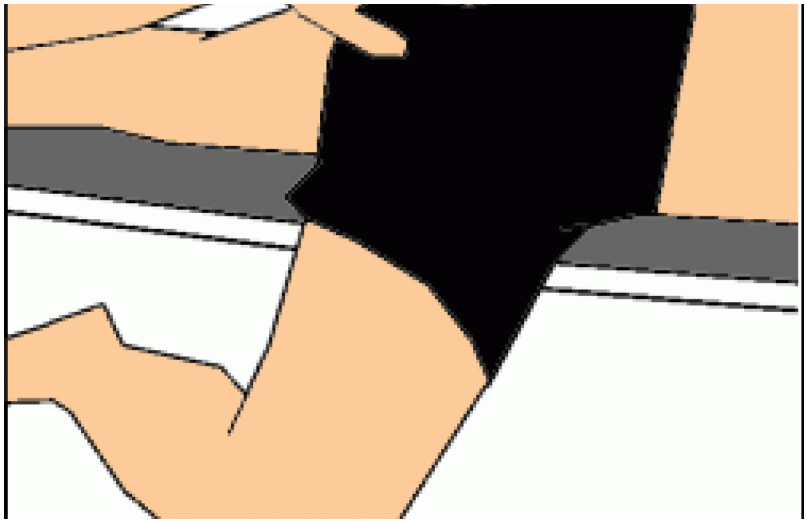
Dynamic Chiropractic



SOFT TISSUE / TRIGGER POINTS

"Strain-CounterStrain"

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I attended a basic course in "Strain-CounterStrain" (positional release) recently through the Jones Institute, the originators of this work. I introduced this work in my last article [www.chiroweb.com/archives/21/09/15.html]. Counterstrain has a deceptively simple appearance, but there is great depth available to those who really study this work.

As chiropractors, we are trained only in "direct" techniques, going directly toward the barrier, but there is another basic direction in which one can release a joint or fascial restriction. An "indirect" technique means we go in the direction of ease, away from the bind. To go only in one direction is inherently limiting; to go only in the direct direction using only one basic method, the high-velocity thrust, is even more limiting. There is a whole world of techniques out there with which to expand our toolboxes and improve our results.

Back to counterstrain: In my last article, I talked about the beginner level of counterstrain evaluation and treatment: finding the position of comfort by asking the patient at what point the tenderness diminishes. Fine-tune this procedure by asking the patient to rate the reduction of pain by percentages. Once you reach 50-percent reduction, you are close to the ideal position. It may take only a couple of degrees of change to find the 80 percent to 100 percent reduction of pain that indicates the ideal position; the point of maximum ease. Hold this point for 90 seconds and slowly, passively, bring the patient out of this position. A complementary skill is to use palpation to find the mobile point - the wobble point - the position at which the tissue softens and relaxes maximally. You move the patient until you find a position at which the tender point begins to soften, then fine-tune with small, three-dimensional motions.

Initially, I thought I could find a position based on trial-and-error that softens the tender points. Wrong - or at least bull-headed. Lawrence Jones and others spent decades figuring out the ideal positions, so why reinvent the wheel? Some of these positions are downright weird-looking at first, but work

amazingly well. If you want to learn this work, take a class and get the books. The basic principle, relative to the joint that is restricted and the posture that is held, is to exaggerate the lesion.

Jones' original text, *Jones Strain-Counterstrain*, has been updated through the years. It has a wealth of background material, several articles on the physiological basis of the work, and excellent clinical comments on the significance of different points. I find it a bit cumbersome to use day to day, so I tend to use the positional release text in the office for finding points and looking up corrective positions.

For many years, the scientific principles behind this type of work were not understood. Irwin Korr's work on muscle spindles and facilitated segments, written in the 70s, provides a theoretically grounding for this concept. The short version of the theory goes something like this: The counterstrain point is on the opposite side of a strained or suddenly stretched joint. This is the overshortened side - suddenly shortened and then rapidly returned toward normal length. The shortening quiets the proprioceptive activity from the muscle spindles. The gamma gain is instantly set to accommodate this shortened position.

