

1

Healing Yourself through Self-Help Techniques

A True Story	11
A Few Words Before You Start	12
Self-Treatment	14
What Is My Point?	16
Self-Help Trigger Point Release Techniques	20

A True Story

Let us begin with a true story about John, who, according to his mother, was a “very, very sick little boy”; he nearly died of scarlet fever just before his third birthday. By the age of five he had developed whooping cough and chicken pox, and he was left with shaky health. In his teens, even though he played lots of sports and tried to stay healthy, John developed digestive problems; at age 14 he weighed 95 pounds. He was (eventually) diagnosed with colitis and celiac disease. John also suffered from back pain. At age 17 his father was so concerned that he sent John to the Mayo clinic in Rochester, Minnesota, where he was eventually diagnosed with Addison’s disease of the adrenal glands (hypothyroidism).

In the course of time, John developed muscular pain. His problems started after a spinal accident during military service, as a result of which John underwent major back surgery. This was only partially successful, so he was treated with drugs and a back brace, but his pain got worse and worse; according to his brother it was a “constant source of difficulty.” As time went on, he could not touch his toes or even do up his shoelaces. Sometimes he had to use crutches, and he was on constant medication. This medicine helped him temporarily but also left him with unwanted side effects, such as depression, osteoporosis, chronic constant muscular pain, and muscle spasms.

Janet and John

Finally, when John was in his late 30s, a friend introduced him to the “controversial but brilliant” MD Dr. Janet Travell, who was pioneering a new type of treatment called *myofascial trigger point therapy*. She treated him regularly and also recommended him heel lifts and a rocking chair to ease his pain. After only a few weeks John started getting better: for the first time in his life he was able to manage and reduce his pain. In fact, her treatments were so “profoundly successful” that she helped John to achieve and sustain his wonderful career—a career that changed the world!

John finally found the relief from his pain that had eluded the most eminent of doctors: his problems were mechanical—his muscles had developed trigger points. Dr. Travell's treatment was "natural", mechanical, and simple: she had found a way to release hidden pain-codes locked within his muscular system. John publicly acknowledged Dr. Travell's work and soon appointed Janet as his "Personal Physician", the first woman and one of the few civilians to hold that post. Dr. Travell continued to explore and develop her theories and the science behind trigger points until her death in 1997 at the age of 95. Over time her legacy has been extensively researched, expanded and validated. Now it is time for you to benefit from these simple but powerful techniques.

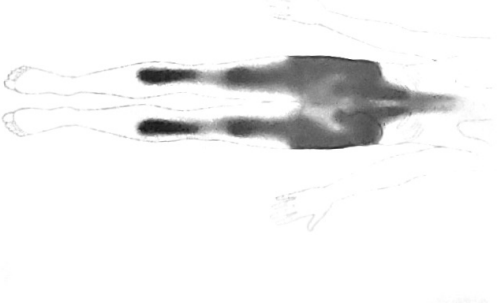


Figure 1.1: John F. Kennedy's pain map (suggested). Erector spinae bilateral lower; gluteus maximus, minimus and medius both sides; tensor fasciae latae both sides; gastrocnemius both sides.



Figure 1.2: Photograph of Janet Travell and John F. Kennedy, her most famous success story; <http://www.janetravellind.org>

A Few Words Before You Start

There are many reasons why you might have trigger points, so it is important to consider your trigger point pain in the context of the rest of your body. It must be stressed that the techniques offered in this book are not a substitute for therapy from a qualified practitioner; although aches and pains from trigger points are common, there can sometimes be an underlying pathology. *It is advisable to always seek a proper diagnosis from a qualified medical practitioner or experienced manual therapist.*

Acute and Chronic Pain

Authorities estimate that in 75–95% of muscular pain cases, myofascial trigger points are a primary cause! Therefore there is a high probability that understanding what trigger points are, and learning how to "switch them off," will help you overcome your pain.

