Changing Your Story

By Walt Fritz, PT

What if I asked you to strip away the story you tell when describing your modality?

Is it possible to be a myofascial release (MFR) therapist without believing the work primarily engages/involves fascia? Is it possible to teach myofascial release without using a fascia-based explanatory narrative? I believe the answer is yes to both of these questions. Some in the USA have branded me a heretic for such statements and beliefs, but if we define heretic as, "*one who dissents from an accepted belief or doctrine*" [1], then count me in, as I am a fascial-narrative heretic. Why do I disbelieve?

My moving away from what may seem like reams of fascial and myofascial release proof was prompted by many factors, one of which I include below in a blog post I recently made on my Myofascial Release Blog. The article covers just one small part of what became my *MFR Conversion*. I still use MFR every day and teach it to MTs, PTs, and SLPs, but I believe vastly different "things" are occurring under my hands than what was originally taught to me. I still call my work MFR as it is what I've done with my hands for the past 25 years. To me, MFR can be about the physical actions we perform with our hands and bodies without needing to adhere to a rigid set of MFR rules and beliefs. As I teach this work I am amazed at the wide breadth of explanations therapists use to describe and explain their MFR work, so much so that the lack of a uniform brand identity makes me feel even more comfortable with my neurologically-explained model of MFR. Fascia purists may take issue with what I have to say, but that is how we learn and adapt; through cognitive dissonance and debate. I think it is outright silly to believe that we can grab hold, or poke at a person's skin and state that we are primarily affecting shortened/restricted fascia (or all of the other dozens of things manual therapists believe they are impacting). Is it possible? Certainly, but can all of the claims made by therapists be possible as well? Most are improbable.

What if I asked you to strip away the story you tell when describing your modality? Could you describe the actions of your hands without the jargon inherent in the story of your modality? It might be pretty hard to do, as it may be hard to separate actual plausible science, anatomy, and physiology from what you were taught as the science that supports the work you use. You have to say something that sounds science-like, but what if you had to change your story? Could you do it and would you even wish to try? You would need something to explain your work, though my explanation seems to get simpler by the year.

