Fascial Release for Structural Balance combines manual therapy skills with the exciting new field of structural therapy, which employs the unique and newly discovered properties of fascial tissues. Fascia, our biological fabric, plays a vital role in support, posture, and stability. Through informed assessment and manipulation of fascial patterns, you can help eradicate many of your clients’ chronic strain patterns—for good.

The book is designed for any bodywork practitioner using manual therapy. Physiotherapists, osteopaths, chiropractors, and massage therapists can help their current and future clients by giving them a structural analysis and creating a treatment strategy using the techniques included in this book. The authors bring together a unique introduction to fascially informed structural anatomy with a method for postural analysis and detailed and easily applied techniques.

James Earls first trained in bodywork in 1991 before studying with Thomas Myers in 2000. He now practices Structural Integration and massage therapy in Belfast and is the director of Ultimate Massage Solutions and Kinesis UK, which bring high-quality training in the Anatomy Trains approach, Fascial Release Technique, and Structural Integration throughout Europe. Earls is a popular presenter and writes regularly for a range of bodywork magazines.

Thomas Myers has practiced integrative structural therapy for over 30 years in a variety of clinical and cultural settings. He is the author of Anatomy Trains (Elsevier 2001, 2009) and numerous collected articles for journals and trade publications. Myers directs Kinesis, Inc., which offers certification in Structural Integration and continuing professional development courses worldwide for manual and movement therapists from many professions.

"What a great idea to combine James Earls' expertise and philosophy with Tom Myers' classic contributions to structural bodywork. This is the long-awaited expansion of the Anatomy Trains theoretical concepts into a clearly written, functional 'how to' manual that is a must-read textbook for all bodyworkers of all ranges of experience— not just structural integrators."  

"Fascial release has never been made more understandable and achievable—a well illustrated and excellent read."
Leon Chaitow, ND, DO, Honorary Fellow, University of Westminster, London. Editor-in-Chief, Journal of Bodywork & Movement Therapies

"This book is a thorough and refreshing approach to regional fascial release technique."
Erik Dalton, PhD, author of Myoskeletal Alignment Techniques®

"With a wonderful blend of art and science, this text brings together many aspects of structural change grounded in anatomical precision. It lets you see the relationships surrounding the body and how they link to produce the various patterns you will see in your clients; equally importantly, it gives you the strategies to address them."
Robert Schleip, PhD, MA, Director of Fascia Research Project, Institute of Applied Physiology, Ulm University. Research Director of the European Rolfing Association
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Introduction/How to Use This Book

Each person’s structural pattern is unique – an expression of the many variables that combine to create the shape in each of us. Thus any analysis of structure is necessarily limited. Whether by conscious or unconscious choice, by inherited design or learnt habit, through physical or psychological trauma, we shape our body and therefore the tissue that supports it into one of the six billion possibilities that is you or your client. To cover each and every of the possible vagaries of shape would require a tome many times larger than this one.

In this book we have therefore guided you to see many of the common tendencies, with visual examples where possible. Each chapter gives you an introduction to the structural anatomy of a portion of the body, followed by hints and ideas on what to look for when analyzing clients, rounded off with strategies and tools to address the fascial sheets and guy ropes within it.

Due to the holistic nature of human patterning, it is difficult to give a linear and methodical analysis of each and every possibility, and it would bore the reader to do so. Where the logic behind a technique was not clearly covered within the anatomical or BodyReading introduction, we have given structural examples alongside the technique.

In some cases only one example is given, as it would again tire the reader to be constantly reminded that ‘if the opposite pattern is present then the tissue relationship will be reversed’. A simple understanding of the antagonistic relationship of muscles is presumed. Although this book can stand alone, many of the techniques presented here draw on the Anatomy Trains theory set forth in, Anatomy Trains: Myofascial Meridians for Manual and Movement Therapists (Myers 2009), and we have not repeated all of the detail of each Anatomy Train. That information is readily available in other sources should you wish to research it further, though a summary of each is given in the appendix for easy reference. Nevertheless, readers unfamiliar with ‘Anatomy Trains’ will still find in this manual many of the necessary tools and much of the understanding needed to start making changes with their clients’ structures.

The techniques are given in a roughly anatomical sequence rather than according to the Anatomy Trains theory; though where the target area does belong within the territory of a Train it is referenced for your convenience. This allows the practitioner to take advantage of the fascial continuities by extending the release of one area by working on adjacent elements of the same
line. So, for example, if the hamstrings seem reluctant to release or lengthen, then following the Superficial Back Line of which they are a significant element we may achieve further release by working with the gastrocnemius or sacrotuberous ligament. A key for the abbreviations of the lines is given at the end of this section.

BodyReading does take practice and we have a number of other resources to help you with it should you wish to take it further; for more details, see Resources. Likewise, we run a number of workshops throughout the world in which we combine the Anatomy Trains theory, BodyReading, and Fascial Release Technique (FRT).

The techniques that are listed are not complete. Certain areas have been omitted because their intimacy or their delicate nature does not lend itself to learning without the practical guidance available in a workshop or mentoring relationship. These techniques can be creatively adapted to individual patterns in terms of direction, depth, and choice of your body position and applicator tool used – fingers, palm, knuckles or elbow. What is important is your understanding of what you are trying to achieve and the nature of the tissue you are working with. Much of this will depend on palpatory feedback, something that can be learnt only through practice and with a certain amount of guidance. But the reflective practitioner will be well equipped to face a wide range of clients with confidence after working through the many aspects of this book. We hope to encourage the reader to see the techniques as templates and ideas that are malleable to fit the needs of the client and their individual tissue. Working with the idea of each intervention being a ‘communication between two intelligent systems’ and achieving and maintaining the lock in the tissue are two of the most important elements of this approach. We therefore recommend even the seasoned practitioner to spend time with the introductory sections of the book.

Most anatomy taught today uses the traditional elements of the body, generally ignoring the important qualities of the fascial webbing and, in particular, the myofascia which this book addresses. Using the names of individual muscles can give the impression that they are discrete, separate entities in their own right, but several lines of current research are showing the limitations of this way of thinking (Myers 2009, Huijing 2008, Stecco 2009, Van der Wal 2009). In order to describe the mechanics of each of the techniques within this book we have used familiar muscular terminology. But each time we name a muscle we hope to bring to mind the idea of continuous sheaths and planes of strong elastic tissue in which are contained the contractile elements that we call muscles. When we refer to any muscle within this text, please realise that we consider it to have wider connection in the body beyond its traditional origin and insertion.
Our main aim is to encourage you to think and analyze in a different way: rather than being drawn by the client’s story of their pain, look further afield and build a story of their structure, work with them to explore it, develop an alternative strategy and experiment with a structural approach using fascial release. This book provides an introduction to this exciting and rewarding approach to bodywork. We encourage you to take it further by attending any of the increasing number of workshops available worldwide. We look forward to meeting you in person one day soon.