Trigger points may arise for many different reasons; some of the most common factors to be aware of are:

- Head-forward posture (upper crossed pattern)
- Round shoulders (upper crossed pattern)
- Head to one side—telephone posture
- Occupational ergonomic stressors
- Slouched standing (lower crossed pattern)
- Slouched sitting (e.g. computer screen/ergonomics)
- Cross-legged sitting
- Habitual postures and/or habits
- Driving position
- Scoliosis
- Joint hypermobility
- Lifting/carrying
- TMJ syndrome
- Whiplash
- Primary short lower extremity (PSLE)
- Repetitive activity or sport
- Chronic vitamin and/or mineral deficiency
- Iron deficiency and hypothyroidism
- Medication induced (iatrogenic)

With any long-standing or chronic pain, there will be compensations and adaptations in a range of muscles locally and even remotely from the pain area.

Trigger points can be active (painful) or inactive (latent); they can also manifest in secondary muscles or as satellites in and around the vicinity of the primary pain. They can mimic angina, bursitis, prostatitis, appendicitis, cystitis, arthritis, esophagitis, carpal tunnel syndrome, pelvic inflammatory disease, diverticulosis, costochondritis, sciatica, and pain from a heart or gall bladder attack.

Trigger Points 101

The term *trigger point* was coined in 1942 by Dr. Janet Travell to describe painful lumps or nodules felt within tight bands of muscle. Trigger points all seem to have the following characteristics:

- Pain, often exquisite, is present at a discrete point.
- A nodule is embedded within a taut band in the muscle.
- Pressure reproduces the pain symptoms, with radiations in a specific and reproducible distribution (map).
- Pain cannot be explained by findings from a neurological examination.

One of the most important features of trigger points is that they may be embedded in the muscles remotely from where the pain is felt. It is partly for this reason that so many therapists fail to help. More often than not, therapists and doctors tend to look at the place that hurts rather than find the source of the pain. A trigger point makes its host muscle shorter and fatter and reduces its efficiency; this can lead to pressure on nerves and blood vessels. Understanding trigger points and their maps will help guide you toward finding the source of your pain.

What are the physical characteristics of trigger points?

Our language for describing sensation is not highly sophisticated; unfortunately we have not yet evolved a suitable vocabulary to classify what we feel with our hands. With this in mind I will attempt to classify what trigger points feel like:

- Small nodules the size of a pinhead
- Pea-sized nodules
- Large lumps
- Several large lumps next to each other
- Tender spots embedded in taut bands of semi-hard muscle that feels like a cord
- Rope-like bands lying next to each other like partially cooked spaghetti
- Skin over a trigger point slightly warmer than the surrounding skin (due to increased metabolic/autonomic activity)

What is trigger point therapy?

Trigger point therapy covers a range of techniques aimed at deactivating these painful knots. Many approaches are practical and "hands-on"; they can be performed at home with a partner or on your own with trigger point "tools." Combined with some simple lifestyle changes, trigger point therapy can yield dramatic, immediate, and sustainable results. The goals of this therapy are simple:

- To identify the correct trigger point(s)
- To pinpoint how or why they manifested
- To use appropriate techniques to deactivate the point(s)
- To develop strategies to prevent them returning

Pressing on trigger points:

- numbs and reduces pain in the treated area and in the area of the perceived pain;
- attenuates the pain feedback pathways;
- breaks the vicious cycle of pain and spasm;
- stretches tight structures, which will have an indirect effect on other tissues;
- opens out the plastic-wrap-like myofascial bag surrounding, investing, and supporting the muscles;
- stimulates the blood supply, to clear away debris and toxins;
- increases the release of powerful pain-killing agents called *endorphins*;
- affects the autonomic/automatic nervous system.

What is a referred pain map?

Trigger point referred pain is not the same as the referred shoulder pain of appendicitis or the jaw/arm pain associated with a heart attack! When you hold a painful trigger point for 5–6 seconds, part or all of the map should activate; this should reproduce your symptoms (often remotely from the area pressed).

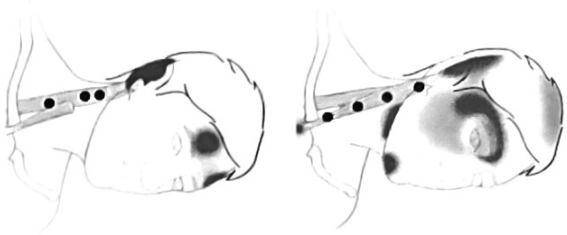


Figure 1.3: The SCM referred pain patterns.