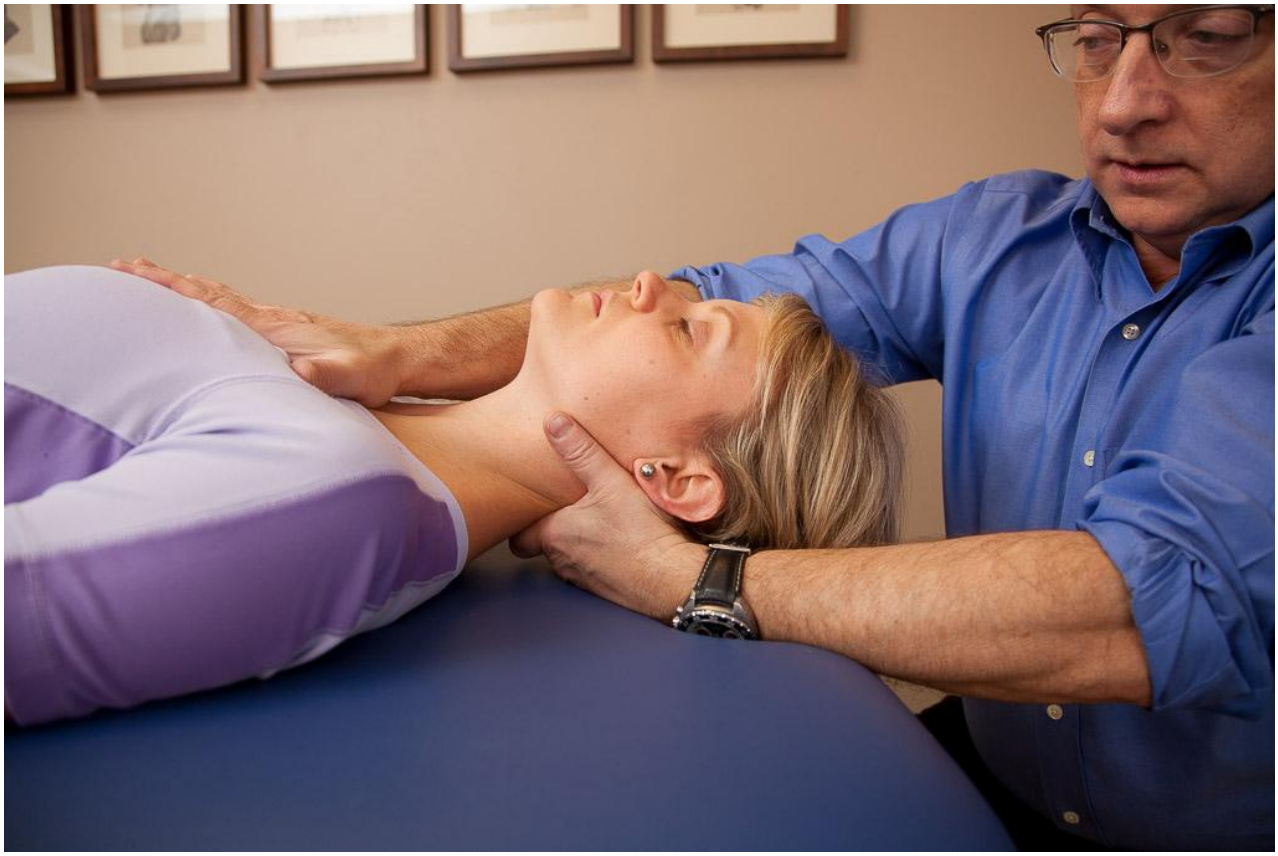

Figure 1. Walt Fritz performing the sequence formerly known as the thoracic outlet release. Photo property Walt Fritz, PT

Changing one's story is often viewed as shifty or even indecisive, as if you cannot decide or are trying to cover up something. I disagree. I've written extensively about how I moved from a narrative (story) of myofascial release in the traditional, folkloric sense, which credits so-called fascial restrictions as being the cause of most pain as well as the key to the remediation of pain into a story of simplicity and plausibility. Apparently my story was so compelling it garnered a request to tell it earlier this year at the Registered Massage Therapists of British Columbia Manual Therapy 2016 Conference. The story I now tell and teach is a simple one, one deconstructed from the stories of fascial fantasies. But as a therapist (PT) with over 30 years in practice, I've heard literally hundreds of stories on how we are creating change in the body as well as the cautions as to what will happen if we do not follow the recipe set forth in that line of training's rulebook.

The story told by most manual therapy trainings might be called *inherited narratives* (Thanks to Phil Greenfield for this term) in that the beliefs and explanatory models have been passed down over time. While new science might be sprinkled in for good effect, most of these narratives have remained unchanged for long periods of time. The narrative I was taught in my initial myofascial release training was certainly an inherited one, as the concepts of MFR (and its explanatory model) stem from osteopathic literature from the early 1900's. I have begun to use the term folklore to describe the way MFR is taught; as many therapists repeat the inherited narrative verbatim without questioning its validity or authenticity. But this is true for much of the work that we all do. If I attempted to deconstruct most of what I was taught in physical therapy school and eliminate all that was not fully vetted as scientifically valid, I may have little to do with my days. Though I've allowed the MFR story I was taught to gradually slip away , initially it served me well and I questioned little of its truth. Over time, as I moved away from my MFR roots, the inherited narrative of

MFR seemed to matter less and less. I also learned drastically conflicting stories from other people. Recognizing that my biases clouded my abilities to see real truth, I began to embrace the concept of attempting to be less wrong. Saying that I am less wrong, when it comes to explaining my work, may sound condescending or superior, but I believe that it comes from a place of humility. With a broad-based education, credible continuing education, and critical thinking, I do think we can be less wrong about the work we do. I do not mean to criticize those who believe differently and certainly not those who taught me these concepts. Science moves forward and I thank those in my past.

Many different influences caused me to change my story, though the need to do so was not due to a lack of efficacy, as I think the MFR work I did has always been effective. But the story I was taught way back in the early 1990s always bothered me a bit. I found it a bit far-fetched that such important concepts of anatomical structure and physiological properties were not taught to other health professions, physicians included, but were being taught to me in a continuing education seminar. But I like a good story, so I played along… just to hear the ending. One key point of the MFR work I was taught was the concept that fascial restrictions go beyond the origins and insertions of individual muscles, which was said to explain why patients feel far-reaching symptoms while we are treating them. Such far-reaching sensations were a key aspect of explaining MFR from a fascial perspective, and I used this explanation with my patients for many years, as well as teaching it in the early days of my Foundations in Myofascial Release Seminars. It was a good story told by some pretty good storytellers and I had no better story to explain the phenomenon, until I learned one. Let me tell you about that new story.

Frequent feedback I heard when performing a technique that is termed a thoracic outlet release are reports of sensation or referral of familiar symptoms throughout the face. When my patients told me this, I repeated the story I had been taught explaining the concept of fascial restrictions and how they reach beyond the origins and insertions of individual muscles and can refer into far-reaching areas of the body (By then I told that story really well!). Most patients would just nod or grunt in apparent understanding, but I started to notice how frequently I heard these reports. This was surprising, since it was the belief that fascial restrictions were unique to each individual, based on their history of physical (and emotional) trauma. Why were so many people telling me nearly the identical referral pattern? I filed it away for future worrying (I do that a lot. Why waste good time worrying about such things when there were more pressing things to worry about? I tend to compile worry to-do lists). It seemed that with a sustained hold in the above mentioned (and previously pictured) sequence, symptoms improved not only in the area of treatment, but also into the referral patterns through the face. Seeds of scepticism were planted.

