

MIND *of* Body

By John F. Barnes, PT

Myofascial Release for Incontinence



The myofascial systems surrounds and interpenetrates every nerve, blood vessel, duct and organ in the pelvic floor. Trauma, inflammation, surgical scars, and childbirth very commonly tighten the myofascial system around these structures.

Myofascial restrictions can produce enormous pressures (approximately 2,000 pounds per square inch) on the structures of

the pelvis creating effects that have been labeled pelvic pain, back pain, menstrual pain and dysfunction, endometriosis and incontinence. As the fascia tightens around the bladder and urethra it does not allow the bladder to expand as it fills with urine.

This can create an environment for pain and chronic infections, as well as frequency or stress incontinence. Torsions of the pelvis episiotomy scars and falls in the coccyx can also cause or complicate these all-too-common symptoms.

Myofascial release-gentle non-invasive safe-can be highly effective in resolving these these problems in people of all ages.

Many times, utilizing biofeedback with myofascial release can enhance its effectiveness by reeducating the individual to reduce high-tension levels or to focus awareness for improvement of strength and function.

The following information is taken from chapter 21 from "Myofascial Release the Search for Excellence" John F. Barnes, John D. Perry and Leslie B. Talcott were contributors of this segment.

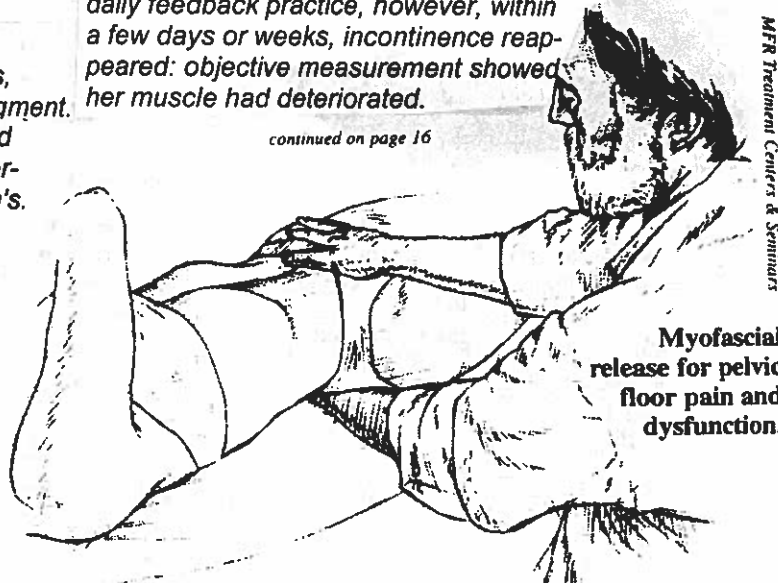
At first glance electromyography (EMG) perineometry and myofascial release might seem as antagonistic alternative therapeutic approaches to dealing with pelvic muscle dysfunction's. As a form of technologically sophisticated electronic biofeedback, EMG perineometry is a rigidly scientific precisely quantifiable, computerized discipline. In sharp contrast, myofascial release is usually considered a highly refined therapeutic art requiring personal sensitivity, centering, compassionate caring and intuitive concentration. The former is definitely left brain work, whereas the latter is right brain activity. It is precisely this divergence in perspectives that allows the two approaches to combine and cooperate in treating several severe pelvic muscle dysfunction's more effectively than either could alone.

CASE REPORT: FIVE SURGERIES

A particularly good example of the dangers of repeated surgery is a 45-year-old woman seen at irregular intervals in our clinic for four years. She occasional stress incontinence during childhood and adolescence, presumably an inherited weakness. After her first delivery, she was bothered by pain in the area of her episiotomy scar, and she frequently required codeine after a severe perineal tear (that) resulted during her second delivery. Her condition worsened after plastic surgery for the tear and a subsequent anterior and posterior repair. Finally after a vaginal hysterectomy, she was rehospitalized for three weeks with vaginal infections and bleeding. Several years later, she had an ovary removed and finally another anterior and posterior repair and bladder suspension operation to correct the previous surgeries. Throughout a 20-year period, she was frequently incontinent and remained so after the final operation.