We wish you every success.

**Thomas Myers & James Earls**

**Key to Anatomy Trains Abbreviations**

- SFL – Superficial Front Line
- SBL – Superficial Back Line
- LTL – Lateral Line
- SPL – Spiral Line
- DFL – Deep Front Line
- SFAL – Superficial Front Arm Line
- DFAL – Deep Front Arm Line
- SBAL – Superficial Back Arm Line
- DBAL – Deep Back Arm Line
- FFL – Front Functional Line
- BFL – Back Functional Line
Human Patterning

All therapists of whatever method, but especially manual therapists, are seeking greater order in human movement patterning, making forays into the porous border between structure and function. Any change of behavior is a change of movement. But for sustained change in the postural basis of movement, attention to the fascial tissues and their properties is essential.

Every tangible structure in the real world is a compromise between the need for stability – necessary to maintain a coherent structure so that repetitive processes can happen easily and reliably – and mobility, which allows the structure to deal with all kinds of environmental novelty responsively and without ‘breaking’ essential parts.

While banks and mountains lie at the stability end of the spectrum, living creatures tend to lean toward the mobility end. Plants, mostly anchored, have settled on fiber made from the carbohydrate cellulose as their main structural element. Large land animals, including humans, primarily use the pliable protein collagen fiber for creating structures that are stable enough to be physiologically viable and at the same time thoroughly mobile in their ability to move through the environment and manipulate it to their own ends.

Thus, a thorough familiarity with the properties and positioning of collagenous tissue – which makes up most of the tendons, ligaments, aponeuroses, muscle envelopes, organ bags and attachments, and sheets of biological fabric – is vital to successful manual therapy and physical training. Understanding muscles and nerves – though essential – is not enough. Approaching the fascia requires a different eye, a different touch, and tissue-specific techniques.
This stability/mobility compromise can lead to ‘compromising’ situations at both ends of the spectrum. On the stability end, parts that should stay mobile relative to other parts can become fascially or neurologically stuck together and unable to move differentially. This results in congestion and mechanical strain locally, or additional loading in linked – but sometimes quite distant – ‘elsewheres’ (figure 1.1).

On the other side, sometimes parts that should stay closely bound become too movable relative to each other, and this hypermobility can cause friction (and thus inflammation and its aftermath). This excess movement also necessitates either muscular or fascial compensation (read: contraction or binding) somewhere else to create enough stability for function (like walking, standing, sitting, work or sport) to continue without breaking down.

Muscle ‘knots’, spasms, long-term tension in trigger points, less-than-efficient movement patterns, thickened or glued fascia, ‘dead’ areas of sensori-motor amnesia and, of course, tissue pain are all ultimately sequelae of the body’s attempt to deal with these stability/mobility issues as best it can under the available circumstances.
So, as therapists seeking to restore structural integrity and balance for our clients, we address ourselves every day to this complex array of adaptations in the ‘neuro-myo-fascial’ web. Welcome to a practical guide to negotiating these patterns via manipulative interventions in the highly innervated muscle and connective tissues.

In this book we concentrate especially on the fascial/connective tissue part of this patterning troika. Everyone knows their muscles and bones, and much study has gone into them. The connective tissues that mediate between the two have received less focus and are thus less well understood. It is to the properties and disposition of these adaptable tissues that we now turn our attention.

One caveat: Any linear presentation, e.g. this book, must necessarily present the approach in terms of individually named ‘parts’, but the challenge for any therapist is to assemble such piecemeal ‘techniques’ into an artful and holistically comprehensive approach to the client’s unique overall pattern. Chronic problems especially involve diverse tissues over wide areas of the body, and cannot be dealt with effectively solely by local treatment at the site of pain or dysfunction.

Developing the visual and palpatory assessment skills to create such bodywide session or series strategies with techniques such as these is the goal of our short courses and longer trainings, see Resources.

**Introduction to the Fascial Webbing**

*Fascia is the missing element in the movement/stability equation. Understanding fascial plasticity and responsiveness is an important key to lasting and substantive therapeutic change.*

Although anatomy books and technique libraries (including this one) are quick to label and identify these discrete bits, it is important to remember that humans are not constructed from parts like an automobile or computer. No ‘part’ of a biological creature could exist without constant and unbroken connection to the whole.

**All One Net**

Your fascial webwork began as a unified whole about the second week of your development, and will remain a single connected web from top to toe and from birth to death. From the moment of its inception, it has been folded and refolded in the complex origami of embryological development into a human who can stand, eat and read on its own. When we identify the different parts of this webbing – your dura mater, lumbar aponeurosis, mesentery, iliotibial tract or plantar fascia – we need to remember these are man-made names for subsets of your indivisible whole.
While every anatomy lists around six hundred separate muscles, it is more accurate to say that there is one muscle poured into six hundred pockets of the fascial webbing. The ‘illusion’ of separate muscles is created by the anatomist’s scalpel, dividing tissues along the planes of fascia – and in the process obscuring the uniting element of the fascial webwork (figure 1.2). Of course these distinctions are useful, but this reductive process should not blind us to the reality of the unifying whole.

After birth, this single ‘organ’ is subject to the shadowless force of gravity – perhaps the largest force in shaping it, for better or for worse – interacting with the possibilities offered by our genes and the opportunities (or lack thereof) offered by our environment. It can be torn by injury or cut with a surgeon’s blade, and it will do its best to self-repair. It shapes itself around our patterns of movement in breathing, walking, occupation and avocation. It is shaped by our psychological attitudes, by the movements they allow and do not allow. Finally, it is subject to the inevitable depredations of aging – degeneration, fraying and drying out – until we are finally ready to leave it behind.

Figure 1.2: The Superficial Back Line in dissection. Turn the scalpel on its side and you can readily see the fascial connections which link muscles in longitudinal series – part of the single net of fascia that runs from the toes (bottom) to the nose (top).

Through all of this it will remain a single, unifying and communicating network, holding us in a characteristically recognizable and physiologically viable shape, turning the contraction of the muscle tissue into sensible movement by transmitting it to the bones and joints, and in concert with the nerves and muscles generally managing the constantly changing mechanical forces that impinge on us via our contact with the rest of the world.

You cannot remove a cubic centimeter from the body’s meat without bringing along some of this fascial net. This fascial system, which combines tough fibers with an amorphous gel of gluey proteoglycans (ground substance) in an aqueous medium, provides the environment for each and every cell, invests every tissue, surrounds every organ and binds the whole system into shape. With its intimate connection to every tissue structure, it also has a large role in physiological maintenance and immunity, but we will leave these roles for others to explain and focus on its mechanical functions.

