the mind and body through our powerful work!

Over the past couple of decades, we have not only discouraged but have become afraid of touch in our society. Schools and workplaces often frown upon connecting through touch, leaving us craving this fundamental mode of human interaction.

As researcher, Ken Wilbur wrote in *The Spectrum of Consciousness,* "For every mental 'problem' or 'knot', there is a corresponding bodily 'knot', and vice versa since, in fact, the body and the mind are not two. That is, psychic conflict, guilt, shame, unresolved grief all can be lodged in the body as body memories and when the site of the psychic difficulty is deeply touched through massage or other manipulation, it can not only release the physical pain but may make the psychic pain accessible.

It is time to think outside the box or our treatment room walls and explore the vital role that massage therapists can play in the overall integrative healthcare model.

For the past 25 years, I have boldly stated on countless occasions that I do NOT believe in the philosophy that we as Massage Therapists offer alternative care!

No one benefits from an US vs THEM approach to wellness. A conventional medicine vs complimentary medicine approach to healthcare is limiting and quite frankly detrimental to both the health of our society as well as the fiscal health of our system.

Professionals from both the conventional and complimentary healthcare systems have invaluable skills and experiences to share. Empowering patients and healthcare professionals alike to break down the silos and work together with a patient centred approach is the only way to promote optimal health for Canadians of all ages!

I truly believe that we are BETTER TOGETHER and I am on a BIG MISSION to play an instrumental role (alongside some other amazing healthcare professionals who also see the value in my vision) in changing the way we approach healthcare in our country!

I am not looking for perfection but rather progression with a working model that will help to educate and empower people to invest in their health, take a more ACTIVE role in it and to create a template that all of us can begin to follow on our path to wellness.

I am very excited to share that I am about to launch an amazing project of collaboration of a guidebook with a team of healthcare professionals from all disciplines; massage therapists, physicians, naturopathic doctor, pharmacist, optometrist, dietitian, counsellor, and midwife to name a few, to work together with the patient at the centre, to illustrate to both the general public as well as other healthcare professionals that working together nets superior results.

The hope is that this book will serve as a catalyst for conversations with policy makers about the future of our healthcare system. In fact, this is already starting to happen! I am humbled and honoured to accept an award at the Canadian International Women's Day Gala appointed by the UN for my leadership in integrative health.

I have never been more proud to be an RMT and I will continue to work passionately to elevate our profession.

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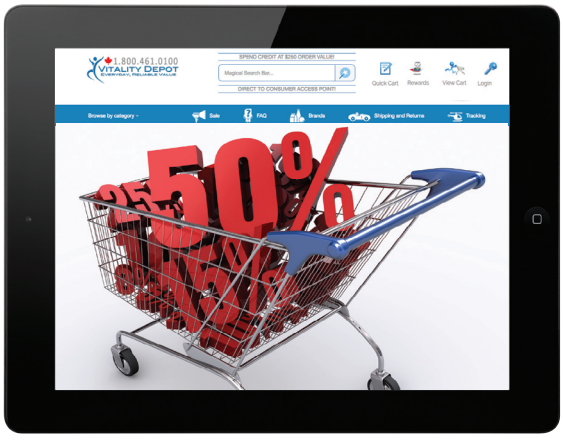

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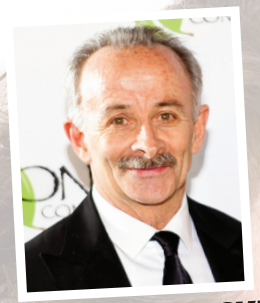