What is the autonomic nervous system (ANS)?
Our ANS is concerned with our vegetative functions, such as sweating, digesting, and breathing. Trigger points can cause or contribute to many perplexing ANS symptoms, including sweating, skin blanching, coldness, gooseflesh, redness, excessive sweating, dizziness, dysmenorrhea, tinnitus, dysfunction, earache, stuffiness, and difficulty breathing.

Self-Treatment

Simply understanding what trigger points are and how they may be the cause of your pain is therapeutic. Reproducing your pain in the therapeutic context validates that you are not “crazy” and gives you a powerful self-help tool. I believe that it is essential to empower my patients to get better on their own, and that “knowledge is power.” Please study the muscles, understand the process of treatment, and orientate yourself before you start.

Self-treatment will help you to understand, manage, and control your pain on your own, at home, and without a therapist. Once you get used to working with trigger points, you may even find your friends, relatives, and neighbors all want treatment. Who knows, you may even become a therapist yourself one day!

Throughout this book I have indicated the most effective self-help techniques and stretches based on my many years of practice.

What equipment do I need?

You should use a bed (or a couch), although sometimes a table with some padding will suffice. You will need some cream or lotion for the stroking massage technique. You might want some pressure “tools” to save your fingers and hands.

How do I know it is a trigger point?

You are looking for:

- Stiffness in the affected host muscle
- Spot tenderness (exquisite pain)
- A palpable taut nodule or band
- Presence of referred pain
- Reproduction of the symptoms (accurate)
- Possible loss of skin elasticity in the region of the trigger point

The affected area may be moister or warmer (or colder) than the surrounding tissues, and may feel a little like sandpaper.

What bits of my hands should I feel them with? (see Figure 4.1 in Chapter 4)

- Finger pads: remember to cut your fingernails (shorter is better).
- Flat fingers: use the fingertips to slide around the skin across muscle fibers.
- Pincer: pinch or grip the belly of the muscle between the thumb and the other fingers, rolling muscle fibers back and forth.
- Flat-hand palpation: useful in the abdominal region (visceral).
- Elbow: allows a stronger and shorter lever, which can be a distinct advantage.

How do I press/self-treat a trigger point?

For those of you who have worked with trigger points before, this concept will be very familiar. For the rest of you, there are two very simple, safe and effective techniques: (1) Ischemic compression technique (ICT), and (2) deep stroking massage (DSM).

How much pressure do I use?

This is something that comes with experience, but as a rule of thumb the more painful the tissue, the slower and deeper the pressure. In all cases, the key words are “work slowly,” “sensitively,” and “thoroughly.” Deep stroking massage should feel a bit like gently squeezing toothpaste out of a tube.

Another factor that determines the amount of force required to make a change is the muscle type (phasic type I/tonic type II fibers) and your morphology. This

will affect the depth of treatment. If you are “stocky,” you should expect to have to work quite vigorously, especially into the postural muscles. If you are slight, you will not need to use as much force to cause a change in the tissues (see Chapter 2).

Which direction should the pressure/force be applied?

It is desirable to apply steady, deep, direct pressure to the nodule or pea-like trigger point. I have tried to represent this by the idea of a *hot zone*. The *heart* of the trigger point is located somewhere in this zone. You want to find the direction of pressure that, where possible, exactly reproduces the pain. It often amazes me that a slight change in the direction of the pressure can cause a totally different pain elsewhere. You will feel when you are “there.”



Figure 1.4: Hot zones.

How do I know when I have done enough pressing?

- Hold the trigger point for 6 seconds:
- If the pain diminishes rapidly, stay with it until the trigger point softens or evaporates beneath your pressure.
- If the pain stays the same or gets worse, come away for 15 seconds and then try again.
- Repeat 3 times if necessary.
- If the trigger point still does not deactivate after the third repetition, note it down as it may be a secondary or satellite point.

What do I do after I have come away from the point?

Follow all deep work with a gentle generalized effleurage massage. The area where you did the deep work may still be tender, but do not avoid it. This will help to disperse pain-inducing toxins from the area and stimulate the repair of the fascia.

Are the trigger points and referred pain patterns the same for everyone?

Generally yes, but they can sometimes move around depending on your size, shape, weight, etc. These factors will change the fat/muscle ratio and skew the position of the trigger points. They will also have an effect on the planes of the fascia, and hence the location of the trigger points. Similarly, scar tissue or keloid may cause a deviation in the myofascial strain pattern and hence the location of the trigger point.