Fascial Elements
To deal with this wide variety of forces, our connective tissue cells create an equally wide array of building materials by modifying a few surprisingly simple elements. Bone, cartilage, tendon, ligament, heart valves, sheets of tough fabric that surround the muscles, delicate gluey webbing that supports the brain, the transparent cornea of your eye and the dentin in your teeth – all of these and many other structures are made by connective tissue cells (figure 1.3).
Figure 1.3: Cells such as fibroblasts and mast cells form connective tissues by altering the elements in the interstitial space, by altering the proportions of the constituent elements: fibers, gluey proteoglycans and water.

Using proteins supplied by our food via the bloodstream, connective tissue cells turn out the ubiquitous intercellular elements that hold our trillions of cells together. The principal element of our structure is tough collagen fiber, which is interwoven with other fibers – elastin and reticulin – in a bed of gluey mucopolysaccharides, also manufactured by these cells. These large sugar and protein polymers bind various amounts of water to create many configurations with a spectrum of properties that serve our varying needs for stability and mobility.

In bone, the leather-like dense web of collagen is embedded in an apatite of calcium and mineral salts that replaces the ground substance, producing the most rigid yet still resilient tissue in our bodies – the memento mori that lives on after us when our other tissues have melted away. Cartilage has the same leathery base (though cartilage can vary with more or less collagen, or elastin) but the rest of the interstitial space is filled with a silicon-like chondroitin.

In tendon and ligament, the fiber predominates, with only a small amount of glycoproteins within the network of fibers arranged in regular crystalline rows. In aponeuroses, there is a similar proportion of fiber to glycoproteins, but the fibers run every which way, like felt.

In the loose tissues, like areolar tissue or fat, fibers are interspersed within larger amounts of aqueous glycosaminoglycans. The lower viscosity in these tissues allows for easy dispersion of a variety of metabolites and infection-fighting white blood cells.

Within limits, the connective tissue system is able to modify these elements to deal with locally changing mechanical conditions, creating stronger ligaments and denser bones in response to the demands of (say) a summer dance camp, and of course to heal wounds, mend broken bones, or repair...
torn fabric. Unfortunately it can also modify itself in a downward direction as well, in response to a sedentary lifestyle, or a psychologically or occupationally based chronic pattern of holding.

Recently we have learnt that the cells themselves, at least a special brand of fibrocytes called myofibroblasts, can actually modify themselves to tie into the fascial webbing they have created via the integrins we discuss on page 13, and exert a force to contract it (figure 1.4). Up until this was discovered, it was assumed that muscle was contractile, but the fascia was passively plastic. Now we know that under certain conditions the fascia can contract, by means of these cells altering themselves to be like smooth muscle cells, and exert a contractile force into the surrounding fascial net.

![Figure 1.4: Myofibroblasts add cellular contraction to our picture of the fascial net. Under certain conditions, some fibroblasts hook their cellular structure into the connective tissue matrix, and then exert a slow, smooth muscle-like contraction into the fibrous webbing.](image)

These conditions are very interesting, because unlike any other muscle cells in the body – smooth, cardiac, or skeletal – these hybrid connective tissue cells are not innervated. Instead of being stimulated by nerves, they are stimulated either by certain chemicals like antihistamines or oxytocin, or by sustained mechanical tension through the fascia they are connected into.

Myofibroblasts take some time to build into such a contraction – twenty minutes minimum – and some hours to completely let go, so this is not an immediate compensatory contraction such as we might see in other muscle tissue. But the combined contraction of many myofibroblasts does exert a significant pull on such large sheets as the crural fascia around the lower leg, the
thoraco-lumbar fascia in the lower back, or the palmar or plantar fascia, where overactivity of these cells may contribute to fibromatosis or Dupuytrens’ contracture.

While little is currently known about the clinical implications of the presence or contraction of myofibroblasts and what it might indicate for the manual therapist, it does represent a significant departure from the established ideas, and shows us that what we ‘know’ about the fascia – i.e. it does not actively contract – is subject to change.

**Fascial Signaling**

The biochemical signaling that governs such tissue changes on the cellular level is just yielding its secrets to researchers, but the implications of this new mechanobiology are far-ranging for all manual and movement therapists. Every cell, and especially every fibrocyte, is not only ‘tasting’ its surrounding chemical milieu (à la the work of Candace Pert et al. (1997) with neuropeptides), it is ‘listening’ and responding to the mechanical environment of tensions and compressions as well.

The mechanism through which this happens is via special molecules that stud the surface of most cells in the body, but especially the fibroblasts and their cousins, called *integrins* (figure 1.4). Cells fix themselves within the connective tissue net via integrins. Cells move through the body primarily by reaching out to make new integrin connections at their ‘head’ end and loosening those connections at the ‘tail’ end. The integrins are connected via the cytoskeleton deep into the cell, such that new pulls of the connective tissues can affect the cell’s behaviour, and even how its genes express themselves.

The implications of this finding are profound. It suggests that we could define structural health as a state where each cell of the body lives in its ideal mechanical environment. What constitutes ‘ideal’ varies from cell type to cell type, and can even vary within cell types in different parts of the body.

Muscle cells like a bit of tension in their environment; most nerves work best in low-tension situations. Epithelial cells will express their genes differently in a more tensional environment than they do in a more compressed one.

At the extremes, cells put under too much tension tend to abandon their ‘job’ in favor of reproducing more of themselves to resolve the high tension. Cells that are too compressed tend to commit suicide (apoptosis) in preference to forming a tumor, which is what happens when cells are too crowded.

The ancients searched for the proper proportion of the human body, looking at the golden mean and the relative proportions of different parts of the body. Now, we can define a new ideal of
proportion based on the optimal biomechanical environment for each cell. While we are a long way from being able to measure this in a therapeutically specific way, this concept points to an exciting new marriage between cellular biology and manual therapy.

Another form of fascial signaling stems from the idea that the wet collagenous network forms a liquid crystal, a semi-conducting network. Pressure or tension creates an ionic flow within this web, known as piezo-electricity, and this electrical flow stimulates or depresses the fibroblasts to form (or not form) new fibers (figure 1.5).

![Diagram of neural network](image)

*Figure 1.5: We have long acknowledged the neural net as a signaling network, but the connective tissue network is potentially a second, perhaps more primitive but five times speedier, signaling network.*

In this way, the tension of our movements, especially oft-repeated movements, allows ‘remodeling’ of our connective tissues, including the bones and ligaments, when we put ourselves through the summer dance camp in our example above, or more subtly as our posture changes due to change of occupation, a psychological attitude, or advancing age.