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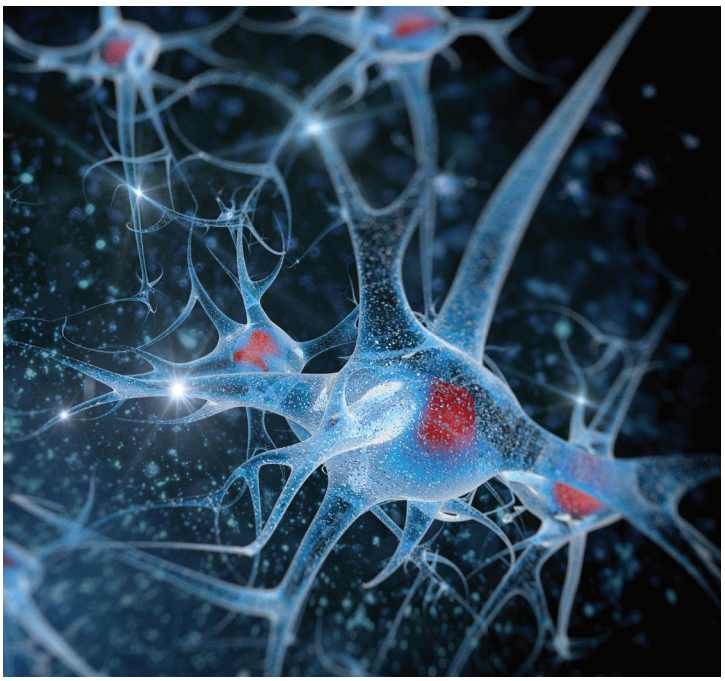
Massage as a Functional Neuromodulation Intervention

BY ALEJANDRO ELORRIAGA CLARACO, MD (SPAIN),
DIRECTOR MCMASTER CONTEMPORARY ACUPUNCTURE PROGRAM

Neurons are arguably the most interesting cells of the body for Manual Medicine Practitioners. Their remarkable properties include: 1. *Neuromodulation* = the ability to modify their own activity *functionally,* and 2. *Neuroplasticity* = the ability to change *structurally* in response to repeated stimuli.

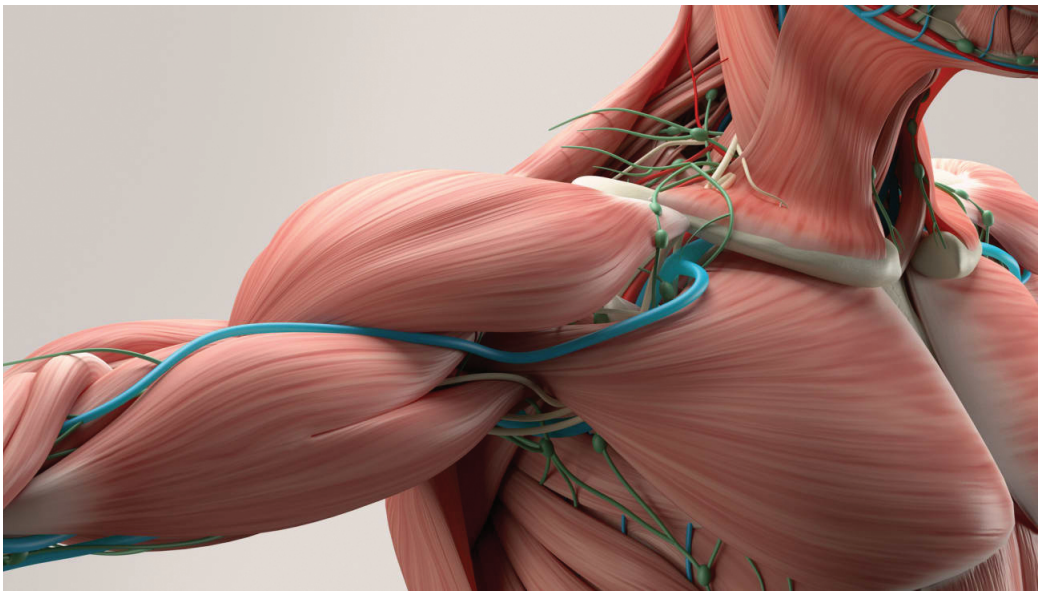
Functional neuromodulation refers to the physiology of the multiple "built-in" neural circuits that participate in the integration and modulation of neural signals at every level of the nervous system. These responses involve both "top down" and "bottom up" circuits. Understanding of these neural pathways and their neurophysiology (see drawing on opposite page) support the thesis that "massage therapy interventions" are fundamentally "functional neuromodulation interventions". Briefly, during "massage therapy interventions" different receptor fields in the somatic tissues are stimulated by mechanical and thermal signals generated by the hands of the therapist. As a result, and depending on the type of nerve fiber stimulated, different **neuropeptides** (such as substance P, endorphins and oxytocin) and **neurotransmitters** (such as glutamate, GABA, and dopamine) are secreted along specific neural circuits involved in the functional neuromodulation of nociception in the central nervous system. The end result: 1. a significant number of nociceptive signals are prevented from ever reaching the brain, which helps with our wellbeing and 2. functionality of the somatic neuromotor and the sympathetic vasomotor systems is preserved, by several mechanisms, including the elimination of nociceptive interferences.