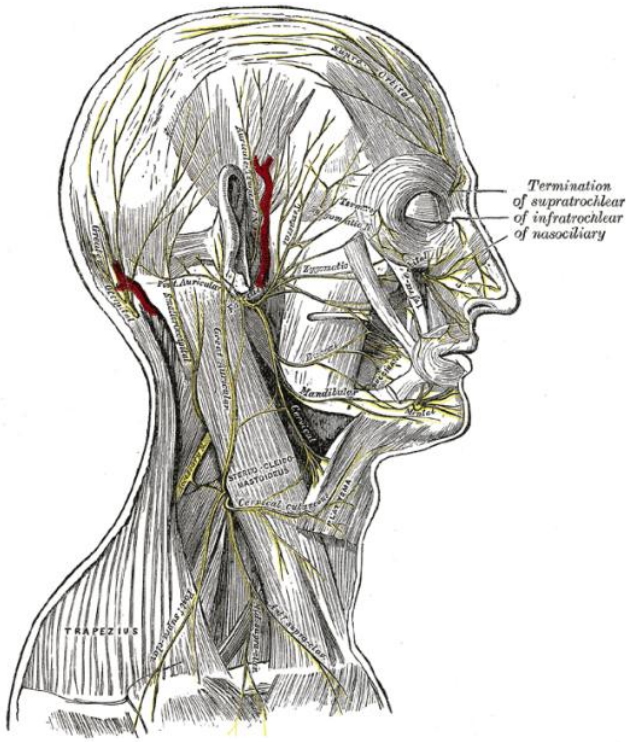

Figure 2. The Facial nerve. From Henry Gray (1918) Anatomy of the Human Body (public domain).

Fast forward to a DermoNeuroModulation class I took from Diane Jacobs, PT. She speaks a decidedly non-fascial language and at a certain place in her lecture she displayed a PowerPoint slide regarding the anatomy and distribution of the facial nerve. She

had spoken at-length about *neurodynamic* technique principles, exposing me to some pretty new and interesting perspectives on evaluation and treatment. She spoke about the potential for engaging a nerve anywhere along its length and having the possibility of impacting and allowing change anywhere along the nerve path. In essence, grab hold of a nerve anywhere and you have the potential to impact the entire distribution of that nerve. Figure 1 shows me performing the sequence formerly known as *the thoracic outlet release* (I have different names for technique sequences today…but that's another story). If you can imagine where my patient is feeling a stretch or engagement, a wide range of response is plausible, including the front of the neck and upper chest region.

Now consider the anatomy in Figure 2. It is a Grey's Anatomy plate showing the distribution of the facial nerve. The facial nerve is the seventh cranial nerve and "*controls the muscles of facial expression, and functions in the conveyance of taste sensations from the anterior two-thirds of the tongue and oral cavity. It also supplies preganglionic parasympathetic fibers to several head and neck ganglia*." The facial nerve functions as a motor nerve as well as sensory and parasympathetic nerve and supplies the exact areas that my patients were reporting all in all those instances of so-called fascial referral. What might explain this phenomenon?

Take a close look at the anatomy plate in Figure 2 and you will see that the cervical branch of the facial nerve runs down through the upper and middle anterior lateral neck regions. When I engage my patients in the stretch shown above in the photo, I believe that I am lightly engaging the cervical branch of the facial nerve. I believe that I am providing neurodynamic technique-like engagement to the cervical branch of the facial nerve, potentially affecting the entire facial nerve. I believe that I am allowing my patients to feel effect into their faces and potentially providing treatment to the facial region from this sequence, not from a fuzzy science explanation of fascial restriction, but from a biologically plausible model of nerve mobilization.

Sitting in Diane's class and seeing the facial nerve in an enlarged image allowed me to immediately see that old, folkloric story of so-called fascial referral patterns in an entirely new light. Does this mean that fascial restrictions do not explain this phenomenon? Not definitively, but when faced with a decision to choose one explanation over another, I now choose the one that is less wrong. I choose the one that science supports without needing to tell a story.

Stories have their place, but they should be told as either fact or fiction. When stories blur I do not believe they belong in the treatment room, where we give skilled care to patients in pain and dysfunction. Try to be less wrong. Change your story.

What about you? Has your story changed?

For Now,

Walt Fritz, PT

Foundations in Myofascial Release Seminars

You can make comments to the original blog post, which is titled. "More Mental Floss for the MFR Brain: Changing Your Story" here, at my Myofascial Release Blog.

[1] http://www.merriam-webster.com/dictionary/