

Find It, Fix It, Retrain It, or Release, Relax, Retrain

by Marc Heller,DC

Author's note: Inspired by Mark Bookhout, RPT, Craig Liebenson, DC, and Vladimir Janda, MD.

I suggest this model as an updated model for optimal chiropractic or other manual care. Rehabilitation is part of acute and chronic patient care. The specific rehabilitation movement can be tied into the specific subluxation pattern. Find the pattern, the three-dimensional way that the spine resists moving. Fix it with adjustments and appropriate soft-tissue release and moving the joint through its full range of motion.

One of the ideal ways to correct these problems releases the joint fixation, relaxes hypertonic short muscles, and retrains other involved muscles. This is the osteopathic mobilization method, muscle energy or postisometric relaxation applied to the specific joint. Muscle energy can help retrain the patient subcortically how to move into the restricted area. They need to further learn to glide into the restricted area and retrain the muscles that are needed to reinforce the new pattern. The subluxation, even in acute pain, is often a chronic pattern with a lack of joint movement in a predictable direction. There will almost always be an accompanying pattern of muscle imbalance, most of which has already been mapped by Janda, Bookhout, and Liebenson.

If you do this work, the patient will get a workout right on your treatment table, helping them reinforce the correction of the fixated area. The patient usually bypasses this area in their everyday motion. The exercise is difficult for them to do, as they will not have good neuromuscular control of the muscles needed to go in this direction. The patient learns to move into the direction of joint and muscle resistance, often bringing various PNF style motions to bear on the area, incorporating some of the motion principles of Moshe Feldenkrais and Judith Aston, as well as yoga concepts and stretches. The patient continues this specific exercise only for a short time in truly acute areas (for a longer time if this is a major part of their chronic movement pattern, or if they are motor morons).

An extremely common example in the pelvis would be an anteriorly rotated innominate on the right, with a posterior innominate on the left. The ASIS on that side will be inferior and resist superior movement back into posterior rotation. This is the classic muscular fixation, usually compensatory, and better addressed through muscle retraining than forceful manipulation of the possibly hypermobile SI. The right side of the transverse abs is weak, allowing their origin at the ASIS to drift down. The rectus femoris and psoas and iliacus will often be tight on the right, and possibly on the left also, pulling the ilium forward. The patient will not be able to stabilize the pelvis as they slide their right heel down the table slowly, even if attempting to hold a pelvic tilt. As the patient straightens the bent right leg, the ASIS drops further on that side.

The corrections may include mobilizing the right SI back into posterior rotation, retraining the right (and left) transverse abs, stretching, and relaxing the tight psoas and rectus femoris. Don't forget to look at tightness of the right quadratus lumborum and lats, as well as inhibition and weakness of the left gluteus medius and/or gluteus maximus, and tightness of the left hamstrings and left and/or right piriformis. You may find a whole set of muscular dysfunction along the sling of the right shoulder through the left (and right) pelvis.

Don't just fix the SI. Teach patients how to stay corrected with specific exercises to address their mechanics. Are these muscle patterns universal on everyone with SI rotation? No, but they are a good place to start looking, and many of the components outlined will usually be found. An optimal exercise program would include self-mobilization for the fixated joint and the small muscles around it, and stretching and/or strengthening for the long muscle dysfunctions found in the region. These neuromuscular patterns will contribute to reoccurrence of the fixation and/or articular strain if not addressed.

Much of this work is based on the latest neuromuscular research. I will not footnote it here. Most of it is a combination of others' ideas, processed through my own filters and biases, with thoughts and speculations about a model to more thoroughly address common neuromuscular problems.