Thus, when we enter the client’s neuro-myofascial web, we are seeking to augment or steer natural processes in a direction helpful to healing or more efficient performance, from the cellular and molecular level all the way up to biomechanical whole of performance – daily, athletic or artistic.
In terms of the overall neurology – although the effect of deep touch on the many neural receptors in fascia (most of which are modifications of stretch receptors) has not been finally settled – the general effect seems to be to reset the ‘tone-o-stat’ of the nerves, restoring sensation in unresponsive nerves, and lowering the stimulation threshold of motor nerves that are stuck in the ‘on’ position (figure 1.6).

Figure 1.6: Your fascia is your richest sensory organ, filled with nerves including free nerve endings, Golgi tendon organs, Pacinian corpuscles, Krause’s endbulbs, and Ruffini’s corpuscles – all giving the brain a clear picture of the pressure, vibrations, shear – in fact, any deformation of the fascia.

In the fascia, the effect of deep touch seems to melt the glycoproteins that have become more viscous, and through their thixotropic quality, they can reverse back to a more malleable gel-like, less gluey viscosity. The connective tissue is a complicated colloid that could be compared to a gelatin dessert: put it in the fridge and it hardens; put it on the stove and it liquefies (becomes thixotropic). A similar process is happening in touch (and probably in dynamic exercise and yoga-like stretching as well).

When deep touch is applied with a specific directional vector, the melting of the glycoproteins between the fibers allows the collagen fibers to slide on each other, creating a plastic deformation that results in a sustained lengthening of the tissue. This is quite different – in intent, feel, and result – from stretching elastic muscle tissue. It is this plasticity in the fascia that accounts for the permanence and progressive nature of well-ordered fascial manipulation. Unlike muscle, fascia – once it is successfully lengthened – does not ‘snap back’ into place.
It requires a sustained touch to get the fascia to melt and move, and the specific depth and direction of tissue stretch is vital. Deep touch also affects the many nerve endings in the fascia, and the lengthening effect may proceed from the neurological effect or the thixotropic effect or some combination of both. This book is designed to guide you into a feel for the tissue changes and direction that will give you the maximum result for the minimum effort.

In summary, the nerves, muscles and fascia combine to make myofascial tissues a dynamic place to be. Deep touch can affect all three of these tissues, but the effect on the fascia, when melted and lengthened, is sustained, giving the other two tissues time to readjust to the new mechanical environment. Fascial tissue as a whole – cells, fibers and ‘glue’ – can be deformed by injury, abuse or disuse, but the good news is that it is ‘plastic’ – it can be reformed in response to skilled bodywork, stretching and awareness.

This section has gone some way in explaining the local effects of mechanical strain and therapeutic release on the connective tissues, where every cell, as we mentioned, is now known to be ‘listening’ and adjusting to the mechanical messages coming in from all around it. Additionally however, as therapists, we routinely see that work in one part of the body can cause shifts in some other part of the body quite distant from the site of applied manipulation. For example, work in the ankles may provide relief in the lower back, or opening in the neck may result in a more expanded breathing pattern.

To see how local changes can produce global results, we need to return to the idea of the fascia being all one net, and see the entire design in light of an unusual kind of engineering we use in our bodies called ‘tensegrity’.

**Tensegrity**

*The body is designed to distribute strain globally, not to focus it locally. The immediate forces of exertion in gravity, as well as the more slowly moving forces of compensation for injury and patterns of use, are best understood in terms of a particular type of geometry known as ‘tensegrity’.*

Dealing with tension, compression, bending and shear is the daily bread of engineers. Ever since Descartes, our body has often been described in terms of a ‘soft machine’, where the bones are like girders, the muscles like cables, and the whole structure somewhat like a crane – a series of pulleys and levers understandable in terms of Newton’s laws of motion and (at a deeper level) thermodynamics. While this mechanical approach to kinesiology has given us much insight into the biomechanics of movement, such an analysis has not really clarified even such simple actions as walking. It certainly does not shed light on the kinds of global compensation for insult we are discussing here.
The advent of chaos mathematics, fractal equations, and greater understanding of how living systems hover on the edge of complexity has led to a new understanding of the human stability/mobility dynamic. Rather than seeing the body in the same terms as we see our houses and bridges, we can instead view the body as an example of a unique type of structuring known as ‘tensegrity’ (a neologism derived from ‘tension’ and ‘integrity’), in which the integrity of the structure rests on the balance of tensional forces, rather than a continuity of compressional forces.

Initiated by artist Kenneth Snelson, and developed by designer Buckminster Fuller, tensegrity structures give a contrasting way to see ourselves. Instead of viewing the skeleton as a sturdy framework (which it clearly is not – even the classroom skeleton has to be wired together and hung from a stand) from which the muscles hang, we can see the body as a single tensional webwork, in which the bony struts ‘float’ (figure 1.7).

Verbal descriptions of tensegrity soon get tangled. Pictures help, but playing with, handling, or building a tensegrity structure is the best way to get a sense of how these structures work (figure 1.8).
Such structures are more resilient than the cranes or machines we are usually compared to, and display several unique properties that recommend them as a model for human functioning:

1. **Internal integrity**
   
   Your house or a crane would not work as well if it were turned upside down, but an animal body, including a human, maintains its structural integrity while hanging from a tree, doing a headstand, or spinning through a dancer’s airy leap. Tensegrity structures, because of the internal balance of tension and compression, similarly hold their shape no matter what their orientation.

2. **Strain distribution**
   
   Because the elastic bands in a tensegrity structure are continuous and the compression members ("bones") float in isolation, any deformation (caused either by pushing on a bone or changing the tension on a single string) will create strain that is distributed evenly throughout the structure. This results in small amounts of deformation over the whole structure rather than large amounts of deformation locally.

   *Figure 1.8: The spine modeled as a tensegrity structure. Obviously these simple models only begin to rival the complexity of the spine, but in action they mimic certain aspects of our own movement and behavior in both function and dysfunction.*

This phenomenon has been demonstrated biologically (Huijing 2009), and in this writer’s opinion is highly under-rated in current treatment texts. In short, any injury rapidly becomes a distributed phenomenon patterned into the whole body, and requires a whole-body assessment, and whole-body treatment. A whiplash is a problem of the neck for a few days, a problem of the spine for a few weeks, and thereafter a whole-body problem. Continuing to treat only the neck after this period is an all-too-common mistake.

3. **Expansion or contraction in all axes**
   
   Squeeze a balloon around its center, and it becomes longer. Pull on a rope, and its girth decreases as the tension is increased. Because of their distributive quality, tensegrity structures act differently (and often, so do bodies). Expand a tensegrity structure in one dimension, and it will sometimes (depending on its internal structure) expand in all directions. Compress it, and it will compress not only along the line of force, but in all dimensions, becoming denser and more resilient as it does.
Bodies show this kind of phenomenon also. A body with a serious injury can contract and retract along all its axes, not just the one the insult first encountered. On the other hand, as we open the body in one dimension, it seems to expand into all dimensions – more height, more width, more depth.