During massage therapy interventions, different neuromodulatory circuits are engaged depending on the innervation of the tissues and on the quality of the inputs used. Most massage therapy interventions have the potential to engage the whole variety of skin, fascial, and musculoskeletal somatic sensory fibers, carrying both exteroceptive information (pain, touch, temperature) and proprioceptive information (position sense, joint movement, muscle length, rate of change of muscle length, muscle stretch, tendon tension, ligament tension). For instance, techniques involving tissue distraction will stimulate sensory receptors such as Pacinian corpuscles, Ruffini organs, and small myelinated free nerve endings in the fascia, while gentle but more vigorous work around the joints will involve the stimulation of thick myelinated fibers (type I and II) involved in proprioception and kinesthesia.

Many practitioners still think about massage therapy interventions as primarily "mechanical" in nature (and they are right from the input standpoint), however, as discussed, most of the beneficial effects of massage can be explained by the functional neuromodulation model. This model also explains the beneficial effects observed in response to needling techniques, electrostimulation, and even movement!

As a summary: according to contemporary neurophysiology, we can state that "massage is a functional neuromodulatory intervention" because it activates functional neuromodulatory neural circuits, promoting modulation and integration of segmental, intersegmental and supraspinal sensory-motor-sympathetic signals, resulting in less discomfort and better quality of movement for the recipients of massage therapy interventions.



ASSESSING NEUROGENIC THORACIC OUTLET SYNDROME

DOUBLE CRUSHED NERVE DAMAGE

BY ERIK DALTON, PH.D.

The term double crush syndrome (DCS) was coined by Harvard University plastic surgeons Albert Upton and Alan McComas, who wrote, "Neural function is impaired when compressed axons at one site cause the nerve to become especially susceptible to damage at another site" (Image 1). Their double crush research began after observing that many carpal, cubital, and radial tunnel patients also complained of unilateral shoulder, chest, and upper back pain.[1] While the DCS mechanism is not completely understood, it likely involves nerve sensitization and neuroplastic changes in the pain-modulating systems of the brain and spinal cord.

Neural compression of the brachial plexus is suitably called neurogenic thoracic outlet syndrome (NTOS). These clients present with a variety of symptoms, including painless atrophy of intrinsic hand muscles and nighttime paresthesia. Athletes may have difficulty grasping a racquet or ball, and some report pain. However, I've found that rather than being a main pain event, NTOS is more of an enhancer of symptoms at a distal site, such as the carpal tunnel. Put simply, the brain pays more attention to double crush nerve insults and is more likely to respond with pain or spasm.

Although most clinicians feel that NTOS is an underestimated cause of DCS, assessment is often difficult due to vague, fluctuating symptoms. Instead of chasing the pain, I've achieved superior outcomes by palpating and releasing all fibrous connective tissue sites that may be kinking, stretching, or inflaming the brachial plexus. In the January/February 2016 ("An Alternate Approach to Tennis Elbow," page 102) and May/June 2016 ("Carpal Tunnel Syndrome Revisited," page 102) issues of Massage & Bodywork, I addressed carpal and radial tunnel compression sites. Now, we'll palpate and release NTOS contractures at the interscalene triangle, costoclavicular canal, and retropectoralis minor spaces (Image 2).

Interscalene Impingement

Nerve fibers originating at the spinal cord travel from the neck, through the thoracic outlet, and into the hand, providing sensation and movement during daily tasks. Certain postures or sleeping positions may increase tension and pressure on entrapped nerves.