On the strained side, the muscle spindles are called into play to protect the rapidly lengthening muscle from damage, creating an immediate reflex contraction. On the overshortened side, this is experienced as a sudden lengthening following the shortening. This muscle then reports itself as being strained, even before it reaches its neutral length. This muscle is now stuck in a functionally short position, but reports to the nervous system that it is strained. This nociceptive reflex can last forever, not just the six to eight weeks during which the original strain heals.

Any sudden, unguarded motion (not just a severe strain) can cause formation of a counterstrain point. (Incidentally, the classic chiropractic adjustment - a high-velocity thrust - rapidly stretches the joint. Usually, this is therapeutic, but occasionally a patient reports that he or she hurts more after the adjustment. I don't worry about a treatment reaction that lasts 12-36 hours, but if the postadjustment pain is ongoing, something is wrong. Perhaps I iatrogenically created a counterstrain point via the rapid stretch. Even though the joint may feel even more fixated, a repeat adjustment will not solve this problem. The answer here may well be counterstrain, to one side or the other of the affected area. I didn't really create true tissue pathology or tear anything with the initial adjustment; I just created a noxious neuromuscular reflex. It is my responsibility to know that this is a possibility, and to know how to correct it or to whom to refer the patient for further treatment.

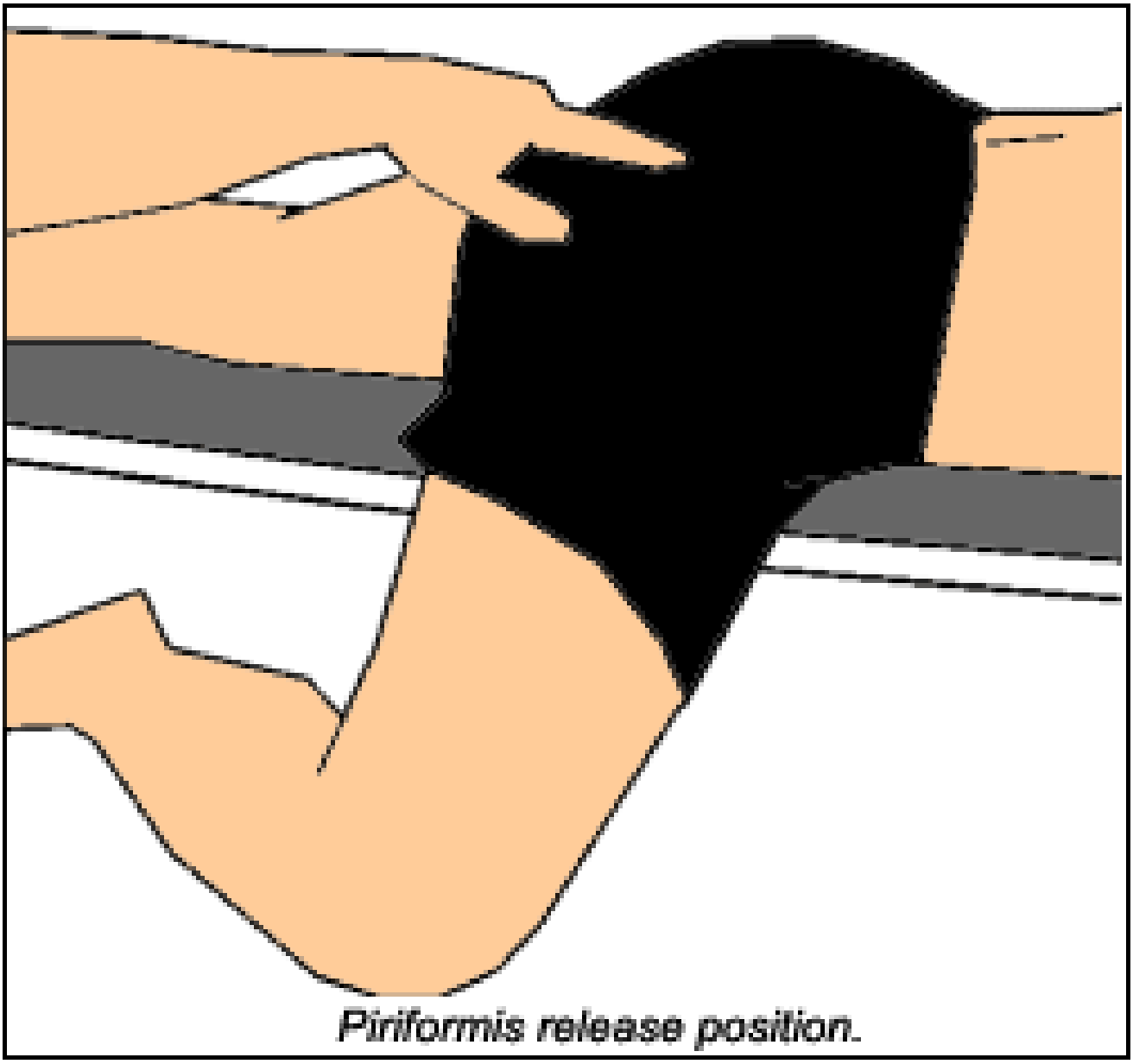
The tender points in counterstrain are not the lesion or subluxation itself. They are a sensory manifestation of the dysfunction; a referred pain zone; an indicator. Counterstrain does not actually treat these points, but uses them as indicators. Keep your hand lightly on the tender point once you find the position of ease, just to monitor. This is somewhat counterintuitive. All of the beginners in our class have made the error of continuing to press on the tender point.