Although the final verdict is not in on exactly how the body’s mechanics work, seeing the body in terms of tensegrity leads to coherent global strategies that greatly enhance the efficacy and longevity of local treatment.

Though the fascia is very important in all the respects we have mentioned – its plasticity, its resilience, its communication and its holistic nature – it is not, of course, the entire picture. We can go some way toward filling in the ‘fibrous body’ by adding the two other whole-body systems, the circulatory and nervous systems. These two systems are more widely understood than the fascial system, and our muscles are clearly tied to the neural signals and nutritional bloodstream for their function. Thus, most locomotor therapies have concentrated on the free flow of fluids to and from the cells or the coordination of movement via unimpeded nerves (figure 1.9).

Figure 1.9: The three whole-body networks were outlined by Vesalius, who published slightly before this book in 1548. In his wonderful etchings, we see how any of these nets would show us the shape of the whole body. The fascial net is the least developed of these three images, and remains so over 450 years later.

Of course these well-documented effects on what is in fact a seamless neuro-myofascial web are very important, and in practice impossible to completely separate. Nevertheless, our thesis is based on the properties of the fascial part of this web that mediates between stability and mobility.
Compared with these other networks, the fascial network is at once faster to communicate – 720 mph for mechanical information versus 150 mph for the nervous system – but slower to respond than either the neural or vascular. The fascia’s remodeling response is measured in days and weeks, rather than seconds or minutes. It is slow to accept changes initiated from the outside, and holds on to what changes it makes. This makes the fascial system a repository of much of the patterning for chronic issues, as opposed to the acute. Of course, there can be acute trauma to the connective tissues, as in a broken bone, severed tendon or sprained ligament, but the effect of this trauma distributes itself across the tissue webbing and tends to persist long after the initial healing of the other tissues.

The inflammatory response that both swells and brings healing proteins to damaged tissue also leads eventually to increased fibrosis, the loss of available movement between layers, and a ‘stickiness’ to the interstitial elements that impedes vascular and lymphatic flow. Chronic tension caused by inappropriate fascial shortness or laxity can lead to neuromuscular trigger points, and the reverse is equally true: chronic tension from anxiety or occupational misuse, disuse, abuse or overuse can lead to fascial thickening.

In conclusion, though many approaches are valuable in intervening in the neuro-myofascial web, there is a case for considering the fascial component of both short-term and long-term therapy for structural imbalance (figure 1.10).

Figure 1.10: A modern rendition of the fascial net, done via computer by Jeff Linn using the Visible Human Data Project. Here we can see the thigh, a small section of what could be mapped in full: the fascial webbing of the body, which would include everything from the meninges through the organ bags and supports, the muscles’ epimysia, endomysia and intermuscular septa, surrounded by the deep investing fascia and the superficial areolar and dermal layers.
Touch is essential, a vital ‘food’ for the body and mind. It is needed to refresh us, steady us, comfort us and nurture us. Touch is required for most of our work and as a necessary method of communication as we make our way through the world. Much has been written of the many types of touch and much research carried out on its effects, but there is very little written on precisely how to develop safe, effective, and profound therapeutic touch to the fascial tissues.

This book is intended to be more than a listing of techniques; it is hopefully a catalogue of ‘intentions’, of ideas on how you can create different effects in the tissue by using alternate styles of touch. We will explore this more in the following section, but first we must look at how we touch, and begin to create a vocabulary to describe what it is that we do. There are many styles of touch: directive, informing, loving, nurturing, abusive, healing, calming, patronizing, or seductive. We can become richer therapists by developing our abilities to choose among a wide range of touch-abilities as possible.

Montagu (1986) in his classic text wrote about the nurturing effects of contact, well documented in the research literature and so well summarized by him, but very little has been written about the mechanics of our main method of therapeutic input. Different authors and teachers have emphasized various aspects of a stroke depending on their own experience. Chaitow (2006) talks of melting into the tissue; Hungerford (1999) warns us ‘not to drop the connective tissue’; Myers (1999) talks about the three I’s of invitation, intention and information. But what is lacking is an adaptive model and vocabulary for all the elements in a complete stroke or intervention.

Our hope is that by using a staged model we can begin to put a language together that can facilitate discussion. With shared terms to express and explain the various methods we employ, we can, as individual practitioners and as a profession, become not only more conversant with the tissue and its wonderful variations, but also more conscious of the various stages we go through and the different types of information we give or receive in each stroke.

Fascial Release and Developing Your Touch

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Under a skilled practitioner’s hands, Fascial Release Technique (FRT) is a wonderfully releasing, pleasurable though occasionally challenging experience for the client. Like many tools, when wielded by a novice, it can be really quite uncomfortable. In order to avoid putting your clients through unnecessary discomfort, we recommend spending some time working through and playing with the five stages below. It is a common mistake to believe that the only thing that matters is ‘getting the work done’, but if we are to be a client-centered therapy, then surely it is our responsibility to stay aware of the fact that we are working on a person, not a collection of dysfunctional tissue crying out for our saving, healing and sometimes over eager touch.

This five-stage model may appear worded for the novice practitioner. This is deliberate, in order that you can see where your style may differ or what you may be leaving out, and which aspects may be emphasized in your stroke to the detriment of others. We believe that even the most experienced practitioner can benefit from the analysis this model can bring.

**DASIE: Development, Assessment, Strategy, Intervention, Ending**

This five-stage model was first developed as a counseling model (Nelson-Jones 1995); we have adapted here for bodywork.

**Stage 1. Development**

Many bodywork approaches talk of ‘melting’ into the tissue and ‘sinking through the layers’, and FRT is no different. Be aware of the layers as you pass through them, allowing the tissue to give way rather than bulldozing your way through. Mold your hands, fingers, knuckles or whichever tool you are using to the shape of the body part being worked. Use only enough tension and pressure to reach that first layer of resistance, going slowly enough to be invited in.

In this stage you are developing your ‘rapport’ with the tissue. It is the initial engagement, the journey from being in the client’s energetic field through each successive layer of tissue to get to the target structure. But it is also more than that; the process is mindful, sensitive to the transfer of energy (of whichever and any and all forms you are sensitive to), sensing that relationship and waiting for that invitation (Myers 2009) or the absorption into the sponge (an image used by Maupin [2005]).

Some schools teach that you can ask your client to exhale as you melt in, and we often find this a useful addition in difficult or challenging areas. If overused, however, the insistence on this element can be distracting rather than enhancing. Experiment using your own exhale to sink your bodyweight into the tissue. Having your center of gravity high and keeping your back heel raised will allow you to position yourself precisely over the desired area. Exhaling (quietly!) and dropping your center of gravity (or sinking your hara) is much easier for the client to receive than if you muscle into it with your arms and hands. The tension necessary to push will result in the client’s tissue resisting, and sets up a struggle, however gentle, that one of you has to win.
Maintaining a relaxed point of contact avoids putting tension into the area being worked as it will try to resist you but also keeps you much more sensitive to variations in the myofascia. The less tone you have in your working limb, the better able you are to sense the changes in your clients.