What about the type and orientation of muscle fibers?

Depending on where they are in the body and the job

they have to do, muscle fibers are arranged into various structures (see Figure 2.4 in Chapter 2). This allows the muscles to generate either more force or a more specific force. Locating a central trigger point will vary therefore according to the arrangement of muscle fibers within any given muscle. In the multipennate fiber arrangement, for example, several trigger points may exist in the middle of each of the functional components.

What creams or lotions can I use?

In general, it is better to avoid oils, as they may cause you to slide off from the pressure points once you have found them. I use plain blue Nivea Creme. Alternatively, arnica cream or plain aqueous cream mixed with some vitamin E oil (with a wooden spoon) may be sufficient. Petroleum gel, talcum powder, or massage oil may also be used if you have a lanolin allergy.

What is the frequency of treatment?

In my experience, for self-help hands-on treatments you should perform these sessions gently no more than once a day and preferably three to four days apart. Balls, rollers, or hooks may be used for up to 10 minutes per session and up to six times a day.

Tools

While fingers, elbows, and thumbs still remain the most readily utilized instruments for treatment, a variety of self-help tools have been developed for manipulating trigger points, including:

- Balls
- Canes
- Knobs
- TOLA System
- Rollers (foam)

Each of these tools has a different treatment effect. In general they are designed either to put pressure on a specific trigger point or to stretch out the muscles after treatment. There are many tools on the market and each has its plusses and minuses.

Tools such as balls and the knobbie can be used instead of your hands and elbows to amplify pressure and reduce stress on your fingers. Other tools, such as the Theracane and the TOLA System, allow you to reach hard-to-access points.

Tools can be used standing, sitting, lying, or side lying. It is easy to overstimulate an active trigger point, so pressure should be applied slowly and gently until it is “just right.” You should hold the point until it softens or the pain yields. It is OK to use pressure tools up to six times a day, depending on how chronic the problem is.

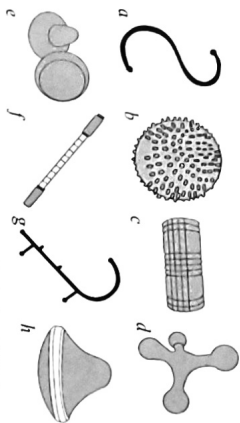


Figure 1.5: Self-help tools for manipulating trigger points. a) backhoeber, b) ball, c) foam roller, d) four points, e) knobble, f) one, g) hercane, h) tola.

For more information please visit www.rtielasher.com.

How often should I treat a trigger point with balls or hooks?

This depends on how acute or chronic the problem is. For a chronic trigger point, you can work the area up to six times a day; persistence pays off. An acute problem may require less work than a chronic one. If you see an experienced practitioner, this will change. But I would like to stress that the frequency can vary from case to case because of a variety of factors.

Can I do any harm?

If you identify the correct point and deactivate it with care and love, the answer is—probably not. There may well be some soreness for up to 48 hours after treatment. If the soreness lasts or gets worse, please discontinue treatment immediately and seek a medical opinion.

Will bruising occur?

Bruising should not occur if you follow the instructions, but may occur if you are on blood-thinning medication. With time and experience, bruising becomes increasingly rare. I have found that it is not the depth of treatment (force) that will cause a bruise but usually the result of pressure being applied too quickly (velocity). Try to feel the muscles and tender nodules beneath the skin. Arnica creams and tablets have been suggested to reduce the incidence and severity of bruising. Unfortunately some people bruise more easily than others.

Tip

Try to feel the muscles and tender nodules beneath the skin and build up the pressure slowly; do not come away too quickly.

Will I be sore afterwards or experience side effects?

It is not uncommon to feel sore or bruised for 24–36 hours after treatment, but it is unclear whether these conditions are treatment effects or side effects. Treatment reactions are common and most severe following cervical manipulation; they are, somewhat controversially, proportionally related to treatment efficacy. Reactions may include other associated symptoms, such as fatigue or “flu-like” feelings, increased peeing, lethargy, and increased sleepiness.

Stretching

It is advisable to stretch on the hour, every hour, on the day of the treatment and then three times per day thereafter for a few weeks to several months. Stretching diagrams for each muscle are presented where appropriate.