These tender points, "Jones points" or counterstrain points, are qualitatively different from trigger points. Travell trigger points will tend to refer to another location, to which counterstrain points do not refer. Travell points feel like a band or a fibrotic "glump." Jones points are small and discreet; can feel thick and dense; and the tender point often is found in a hole. Travell trigger points are tender to the touch, whereas Jones trigger points are exquisitely tender, and may make the patient almost jump off the table.

Clinical Application

How does the chiropractor use counterstrain? One way is "fullblast," making this your primary technique; another way is to use this method when all of your other tools fail or don't completely resolve the problem; a third way is to use the Jones tender points as a map. The map gives you a way to keep score: It is a record of tender points that indicate some kind of neuromuscular dysfunction. Use your usual tools, and return to see if these tender points have resolved spontaneously. If some of the tender points remain, it may indicate that you are not resolving the whole of the problem and need to look deeper, using counterstrain or other methods to resolve the reflex dysfunction.

I try to provide specific technique tips in every article. Previously, we discussed stretching the piriformis. Now, we'll do the opposite, using counterstrain via a slacking or "fold-and-hold" method, shortening the piriformis in order to release it. This position is illustrated in the figure at right. You can use this when your usual trigger-point work and adjustments are not resolving a sacroiliac problem, and the piriformis tightness continues to recur.



Piriformis release position.

Have the prone patient move near the edge of the table, as you sit on a stool. Find the tender point somewhere in the belly of the piriformis, and monitor this with moderate pressure. Take the patient's leg into approximately 90 degrees of flexion, and about 30 degrees of abduction. Support the bent leg on your thigh. Remember, you are asking the patient for a percentage feedback on the degree of diminishing of the tenderness. You are also feeling for a softening of the dense hard point. Fine-tune the position with flexion and abduction. You can also add internal/external rotation via moving the tibia. Hold for 90 seconds, then slowly, passively return the patient's leg to neutral. Recheck the point; it should be nearly pain-free and soft. The patient also can use this as a rest-and-relief position if the piriformis tender point continues to recur.

The more tools you have in your toolbox, the better you can help your patients. Sometimes, you just need to look at a problem with completely new eyes - a "beginner's mind." Counterstrain, with its focus on the opposite side of the original strain, its indirect methodology, and its tender points, is a completely different type of technique from what you may have learned. Counterstrain is designed to correct traumatically induced aberrant reflex changes that can cause subluxations or keep them recurring.

References

1. Jones Strain-CounterStrain course, Randall Kusunose, Medford, Oregon, March 2003
2. Lawrence Jones, Randall Kusunose, Edward Goering. Jones Strain-CounterStrain. 1995, Jones Institute.
3. D'Ambrogio and Roth. *Positional Release Therapy: Assessment and Treatment of Musculoskeletal Dysfunction*, Mosby, 1996.

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