Achieve this by getting as much of your force from muscles as distant from the point of contact as possible. For example, if you are using your fingertips they should retain only the tension needed to get through the layers. The initial force comes from your bodyweight coming over the area. As you need to reach deeper levels, increase your bodyweight by altering the angle of your back foot. Push from the ball of the back foot (remembering to engage your core), stabilize your shoulder girdle and arm, and gently lock your elbow and wrist. Only as a last resort should you push with your fingers, as that is more likely to feel ‘pokey’ and uncomfortable.

**Stage 2. Assessment**

So now that you have got ‘somewhere’ you need to check two things – first, is it where you wanted to be? If, for whatever reason, you were trying to find the fibularis muscles, how do you know that you are really on them? Second, if you are on them, how do they feel? What kind of work do they need, and what kind of tool should you be using? Would it be better to use your fingers, knuckles or elbow?

This is the stage of asking questions and obtaining information. Using both active and passive movement, you can gain much of the information you need. Asking your client to invert/evert the foot as you search for the fibularis muscles can help you differentiate them from the soleus. Feeling for the quality of the movement, you can assess which parts of the muscle open too much or not at all. You can begin to find the areas you will need to focus on, but how are you going to do it?

Pick (1999, cited in Chaitow & Fritz 2006) describes three tissue levels, surface, working and rejection, each of them being subsequently deeper than the next. They are not specific layers of the body but dependent on the level of dysfunction or sensitivity in any given area. The surface level mostly refers to the skin; the working level is where most bodywork interventions will take place; and the rejection level is when any resistance experienced is overridden or ignored by the practitioner and pain is experienced. The practitioner must decide at which of these levels they want or need to work. If it is within the rejection level, it should be negotiated with the client, preferably with the more superficial tissue addressed first to further prepare the area. Where these tissue levels exist can vary from area to area (depending on tissue condition), from day to day (depending on diet and stress level, and certainly from person to person (one person’s surface is another person’s rejection level). Stay sensitive in your assessment to identifying and knowing where you are relative to these levels.
Stage 3. Strategy

You are where you want to be with something that needs to be worked – but now you have to decide how you are going to do it. Which direction will have the best therapeutic effect? Which movement will you ask the client to make in order to help your stroke? Which tool (fingers, knuckles, forearm, etc.) will best fit the area? This is the stage of processing the gathered information into a coherent strategy.

Practitioners often skip the two stages of Assessment and Strategy; they are not discrete moments in time but merely part of a thought process, a mindful decision-making ensuring that your work is specific to the needs of the client rather than a treatment by rote. Of course, a certain amount of a ‘recipe’ is needed for beginning practitioners. Those of us from a massage background were given a basic sequence to get through the early days of practice, but as we became more comfortable with the techniques and more aware of their effects on the variations of individual clients and their tissue, we learnt to adapt that template to suit the presenting requirements. With FRT, this can and should be done with each and every stroke.

These are also stages that will become richer with experience. With each client and every venture into tissue, you are hopefully building your vocabulary of touch. Every time you strategise, stroke, and reassess, you have a palpatory experience of success or failure. You are laying down foundations of understanding which styles, strengths or other variations of touch will work (or fail) in each situation. If you ignore the strategy step, you can easily fall into habitual ways of working that eventually narrow your vocabulary and limit your touch-abilities. A pause to strategise helps to build a deep (and non-verbal) reference library – but the speed at which you create this reference tool will depend on how you proceed through the next stage, intervention.

Stage 4. Intervention

Finally, you reach the stage of doing the work. You are into and have checked the area you are working on, you have decided on how to work it, and now you can. As part of your strategy you have already chosen which tool to use. You are locked in the level and area you want to be, and now you slowly glide and/or ask the client to move. However, this stage is not so much about how you perform the stroke, but much more about what effect it is having. The practitioner has to constantly monitor what is happening below and around the point of contact. Is the tissue releasing? Is the right area being challenged with the movement? Is the tissue lifting or moving? Is the client able to receive and process the information you offer to her?
Throughout the intervention, or stroke, you set up a feedback loop assessing its effectiveness. What changes can you make as you go through to assist you in the goals set above? With each change you have to re-evaluate.

![Figure 2.2](image)

*Figure 2.2: With each increase of intensity, the practitioner should be feeling for a little feedback.*

Now you are truly listening to the client and their tissue, setting up what we sometimes refer to as a ‘communication between two intelligent systems’. With your strategy in mind, you are offering information to the client, asking their tissue if it can change, and asking if the work makes sense to them. By listening to the collection of systems under your hand and keeping yourself open to their messages, you will be able to accommodate the abilities of the client’s tissue in your work, providing you can attune your ear to the language their tissue uses to inform you in response to your contact.

Schwind (2006) encourages us to use as many of the other, non-working, surfaces of the hands as possible to aid this communication. Using the supporting hand as a *mother hand*, for a nurturing contact, or as a *listening hand*, is common among many bodywork traditions, but it is only of maximum benefit if it enters into part of this conversation. It should not be there just to provide comfort and ease, but to put the third dimension into what can otherwise be a two-dimensional stroke. Two hands working in coordination with a client’s movement produce many times the therapeutic power of simply ‘doing a stroke’ with one hand.

This is how to grow the vocabulary of your touch, experimenting with all of the many variables and listening for the changes that take place. Schleip (2003) has shown us the many types of mechanoreceptors in the fascial tissue, and each will respond to different forms of stress in its surrounding fibers. We therefore need to learn how to talk to each of them, as they will have different languages.

Variation occurs among clients, and even within different areas of the same client. There will be variations in the type of dysfunction, as well as in the fascial layers or structures, whether regular or irregular, dense or loose, bound or hypermobile. Each has a different language (or dialect, at least), so the wider your vocabulary of touch, the clearer our conversation will be.
Stage 5. Ending
As you begin, so should you finish. If you take all that time to take care of your client, sinking in, feeling the tissue’s condition and listening to it change as you work, then honor both the client and the work by coming out slowly. Sometimes it seems as though therapists forget that they are working with another person; sometimes it seems they are so relieved to reach the end of their stroke that they jump out of the tissue. We are not saying it is wrong, perhaps just a little sudden and impolite to the client. Take your bodyweight back into your forward leg; do not push into the client to jerk yourself up. Once you have your weight back in your legs then you can lift yourself out of the stroke, allowing the tissue time to settle in rather than letting it snap back.