Further complicating the nerve's journey through the thoracic outlet, researcher David B. Roos, MD, FACS, discovered irregular fibrous bands that increased brachial plexus stiffness and decreased movement.[2] Roos classified 10 types of contractures that can stiffen the already unforgiving boundaries of the thoracic outlet container. Despite all the neural roadblocks, it has

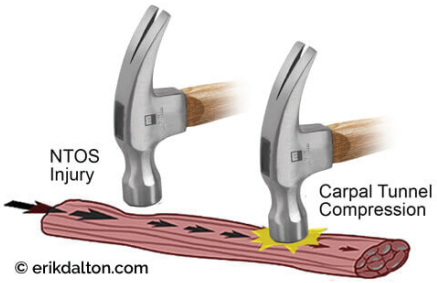


Image 1

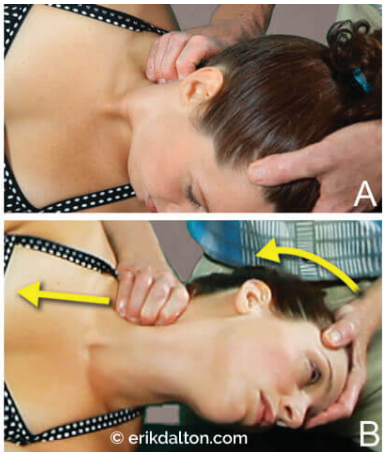


Image 3

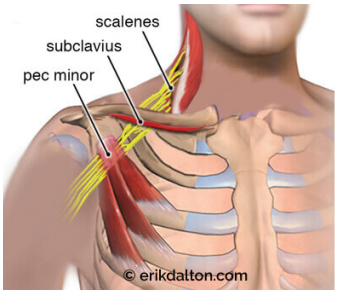


Image 2

Image 4

Image 5

been my experience that many DCS clients respond well to massage, movement, and any type of cognitive training that lowers the brain's threat level during movement. In Image 3, I demonstrate my favorite anterior and middle scalene stretch to create space at the interscalene triangle.

Subclavius and the Costoclavicular Canal

In clients with a drooping clavicle, the underlying subclavius muscle can reduce the costoclavicular canal size and compress the brachial plexus against the first rib. Upper chest breathing can exacerbate the problem, as the first rib elevates during inhalation and can get stuck there. A 2015 study published in BMC Research Notes also noted brachial compression from the subclavius posticus muscle, which ties the first rib to the superior border of the scapula.[3] Rather than dig in to the sensitive tissues under the clavicle, I always begin with the subclavius stretch demonstrated in Image 4. This slow, gentle, graded exposure stretch is designed to reassure the brain that it's now safe to move in previously painful positions.

Retropectoralis Muscle Impingement

Repetitive movements of the arms above the head, common among tennis enthusiasts, may cause friction and overstretch the nerve plexus under the pectoralis minor at the coracoid. The least irritating way I've found to create space here is by stretching the distal fibers that attach to ribs 3, 4, and 5. Notice in Image 5 that the stretch is directed at a 135-degree angle, which is the approximate pectoralis muscle fiber angle from coracoid to the rib insertions.

Many NTOS studies recommend postural correction, including muscle strengthening and lengthening for double crush complaints. However, there is no consensus in the literature as to exactly which muscles should be targeted. Posture is dynamic and the best results are gained through whole-body strengthening and balancing programs such as swimming, yoga, and martial arts. The bodywork goal is to bring mental awareness to areas of restriction and to teach the client it is safe to move through those previously painful barriers.