In initial evaluation, she demonstrated extremely weak vaginal muscles, less than 2 microvolts of net strength (10-second hold) With diligent practice using a home trainer, she was able to obtain 4 to 5 microvolts after a few weeks, at which point she became continent. As soon as she stopped daily feedback practice, however, within a few days or weeks, incontinence reappeared: objective measurement showed her muscle had deteriorated.

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Myofascial release for pelvic floor pain and dysfunction.

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"voice of the tissues" as an inner physician or biological wisdom that comes forward to guide the patient through the process. As the story of the tissues is facilitated, the patient may realize that the experience in the body may have been different, or misunderstood by the mind's organization of the event.



**Often,
the patient can
feel the difference in
his or her body after the
energy cyst has been
released.**



Unconscious decisions may have been made at the time of injury, and these decisions—in Ron's case, to hold onto physical tension and worry—may be impacting the healing process. SER is an opportunity for the body's inherent biological wisdom or inner physician to come forward with the information, including how the body has adapted to the trauma as well as what help it needs to resolve the crisis and proceed with healing.

Throughout the SER therapeutic process, the therapist remains a facilitator, asking questions to bring forward more information to the patient's solutions. As therapists practicing this method, our trust is that this information is present in each patient and our job is to facilitate its expression. Our goal is for the patient to achieve resolution of whatever issue was present in the energy cyst, so that it can release and tissue balance can be restored. We believe this process is the next logical step in responding to the structural cues of the body. It is another component of the body's self-correcting mechanism that occasionally requires gentle assistance in achieving balance.

As described in Ron's story, SomatoEmotional Release can be as simple as releasing pre-operative anxiety still present in the tissues of the leg, hip and back. In the 10 minutes that it took to help Ron tune in to his body, energy cysts released and tissue integrity improved. He also acquired increased awareness of this mind-body interaction, awareness that served him well in his rehabilitation. With this valuable skill, the patient can take responsibility for the healing process from the inside out.

Whether it takes 10 minutes or several sessions, physical or emotional obstacles to healing can be identified and released with an infusion of inner wisdom and awareness to carry forward with the rehabilitation.

References

1. Upledger JE. *SomatoEmotional Release and Beyond*. Palm Beach Gardens, FL: UI Publishing; 1990.

2. Upledger JE. *CranioSacral Therapy II - Beyond the Dura*. Seattle, WA: Eastland Press; 1987.

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She resumed biofeedback practice, and the cycle was repeated many times over three years.

Eventually she was evaluated by a physical therapist who recommended myofascial release. Evaluation demonstrated an anterior torsion of the pelvis bilaterally, and compression of the lumbosacral junction with resultant caudad tension her dual tube, which was responsible for a compression of the occipital condyles and the condyles of the atlas (C1) Extensive myofascial restrictions of the lumbosacral area, upper cervical and trapezius regions, bilateral pelvic floor restrictions and numerous restrictions of the scar tissue were present due to the carious surgeries.

After a series of myofascial release procedures, she began to show dramatic improvement in measured pelvic muscle strength. Whereas before myofascial release she rarely could reach 6 or 7 microvolts, she now began to obtain 11 or 12 microvolts. Measured rectally, her strength was only 7 microvolts. Then she underwent several sessions of myofascial scar releases to deal with a coccyx bone broken years before in sexual abuse. Her rectal perineometry strength increased to 12 micorvolts and her vaginal strength further increased to 14 microvolts. In addition to urinary control, she reported considerably better sexual sensitivity and freedom of pelvic movement during sexual activity.

When all else has failed, patients from all over the world come to our Myofascial Release Treatment Centers with the above mentioned diagnoses. We and the many therapists we have trained in myofascial release experience consistently excellent results with chronic pelvic pain,

endometriosis, fibromyalgia, coccygeal pain, menstrual pain and incontinence problems.

There is help for people suffering these severe problems.

John F. Barnes, PT conducts myofascial release treatment in Paoli, PA and Sedona AZ. Additional information on Myofascial Release Treatment Centers and Seminars can be obtained by calling (800) FASCIAL