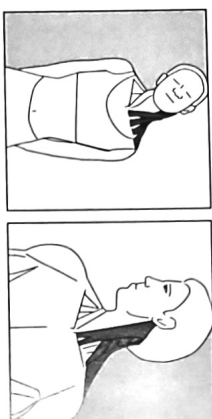


Figure 1.6: Stretching exercises for SCM.

Lifestyle and Diet

Studies have demonstrated that underlying health issues—such as folic acid, iron, vitamin, and/or mineral deficiency—may both contribute to and perpetuate trigger point activity. It is worth noting that tendons do not repair in the presence of nicotine! Furthermore, recent studies have indicated that the modern lifestyle tends to “underload” muscles and tendons, leading to internal fatty changes and increased vulnerability to damage. Other factors such as fatty foods and exposure to free radicals may also have a detrimental effect on our soft tissues. Supplements—for example omega-3, zinc, magnesium, iron, and vitamins K, B12, and C, as well as folic acid—may speed up your recovery.

Self-Help NAT Protocols

I have included my standard NAT protocols at the end of each colored muscle section. You will notice that these contain “super trigger points.” While there is no “one size fits all” for all areas of the body, I have included protocols that have helped many thousands of patients over the years. For more information on super trigger points and NAT see Chapter 6.

What Is My Point?

At the beginning of each colored muscle section (Chapters 7–12) you will find a regional trigger point checklist. Have a good look through the muscle pages and see if any of the pain maps seem familiar. The list of symptoms provided in Table 1.1 (below) should also help you to narrow down your search.

Signs and symptoms	Possible site(s) of trigger points (TPs)
Abdominal cramping/colic	rectus abdominis—lateral border/periumbilical
Abdominal fullness/bloating/nausea	rectus abdominis, especially upper/rectus abdominis paraxiphoid
Ankle weakness	tibialis anterior, peroneus
Anorexia	rectus abdominis
Bed wetting	active TPs in lower abdominal wall
Belching	abdominal (especially rectus abdominis), upper thoracic paraspinial
Bladder pain	upper adductor magnus
Bloating	transversus abdominis, rectus abdominis
Blocked ears/hearing loss/hyperacusis/hypoacusis	pterygoids, masseter
Blurred vision/visual disturbance	splenius capitis, eye muscles, sternal sternocleidomastoid, upper trapezius, orbicularis oculi, masseter (near vision)
Bruxism (grinding and/or clenching of teeth)	temporalis
Buckling ankle	peroneus
Buckling hip	extension of both rectus femoris and upper vastus intermedius
Buckling knee	vastus medialis, vastus lateralis
Calf cramps	gastrocnemius
Cardiac arrhythmia	pectoralis major between 5th and 6th ribs, midway between nipple and sternum right side (inactivate sternal TPs first); pectoralis minor
Car sickness/seasickness	sternocleidomastoid

Signs and symptoms	Possible site(s) of trigger points (TPs)
Clumsy thumb (difficulty writing, buttoning)	adductor pollicis, opponens pollicis
Colic	transversus abdominis, rectus abdominis
Congestion/sinus pressure/sinus obstruction	masseter, pterygoids, internal and sinus areas
Constipation	abdominal, possibly mesentery, obturator internus
Cough, dry hacking	convergence of sternal sternocleidomastoid and pectoralis
Diarrhea	lower abdominal area, right lower rectus abdominis, transversus abdominis
Difficulty climbing stairs	erector spinae, quadratus lumborum, tibialis anterior, soleus, long toe flexors
Difficulty swallowing	longus capitis, longus colli, medial pterygoid, digastricus
Diffuse abdominal/gynecological pain	lower rectus abdominis, upper adductor magnus
Dimming of perceived light intensity	sternocleidomastoid
Disturbed weight perception of objects in hand	sternocleidomastoid
Dyspareunia (pain on sexual intercourse)	piriformis, upper adductor magnus
Elevated 1st rib	anterior scalene (can cause or contribute to costoclavicular syndrome)
Eye, explosive pressure in	splenius capitis
Eye, inability or slowness to raise upper lid	sternal sternocleidomastoid with spasm of orbicularis oculi
Eye, redness	frontalis, superior orbicularis oculi, sternal sternocleidomastoid
Eye irritation, redness	sternocleidomastoid, extrinsic eye muscles
Eye pain	sternocleidomastoid, occipitalis, longus capitis
Eye pain, behind the eye	temporalis, occipitalis, trapezius
Eye pain, deep	sternal sternocleidomastoid