Sometimes it can be more pleasant for the client to spiral (Aston 2006) out of the contact, slowly peeling your skin out of contact with theirs. This is especially true when you work in areas where the skin may be more sensitive, such as around the armpit or the thigh adductors.

This is just one style; remember that the exit is part of your intent. Even shocking the tissue could get the desired response, by either allowing a recoil effect or perhaps by increasing tone and awareness in the area. The important point is that it is a conscious decision and is coherent with your intention to create change with the client.

It is these small details that the client may not be aware of but that make a huge difference in their experience of the treatment. Fascial release can be a challenging treatment, and the more comfortable we can make it for the client, the better they will be able to accept it and embrace its benefits.

We fully realize that the model may seem formulaic for many intuitively driven practitioners; this is deliberate. We have to start being explicit about what it is that mysteriously draws us to the ‘right’ layer, informs us of which direction to work and with which tool. With mindful practice, we can build the ‘intuition’ that comes of unconscious competence, that heightened sensitivity that responds to the needs of the tissue through an innate sympathy with it. Our minds will gradually become attuned to the language of the tissue and rapidly go through these stages with very little conscious awareness on our part.

DASIE is not a technique, nor even a style of touch, but rather a way of describing the process as we interact with our clients’ tissue. By doing so, we hope that we can bring even more depth to the three-dimensionality of our work. We aim to listen to the tissue at every stage and adopt, initially, a conscious direction to our work. As our expertise grows, we allow this to become a preconscious process, but never an unconscious treatment by rote. We should always be aware of the entire person and their many levels as we treat, being responsive to the needs of each level and reacting in such a way as to develop a three-dimensional communication through touch.
**Fascial Release Technique**

Having focused on how we enter and exit, we now need to look at the mechanics of FRT, because the style and intention of it differs from that of many other forms of bodywork. Generally when performing massage techniques, the therapist glides over the top of the myofascia, applying compression to the tissue in order to stimulate the flow of fluids and to affect neuromuscular tension (figure 2.3).

In order to manually stretch the connective tissue, the therapist needs to use a different style of contact. This is done by first applying a downward pressure, sinking to the first level that gives resistance and then dropping the angle of contact in order to create a wave in front of the point of contact (figure 2.4). This wave is then maintained in front as the stroke is performed. The stroke must be carried out slowly and at a speed determined by the interaction of the tool being used (thumb, forearm, elbow, etc.), the amount of lubrication available along the surface, and the rate at which the client’s tissue can melt and open up as you work along.

![Figure 2.3: Massage stroke applying compression.](image)

![Figure 2.4: Fascial Release stroke.](image)

We sometimes think of it as taking an elevator down to the floor (tissue level) you want to be at. As you walk out the door, you drop the angle of contact, locking yourself into the myofascial layer and then continuing the conversation we discussed earlier between you and your client’s tissue by performing the stroke.

We recommend experimenting with different types of lubricant, starting with only the moisture of your own hands. With too little lubrication, you will jerk or ‘skitter’ over the tissues and be unable to perform the stroke smoothly. If so, wet your hands with a little water. Only if this fails should you try a little moisturiser or wax-based lubricant (see Resources). Too much lubricant, and oil-based lotions or oils in particular, reduce your ability to grip the tissue, making FRT work difficult, painful and ineffective. Remember, always start with less, as it is easier to add a little more than to take it off if you use too much.
**Fascial Layers**

The client may feel a slow pulling and burning sensation – this is partly what you are trying to achieve as you ‘melt’ the ground substance within the myofascia to a more liquid state (changing it from ‘gel’ to ‘sol’) and stretch the connective tissue bag surrounding and within the target areas.

If you are unfamiliar with palpating the fascial coverings around the muscles, try exploring through the layers of your forearm. Using the fingers of your dominant hand, begin by first placing your awareness on the surface of the skin. Feel its resistance to your pressure, the tautness of the skin giving a positive sensation in response to the slight weight of your fingertips.

Try moving the skin over the underlying adipose. Is it separate from the layer beneath? Does the skin move more easily in one direction than the other?

Now sink into the adipose layer. Become aware of the different quality of the sensations in your fingertips. How does this layer differ from being ‘in the skin’? Press a little more firmly and you can feel another tight layer below this, more taut and bouncier than the skin. Can you move the adipose over this second skin? Feel how the skin and the adipose move easily together, gliding over this first layer of myofascia: the deep investing layer. Maintaining the pressure to keep your digits in the adipose tissue, angle your pressure toward your elbow, taking up any slack, and then slowly flex your wrist. Can you feel the stretch on the skin? With a firmer grip and more movement, you can feel how this type of contact can become uncomfortable. It is similar to an ‘Indian’ (or, in the UK, a ‘Chinese’) burn, so beloved of school playground bullies and older brothers the world over.

Once you recover from the slight abuse you have just given yourself (and hopefully not elicited too many traumatic memories!) allow your fingertips to descend through the layers again, this time overcoming the resistance given by the deep investing layer of fascia. You will feel yourself now pushing onto the muscle belly, using the tone of the muscle as your guide to assess which level you are on; the focus is the ‘skin’ of that first muscle you encounter. You can check to see if you are in the right layer by flexing your wrist again. Do you feel the muscles stretching below your point of contact similar to your first attempt, or do you feel the tissue around the fingertips pull them toward the wrist?

If you are in the correct layer, you can now begin applying FRT on your wrist extensors by ‘hooking’ the tissue, pushing toward your elbow as you slowly flex your wrist again. Be aware of the different sensations in the tissues between the two different levels of connection. If you have got it right, it should now feel like a deeper burning, but more pleasant. Sometimes clients report it as a ‘good pain’, the tissue almost crying out for the release, stimulation and stretch you are giving it.

To put it into the context of the DASIE model (page 22), you have melted into the tissue (Development), felt the appropriate layer (Assessment), decided which direction to lock and
which movement to make (Strategy), and then done the work (Intervention), finally melting back out of the tissue to finish (Ending).

For each of the techniques in this manual, you should progress through the same process; all of them are mindful, nurturing and listening. With each intervention, you should be working at an appropriate level and having that same conversation, listening for the feedback loop and adjusting accordingly. Experiment on yourself to feel where you are on the surface level (too superficial to feel effective), and the rejection level (ow! get out), and in the working level (just right), a bit of a pleasant challenge. Please, while we will not repeat this in each description, never forget that you are in a constant relationship not just with the client but even more directly with their tissue, and both deserve to be heard. Each movement should be carried out with the same care and attention as that of the sculptor’s chisel on irreparable marble.