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Rabbit Holes

Recognizing the rabbit holes of bias

BY WALT FRITZ, PT

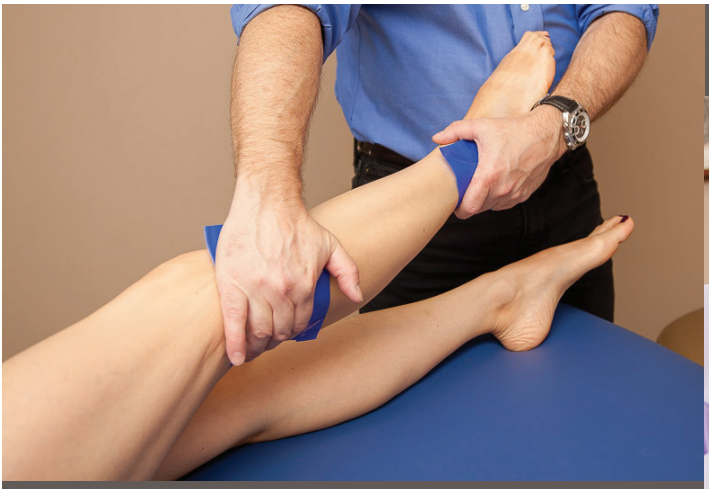
I've become fond of writing of rabbit holes. I use the concept in many of my workshop presentations, as well as on a few of my recent blog posts.

For those of you who have followed my writings or teachings, you know that I speak often of the overlap between our many ways of treating and engagement with patients, both in terms of the way we hold our bodies and move our hands. If viewed from a distance, most people may not be able to discern any major differences between what all of us do for a living. Sure, some of our hands are moving/massaging while others are more still, some of us work dry while others work wet. Some of our patients are quiet and passive during a session, while others may be active, moving or allowing themselves to be moved by the therapists. But there are only so many ways to touch and most of us are touching skin, even though we feel we are reaching and impacting many different tissues, structures, and pathologies.

There is always information that seems to conflict in every line of education and within each profession and manual therapy is no different. For instance, in my profession, physical therapy, the benefits of movement are seen as universal, but movement is often co-opted by those with a movement = strengthening bias, where weakness is seen to be the reason why pain exists. That bias is reinforced by improvements in pain when their chosen form of movement (strengthening) is applied. Strength is often hindered when pain is present, as movement or resisted movement will hurt; inhibiting the strength shown on testing and making the patient seem weak. Movement, in the form of strengthening, is then applied/dosed and pain diminishes. When the PT retests strength, the patient will typically test as stronger. The patient no longer hurts to move so there is no hindrance to movement. Movement is a very common, nearly universal asset to the reduction in pain and discomfort ("I was stiff/painful when I first got out of bed, but after moving around a bit I felt a lot better"). Strengthening is one form of movement, but so is walking, swimming, dancing, yoga, Pilates, etc. All are simply different rabbit holes taken to relieve pain or improve movement ability. If you were to be stuffed down one of these holes, where gains are seen in pain when applying your principles and beliefs, be it through strengthening, swimming, etc., it gets very easy to assume that you are one of the chosen ones; using the best form of intervention, with your biases confirmed. But peek out of your rabbit hole and see what others are doing. Chances are they are having some pretty good outcomes as well. Watch it, though, as confirmation bias tends to make us more than a bit smug. Who needs to look down other rabbit holes when we are having such good success?

Our education, continuing education, and personal experience in the clinic will often lead us down similar rabbit holes of bias. Schooling tends to be broader in scope, with various methods used to explain pain and the effects of our interventions. Not having attended a massage program, I can only repeat stories I've been told by massage therapists I've encountered over the years, who relate that massage training varies (often greatly) from school to school. One school may be more neuromuscular in approach, while others may be more Swedish massage oriented. You may encounter an instructor who completed in-depth continuing education (CE) training after graduation and they bring this information back into their classroom, passing along the trigger point or myofascial belief system to all of you. It becomes quite easy to play off of the enthusiasm for such an instructor to believe that their chosen form of intervention is indeed superior to others. But with so many different CE choices, how can one know which, if any, are really the best?

Fights are easily started over discussions such as this, but I am a firm believer that all manual therapy, massage, and related modalities/approaches get very good outcomes. I am saying this as a CE provider who makes a living off of teaching my version of MFR to others. I know that I should be banging the drum of superiority to all of you, but I know this to be untrue. All manual interventions tend to have outcomes that are viewed as positive. Part of this outcome comes



from a self-selection of patients who seek us out. If a prospective patient believes that a manual therapy form of intervention will help them with their pain, they in turn will seek us out for our expertise. Conversely, if I, a believer in the benefits of manual therapy, was forced to see an exercise specialist, my pre-existing biases and preferences would probably have doomed that relationship from the start. The patient who steps in our door may have further self-selected by reading our website (you have a website, right?) and reading about our approach. How well we tell the story of our modality often dictates outcomes as well, at least that is what evidence on the placebo effect has shown. There is no stipulation that our story needs to be accurate; we just need to tell a good story. (See a blog post I wrote on this topic, around a conversation with Brian Fulton, RMT, here.)