Signs and symptoms	Possible sites of trigger points (TPs)	TMJ lateral pterygoid, deep masseter	Toe cramps long extensors of toes	Tooth pain and sensitivity (cold, heat, pressure) trapezius, masseter, sternocleidomastoid, pectoralis major	Trigger finger hand and finger flexors, finger flexor tendon sheath	Trigger thumb flexor pollicis longus tendon sheath	Upper respiratory dysfunction pectoralis major (bunch), intercostals	Vertigo sternocleidomastoid, upper trapezius, splenius capitis, semispinalis cervicis, temporalis	Vocal dysfunctions laryngeal muscles, digastricus, pterygoids, anterior neck	Vomiting abdominal (especially rectus abdominis)	Vulvodynia pelvic floor, psaos, rectus abdominis, and obturator internus	Walter's cramp brachioradialis, forearm extensors
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Signs and symptoms	Possible sites (TPs) of trigger points (TPs)	Reaction of the muscle multifidii	Ringling in ears pterygoids, masseters, medial pterygoid, splenius capitis, sternocleidomastoid, temporalis	Salivation, intense mid temporalis	Sensitivity to sound and light occipitals	Shin-splint-type pain extensor digitorum longus, tibialis anterior	Shin-splint-type pain flexor digitorum longus, tibialis posterior	Shortness of breath levator scapulae, scalenes	Shoulder impingement syndrome serratus anterior	Stitch in side serratus anterior and/or external oblique, diaphragm	Swallowing, sore and/or painful longus capitis, pterygoids, digastricus, sternocleidomastoid	Swelling, foot and ankle piriformis, soleus	Swelling, hands scalene	Swelling, throat digastric TPs (mimics swollen lymph nodes)	Swelling, leg piriformis and other short lateral rotators, adductor longus/brevis	Swollen glands digastricus, sternocleidomastoid, pterygoids, anterior neck	Tachycardia arrhythmia (including pectoralis major, intercostals, autonomic concitants)	Testicle, retraction erector spinae	Thigh and leg weakness rectus femoris	Thoracic-outlet-syndrome-type pain latissimus dorsi, teres major and subscapularis, pectoralis minor, pectoralis major, scapulae, triceps brachii	Throat drainage pterygoids, anterior neck muscles, digastricus	Thumb cramps abductor pollicis longus	Tidal volume reduction intercostals
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Table 1. Sites of TPs and associated symptoms (adapted from Startansky & Sharkey (2013)). These are listed in the following references: Becerra Rocha et al. (2008), Doggenwiter-Witzgal (2004), Funn & Kinzie (1984), Gjerum et al. (2008), Sharkey, Simons (1998), Starikoff & Copeland (2001), Teachey et al. (1998), Startansky & Sharkey (2001), Teachey (2004), and Travell & Simons (1992).

