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'MFR is a broad umbrella term for techniques that manipulate the myofascia'

Myofascial release

This article aims to explain what Myofascial release (MFR) is, how and why I apply it and also how it can help everyone!

MFR purists are pulling their hair out as they feel the term has been used interchangeably with other soft tissue techniques and some may therefore say that a pocket of therapists claiming to provide MFR are perhaps providing a watered down version of what was initially intended...



To me, MFR is more than what I initially knew to be 'fascial release'. The inclusion of the prefix 'myo' (denoting a relationship to muscle) is crucial as you are unlikely to affect one and not the other. Another 'controversy' is the term 'release'.... many people believe this term to be inaccurate or misleading as fascia is unlikely to be 'released' per se. My thought is that the technique, when applied appropriately, will free up the layers of skin/fascia/muscle etc. (from adhesions and/or scar tissue) from superficial to deep and may also achieve a longitudinal 'release', however this is contentious. Such release is desirable as adhesions and scar tissue restrict the way we move, limiting the range of motion around our joints which can lead to joints becoming impinged and thus painful.

Fascia itself is continuous throughout our tissues as well as encasing muscles subsequently leading to close relationships with neighbouring tissues. For example, the lower back fascia is

continuous with the gluteal fascia across the pelvic rim suggesting that 'releasing' one will affect the other.

The Anatomy Trains concept as introduced by Thomas Myers and taught in the UK and beyond by James Earls offers up several fascial lines or 'trains' suggesting a global integration throughout our body. This theory allows therapists to think outside the box and consider other areas of the body that may be influencing the problem area. However, for me, as I'm sure Myers and Earls will agree, we must also consider tension that does not run in perfect lines and delve a little deeper, away from such a simplistic model.

So now we've addressed the *vitaly important* political semantics and the science bit let's review the technique as I apply it. Essentially, as I have alluded to, the aim of MFR is to free up adhesions to allow myofascia to function as it should, in fluid motion along the orientation of its fibers without restriction. It is also utilised to optimise the health of the structures (ridding waste products and encouraging blood flow).

The term MFR is a broad umbrella term for techniques that manipulate the myofascia in order to optimise it. Such techniques include stretching the tissues either longitudinally or transversely incorporating either passive (therapist generated) or active (patient generated) movements to free up the tissues. Some therapists also like to hold tissues under prolonged tension to elicit change in a more patient approach. Personally, the best results I achieve involve active release whereby the tissues are locked by me in a specific orientation and the direction of bind is countered by the client actively moving, thus creating a 'release'.

Another approach that sits under the MFR umbrella is one that I also use regularly which involves a tool often made from engineered steel. This specific branch of MFR is called Instrument Assisted Soft Tissue Mobilisation (IASTM) and it requires the therapist to engage the tool (see image below) with the tissues to generate a more specific contact than perhaps a human hand can elicit. Again the focus is on increased blood flow, breaking up adhesions and scar tissue as well as other benefits including enhancing the healing process. My preference with this technique however moves me towards a static treatment application with a focus on increased blood flow (especially good for healing ligament injuries) rather than an active client movement as the contact feels too harsh and patient comfort is of paramount importance.

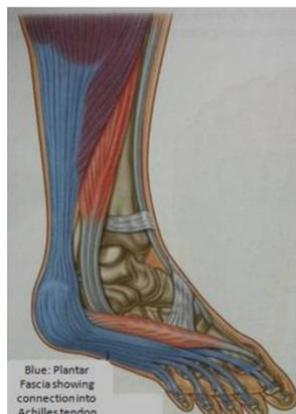


PS. This looks way more menacing than it actually is!

You may hear of Myofascial pain syndrome - this is where areas of the body are uncomfortable or painful as a result of dysfunction in the myofascia often including referred pain from other areas which of course makes it more challenging to diagnose the underlying cause. Trigger points (Tp's) are often to blame here, however I will discuss trigger point therapy (TpT) in it's own right despite TpT reasonably falling under the MFR umbrella.

Following treatment to the myofascia in its various guises the tissues will be more pliable, adhesions and scar tissue will be freed up, waste products will be dispersed and blood flow will be encouraged. Subsequently, range of motion around the joints will feel both subjectively (client) and objectively (therapist) freer and client comfort levels should also be significantly improved.

A key Case study that springs to mind here is a male client of mine who has suffered over an extended period with Plantar fasciitis. The plantar fascia is a thick fascia on the sole of your foot that runs from your heel and expands in width to the base of your toes. As suggested such fascia is not isolated and therefore is continuous with neighbouring tissues. The plantar fascia blends with the tissues surrounding the heel (calcaneus) therefore creating a relationship with the Achilles and the 3 muscles that insert into the Achilles (Gastrocnemius, Soleus and Plantaris).



Picture courtesy of Anatomy Trains Superficial Back Line. Myers 2000.

So, when treating this gentleman it was important to release the plantar fascia itself with active release techniques involving client movement as well as the IASTM to help increase blood flow and free up adhesions. Furthermore, it was also important to treat the Calf muscles and also explore the posterior chain (Hamstrings/Glutes/Back) in line with the Anatomy trains theory discussed earlier.

Following a treatment series as well as trigger ball release and stretching my client was able to manage his issue and become free from the discomfort that we so often just persevere with.

I hope this offers an accessible insight into one of the sets of techniques that I use and also a glimpse into my focusses as a practitioner and what the treatment process looks like.

Thank you for reading and there's much more to come!

Dan Keogh

Owner at Focus Soft Tissue Therapy