As a student of myofascial release for the past 26 years, I've heard a lot of good stories. Many of those stories revolve around the superiority of myofascial release as the best modality for all sorts of ills. I was sold on MFR and bought the whole story. I then sold it to others; first to prospective patients, then to therapists as I began teaching my own workshops. I had great results and since MFR utilized slow, prolonged, stationary holds on the fascia (skin) and worked in a dry manner (no lubricant), I became annoyingly certain that this sort of engagement was obviously superior to all other forms of manual therapy. After all, those other modalities did not address the fascial component like I did, so of course their results were less-than or temporary. I was a pretty annoying guy back then, though confidence in yourself and your abilities can be seen in our world as a real positive. I was stuck headfirst down that fascial/MFR rabbit hole, seeing no need to ever come up/out. But I finally did, though it was not until I had left the MFR camp in which I was trained. Once removed, I started poking my head up to look around. It started as I began to question many of the fascia stories I was taught, seeing how much of the published evidence on manual therapy posed some conflicting information. When I pulled myself completely out of the hole, I allowed myself to jump down a few other holes of competing narratives. The neurological narrative seemed especially interesting to me, as the folks who introduced me to it had some pretty compelling points and was more acceptable to those in the general medical community. But what became evident is that nearly every rabbit hole, every modality, seemed to have a ripping good story to explain and validate the effects and superiority of their modality. Deconstructing the individual claims of each is beyond the scope of this article. But if one thinks for a bit about the claims made by each modality or type/style of training you've undertaken, you can easily see how the claims made conflict with each other. Can we really be impacting all of the various structure, anatomy, and pathology that we were taught, all while standing on the outside of a patient and touching them through their skin? And, are there universal aspects of our work that can improve efficacy and outcomes?

> OUR EDUCATION, CONTINUING EDUCATION, AND PERSONAL EXPERIENCE IN THE CLINIC WILL OFTEN LEAD US DOWN SIMILAR RABBIT HOLES OF BIAS.

I would venture a guess that even though each modality makes ownership claims to their ability to singularly and selectively impact one and only one tissue/pathology to the exclusion of all else, there is massive overstatement (exaggeration). For example, there are forms of manual therapy/bodywork that claim that pain is due, at least in part, to inhibited muscle groups. The narrative states that unless one reduces inhibition, pain/dysfunction will continue. MFR states that pain is due to unresolved fascial restrictions and/or emotional past stuck in the fascia and that unless those fascial restrictions are properly released, pain/dysfunction will continue. Trigger point therapy states that pain is due to unresolved trigger points and that unless those trigger points are properly extinguished, pain/dysfunction will continue. The various postural approaches to manual therapy pin pain on poor posture and that unless postural deficits are reduced/eliminated, pain/dysfunction will continue. Upper cervical therapists feel that all dysfunction stems from C1 being misaligned and that unless C1 is put back into proper alignment, pain/dysfunction will continue. Craniosacral therapists believe that pain and dysfunction stems from cranial lesions and/or interruptions in craniosacral fluid dynamics and that unless these issues are resolved, pain / dysfunction will continue. Those trained from a foot alignment perspective feel

that body wide problems stem from poor foot alignment and that until the feet are properly aligned, via manual therapy or orthotics, pain/dysfunction will continue. I truly could continue this comparison for a lot longer (I've peeked into a LOT of rabbit holes!), but do you see where I am heading? We get so convinced that our modality's story is accurate, and so enamored by our outcomes, that we make claims such as these and turn a blind eye to everyone else's work. All methods of interventions can claim a certain amount of positive outcomes and each method has validity. But how can such seemingly disparate methods of intervention all have good effects?