Signs and symptoms	Possible sites (TPs) of trigger points (TPs)	Kneecap, locked lateralis vastus medialis, vastus lateralis	Light sensitivity frontalis, superior obicularis oculi, sternal sternocleidomastoid	Loss of attention or focus lateral rectus capitis anterior and lateral	Lumbago/low back pain ilicostalis lumborum, longissimus thoracis parvissimi and other	Nasal and sinus congestion pterygoid	Nausea abdominal, upper thoracic paraspinalis, transversus abdominis, temporalis	Nipple hypersensitivity/increase to clothing pectoralis major (check both sides)	Painful bowel movements obturator internus	Palpable rigidity and lower abdominal wall T9 level of erector spinae	Petrol seal seizure-like symptoms rectus capitis major/minor	Phantom limb pain after removal, TPs in the flesh surrounding the organ cause pain in the area of the removed tissue	Planter fasciitis superficial/deep intrinsic foot muscles	Postnasal drip pterygoid, sternocleidomastoid	Projectile vomiting "belch button" TP on either side, at or just below angle of 12th rib	Radial artery entrapment pectoralis minor	Reflex oblique upper external abdominal	Restless pain on prolonged sitting gluteus maximus, piriformis, transversus perineal, inguinal ligaments, sacrotuberous
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Signs and symptoms	Possible sites (TPs) of trigger points (TPs)	Eye tear production, excessive front area temporalis, mid temporalis, sternal	Female sexual dysfunction piriformis and other short lateral rotators, pelvic floor	Flatulence abdominal	Food intolerance transversus abdominis	Foot drop, foot slap tibialis anterior	Full sensation in rectum obturator internus	Genital pain upper adductor magnus, transversus abdominis	Grip strength, loss of infraspinatus, scalenes, brachioradialis, abductor	Headburn upper abdominal external oblique, upper rectus abdominis, paraspinalis	Hiccups diaphragm, uvula	Hyperscisia (hypersensitive hearing) temporalis, medial pterygoid	IBS (irritable bowel) rectal TPs, abdominal (especially obliques, mid-pelvic floor, upper adductor	Impotence piriformis and other short lateral rotators, pudendal nerve and blood vessel entrapment	Inability to stand up psaos	Inability to sit still gluteus maximus, obturator internus, gluteus maximus, upper adductor magnus	Incontinence, urinary and fecal obturator internus (both)	Indigestion rectus abdominis	Jaw opening masseter, many area TPs; the opening may cause restriction of 10–20 mm	Knee weakness rectus femoris, popliteus
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Self-Help Trigger Point Release Techniques

For the purposes of this section, we will focus on two techniques—compression and deep stroking massage. These techniques are described in the work of Simons et al. (1998). More techniques are discussed in Chapter 4.

Inhibition Compression Technique

This technique involves locating the heart of the trigger/tender point. When this is compressed it may well trigger a specific referred pain map (preferably reproducing your symptoms). This technique involves applying direct, gentle and sustained pressure to the point:

PROCEDURE

1. Identify the tender/trigger point you wish to work on.
2. Place the host muscle in a comfortable position, where it is relaxed and can undergo full stretch.
3. Apply gentle, gradually increasing pressure to the tender point until you feel resistance. This should be experienced as discomfort and *not* as pain.
4. Apply sustained pressure until you feel the tender point yield and soften. This can take from a few seconds to several minutes.
5. Steps 3–4 can be repeated, gradually increasing the pressure on the tender/trigger point until it has fully yielded.
6. To achieve a better result, you can try to change the direction of pressure during these repetitions.

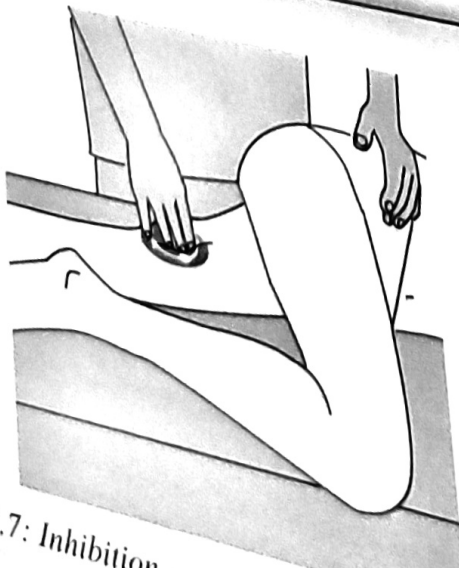


Figure 1.7: Inhibition

Deep Stroking Massage Technique

This approach follows a technique advocated by Travell and Simons (Travell & Simons 1992; Simons et al. 1998), and involves a deep, slow stroking technique over a tender/trigger point rather than a compression as described in the previous technique. As well as deactivating the trigger point, this technique can have a stimulating or tonic effect on the host muscle.

PROCEDURE

1. Identify the trigger point and note the muscle fiber direction.
2. Place the patient in a comfortable position, where the affected/host muscle can undergo full stretch.
3. Lubricate the skin if required (I use simple blue Nivea Creme).
4. Identify and locate the tender/trigger point or taut band.
5. Working from the insertion of the muscle toward the muscle origin, perform slow stroking massage using your thumb/applicator just beneath the taut band, and reinforce with your other hand; it should feel a bit like squeezing toothpaste from a tube. This should be experienced as discomfort and *not* as pain.
6. Hold for 10–15 seconds and then complete the rest of the massage stroke toward the end of the muscle.



Figure 1.8: Deep st