You can now explore through all of the musculature of the forearm. Feel for the differences in tone, not just in the muscle but also that fascial skin, the epimysium. Compare the flexor compartment to the extensors. Use movement to find the intermuscular septum between the muscles. Use movement to identify exactly where you are playing with flexion and extension in combination with radial and ulnar deviation. What difference does it make in the tension produced under your working hand? Can you sense that certain directions of movement give a better challenge to the tissue? As you become more proficient in using the technique, through regular practice, all of this will give you information about the area you are working on, its condition and where you need to focus your attention. You will be able to subtly alter the angles of movement to make your work even more effective.

**Body Mechanics**

As we saw earlier, there are many different types of fascia: dense connective tissue, both regular and irregular, adipose and areolar. We will be working with them in their different manifestations within the body. Each of them having various qualities and abilities to change, they will respond to stress in unique ways, creating diverse symptoms within the tissues and through the rest of the body. It should be obvious, therefore, that not all fascia will be treated in the same way. We need to alter the type and style of contact to suit the nature of the tissue we are working with and to achieve different results.

For example, we can lift and drop planes of fascia (dense irregular) as if we were redraping the fascial fabric over the skeleton; we can divide septa that have become glued together (by the intermediate areolar tissue); and we can release the knots and nodules (adhered dense regular tissue within the myofascia) – all the ubiquitous signs of the trials and tribulations of life. Each of these will require a variation on the basic technique, by varying the angle or the amount of surface contact or the nature of the pressure used.
There are so many permutations and combinations for varying circumstance that it is impossible to display all of them here, and for that reason we recommend attending a full course to gain further mastery. It is also with this in mind that we present these ideas in this book. It is intended as an aide-mémoire for those who have attended such a workshop, and perhaps a pointer for a slightly different direction for some who are already accomplished in such an approach. For the novice practitioner, however, direct, hands-on guidance in this style is often necessary to have confidence in the basic skills on which these techniques are built.

Within this text it is our intention to give you an understanding not only of the mechanics of a technique but also of the clinical and structural reasoning for its application – the ability to go from the assessment phase to forming your strategy, as well as the tools to perform the intervention. The reader must, however, understand the obvious limitations of a book of this size; it cannot cover all eventualities. The ideas here act as templates to give you a framework for achieving a desired goal. Many of the illustrated directions of the strokes are perhaps the most commonly used, but they could quite easily be reversed or otherwise modified for a less common pattern. In other words, these are guidelines, not commandments written in stone.

The more that you understand of the nature of the variations of fascia, the better able you will be to adapt your contact to suit your desired goal. The aponeuroses, the deep investing layer, the large sheaths of tissue of the epimysium can be moved medially or laterally, lifted or dropped, and they can be separated from the underlying tissues, but they will predominantly require a flatter, broad-surface contact, such as the heel of the hand or the ulnar blade. The lengthening of bound or adhered myofascia calls for a more precise point of contact. Fingers, or knuckles, are ideal for applying a focused release or following a tight line of tissue, and often a more assertive approach is used. The encouragement of the areolar tissue to open and divide within an intermuscular septum can require a coaxing, teasing, insinuating touch, using a tool slender enough to weasel its way between the adhered structures.

To get a picture of this, imagine how you would deal with a crooked tablecloth. When adjusting its position on the table, you would use both hands spread out to give a broad contact. But if it had not been washed since the last time you had a party for the kids, it might have a few folds and creases in it that had stuck together because of anonymous spilt substances. In this case, you would use a more precise contact to unknit the adhered surfaces. Engage the client with your weight more than your strength. In a way FRT is a ‘lazier’ form of bodywork, because both your sensitivity and the client’s sensation depend on using a minimum of effort in your strokes. Having ease in your body-use is one of the essential elements for making the work pleasant to receive, and for prolonging your ability to do it and thereby extending your career span. The more you allow gravity to do the work, the less tension you will have to put into your point of contact. This will also make you more sensitive to changes in your client’s tissue and give the client a softer contact.
One important aspect of this is the use of your back leg. It should be more or less straight, and your heel should be raised a little. Many schools seem to teach a flat-footed approach, as it is more stable to push from. But our experience shows that by lifting your pelvis – and, therefore, your center of gravity – you will need to ‘push’ less, and can achieve the movement by simply relaxing your forward leg to allow your bodyweight and gravity to do the work for you. You can then adjust your height by lifting or lowering your back heel, either giving more reach or dropping the angle of contact, and you will have the further advantage of allowing the spine to remain straight rather than hinging on a longer stroke.

As we discussed earlier, getting hooked in at your point of contact is necessary to lock you into the tissue. You can accomplish this easily by having your heel high as you sink into the tissue and then dropping it slightly to lower your angle and get the wave in front of your hand, elbow or forearm.

After you have engaged the tissue, then all of your upper body gently stabilizes to maintain correct form, but it should do this in what seems like the reverse of your natural instinct. Many novice therapists want to push on the tissue as firmly as possible, and therefore lock their hands and give a hard feel to the client. But if you can relax your hands as much as possible and work
initially from your waist and the center of gravity in your pelvis, or your hara, then you can maintain a soft contact, with the force coming from as far away from the client as possible. Your thighs, particularly the front one, will be controlling much of the weight.

Not only does this feel much more comfortable for the client but it also opens you to being much more sensitive to the client’s tissue and any responses they may make as a result of your work. Because the existing tension on your muscle spindles affects their responsiveness to changes in tension, the less tension you have at your point of contact, the more receptive, and therefore responsive, to subtle changes you will be.

**Use of the Hand**
A full hand or the heel of the hand can be a very useful tool to work with the large expanses of fascial sheets. The broad contact allows an encompassing grip.

*Figure 2.6a & b: a) The hands and the heels of the hand in particular are useful for moving the superficial sheets of fascia and for warming and preparing the tissue prior to more specific and deeper work, b) the angle at the wrists should be kept quite low to minimize strain on the joint and surrounding tissue, allowing the force to be transferred through the carpals from the forearm.*
Use of the Fingers

Your fingers are neurologically the most sensitive tool you have, but mechanically the most easily abused. It is very important that you keep your fingers in neutral or slightly flexed. Never allow them to go into extension, as you will challenge their ligamentous integrity and eventually the joints themselves. (This hyperextension may happen inevitably at first, but please work toward the slight flexion as soon as you can.) In figure 2.7, note how the wrist is also kept in neutral. All of the force of the movement is transferred in a straight line from your elbows, through the bones of the carpals and metacarpals, into the phalanges. Adjustments in angle come from your shoulders by way of lifting or dropping your back foot.

Figure 2.7a & b: Note not only the change in angle to engage the tissue from (a) to (b), but also how the hands and fingers remain slightly flexed or extended. Never hyperextend any of the joints.

The first few times you perform this type of stroke, you may feel the skin being pulled from under your nails. This eases with practice, and may be a sign that you are working too hard or need a little water or wax to help with the stroke, as the skin may be slightly dry and giving too much resistance. With practice, you learn many of the subtle alterations that can be made to minimize this.