RECIPES

All modalities and approaches introduce the therapist to recipes and I am not using that word in a negative way. Even modalities such as MFR, which prides itself on not working from protocols and that each individual is treated as a unique being, has recipes. The recipes I was taught were to always have the patients dig deep for their emotional holding patterns, as "it is common knowledge that emotions are stored in the fascia and not in the brain". Yes, those concepts are actually taught. The therapist then advertises these concepts on their website, inviting prospective patients to enter the world of somatoemotional work, for until the patient digs deep to get at the emotional holding patterns buried and stored in their fascia, they will never truly heal. Recipe.

I too teach recipes, applied in the context of the MFR style of engagement that I've used for the past 26 years. Though my hands still do much of what I was taught, with my mind I am heading in different directions. I teach that the probability is low that I am able to selectively target fascia to the exclusion of other tissues with my interventions. I teach that we are not really treating individual tissues or pathologies, but we are treating the human being on our table. We are treating their skin, fascia, muscles, lymph, nerves, tendons, joints, viscera, bones, etc., and it is highly unlikely that we are so skilled as to be able to magically select one tissue for our attention, though that runs in conflict with most rabbit hole modality trainings. I teach that we are impacting skin as a primary certainty and that our ability to primarily impact deeper tissues and structures is a bit of guesswork. I teach that there may be a hierarchy of plausibility as to what we are effecting, from less-wrong to more-wrong. I accept that all therapists have good outcomes and effects when they apply what they've been taught and when they hone their craft over time. I teach that perhaps the most important aspect of my work is to frame it from the perspective of the patient, allowing them to direct the care, rather than applying it from the perspective of ego. I take a risk by saying that many of us were trained to work from our ego, but I say it anyway. What I mean by this is that we are taught principles of our modality and then encouraged to dive deeper by taking additional training and moving into mastery. The more experience we attain, the greater our abilities to detect and solve problems, which is all very ego-based. I have a lot of experience with MFR and am very good at what I do, but one thing is for certain; I do not know what my patient is feeling. I do not know of their full past or present. I do not know their beliefs as to what is wrong with them nor what they think will help them get better. I do not know these things unless I ask. And I do ask. Frequently.

If you come away from one of my workshops with one bit of understanding, it would not be about fascia, neurology, techniques, or other things, but it would be to always include your patient in the process of treatment decision-making. Not just setting goals, but fully immersing them into how areas of intervention are determined, how much pressure they feel is necessary, and to be fully in control of the sessions. Not controlling, but in control.

Bringing a higher emphasis on patient-directed care is what I hope to be remembered for. I do so in the context of a myofascial release style of engagement, but what I teach can be applied to any and all modalities, whether the work is wet or dry or still or movement-based. I believe that all rabbit holes can benefit from a tune-up; a tune-up that adds in a stronger component of patient-directed care. If you take one of my workshops, I'm not going to try and grab you by the ears and pull you out of your rabbit hole. I am going to introduce you to a new model of patient care that applies to all modalities. Rabbit hole therapies will always exist as long as continuing education requirements are in place for us. But I believe that these rabbit holes can all benefit from a strong dose of patient-directed training. I do hope that you will join me.

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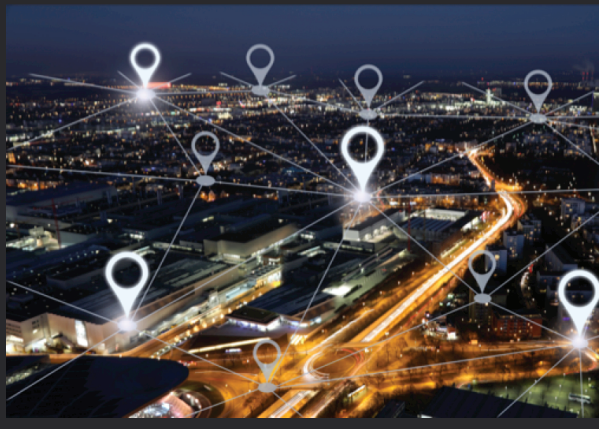

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