

July 27, 2020 4/ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy (notes compiled by Katarina Halm) 200727

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Previous notes, being updated

1/ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy (notes compiled by Katarina Halm) 200707

2/ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy, Matilda, Celeste (notes compiled by Katarina Halm) 200714

3/ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy, Barbara, Celeste (notes compiled by Katarina Halm) 200721

The STATIONARY BIKE is a great thing. You can start with little to no resistance, and then you can add on. Cycling mimics climbing the stairs. (emphasis added)

"Another thing is BLOOD FLOW RESTRICTION [bands]. I bought some online recently. Owen's Recovery Science is the name of the company. The cheaper ones on Amazon are not as good but they do restrict the flow. There will be a good quad and hamstrings activation. It will not interfere with [but enhance] the healing of the bones. You will be cutting off blood for only a minute. You could use this on a bike. The aim is to reduce muscle loss. Also, do not worry too much about the rotation in the beginning of the healing process." (emphasis added)

#### REFERENCE

Owens Recovery Science - Blood Flow Restriction Rehab

<https://www.owensrecoveryscience.com/?>

[gclid=CjwKCAjwmf\\_4BRABEiwAGhDfSTuiXsuV2RCE3STsbuCQqSilXBeWKI4-ZknXbYS9kZ6qduzIi4JlMxoCMisQAvD\\_BwE](https://www.owensrecoveryscience.com/?gclid=CjwKCAjwmf_4BRABEiwAGhDfSTuiXsuV2RCE3STsbuCQqSilXBeWKI4-ZknXbYS9kZ6qduzIi4JlMxoCMisQAvD_BwE)

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I have shown you before how if you strengthen hamstrings and abdominals, it can help expand the rotation in the hip. The external and internal rotation of the hip are limited by the position of the bone in the hip socket.

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We talked about left AIC pattern [see July 21, 2020 notes]. When I do visceral work, I tend to find more tight spots on the right side. Anatomically we appear to be predisposed that way, mostly because of how diaphragm attaches on the right side. Neurologically too.

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There has been change in how therapists treat patients, say when a patient comes in with a neck issue ... the sight of pain is rarely the sight of the issue. "He who treats the sight of pain is lost". We have to identify the most dysfunctional part of the body.

The last part of the **Postural course** talks about the cranium part. [TCMM] pattern. The SPHENOID bone is hugely altered by those patterns happening further down. So that would all make sense.

## REFERENCE

{{ " **Pattern identification** is a method of thinking which provides evidence for treatment by synthesizing and analyzing clinical data and differentiating **patterns** on the basis of **TCM** theories. Structural equation modelling integrates the idea of factor analysis, correlation analysis, and regression analysis " <https://www.hindawi.com/journals/ecam/2012/970985/>}}

## REFERENCE

"The **sphenoid bone** is an unpaired **bone** of the neurocranium. It is situated in the middle of the skull towards the front, in front of the basilar part of the occipital **bone**. The **sphenoid bone** is one of the seven **bones** that articulate to form the orbit.

**Latin:** os sphenoidale" [https://en.wikipedia.org/wiki/Sphenoid\\_bone#:~:text=The%20sphenoid%20bone%20is%20an,articulate%20to%20form%20the%20orbit.](https://en.wikipedia.org/wiki/Sphenoid_bone#:~:text=The%20sphenoid%20bone%20is%20an,articulate%20to%20form%20the%20orbit.)

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**Q. Which part of fascia goes into fascia?**

I may have to consult with Tom Myers - Schleip's fascia perhaps? It seems that between authors those fascial planes are named differently. I am more concerned with what's the most dysfunctional part? And I would work with that from the muscoskeletal perspective. I am sticking to my method.

**REFERENCE**

Dr. Robert Schleip Fascia Fitness PDF  
[https://pdfs.semanticscholar.org/786b/69a90f65a1bb84ee952b7a624eb580de5988.pdf?\\_ga=2.219319184.880133068.1595969347-263879530.1595969347](https://pdfs.semanticscholar.org/786b/69a90f65a1bb84ee952b7a624eb580de5988.pdf?_ga=2.219319184.880133068.1595969347-263879530.1595969347)

.....  
**Q.** From the Feldenkrais® method, if there is a disfunction, we will ask - "how does the body do that"? And then bring new input, for the brain to learn other ways of doing it.

Ian McCarthy: Developmental kinesiology is definitely something I work with. There are mobility (joint mobility, or any kind of tissue extensibility) and stability (motor control) dysfunctions. If I is stability, then the works is from the ground up. I would have patients with back issues rolling on the floor first.

Very often with patients who have neck issues, an osteopath might mistakenly diagnose it as mobility disfunction. But we should not be assuming that. So I would start by laying the patient down and performing their range of motion test again. I is amazing how often that happens.

## **Stability/motor control**

4x4 matrix

<https://www.physiodave.com/the-4x4-matrix/>

### **There are 4 positions we can teach patients in:**

There are 4 positions:

1. Prone / supine - not weight bearing
2. Quadruped -a bit of weight
3. Half kneeling and tall kneeling - a bit of weight
4. Standing: squat, lunge, step up (single stance) - full weight bearing

That's nature's progression. That's how babies learn.

### **There are four loading levels:**

1. assisted / unloaded (Reactive Neuromuscular Training (RNT))
2. unloaded (no load)
3. assisted / loaded (RNT + resistance)
4. loaded (resistance)

This is the motor learning perspective, the neurological perspective.

Say, a patient is standing and ca not turn their head. That would be 4x2. So I would trace it to the level he can do it, all the way to 1x2. IF they ca not do that, then 1x1  
So you'll notice that I am not adding any resistance to the exercise. When I add weight to the exercise, I am basically telling you "I love how you move". But if the motor control is poor, I do not want to put weight on top of that and reinforce a bad pattern.

Let's say someone has poor thorax mobility. IN a clinic setting, I would suggest stretching, tissue relaxation.

If I do not do anything more, that will not last. It'll tighten up again. Because the brain is used to having stiffened thoracic spine. So the motor patterns have not been addressed.

So we need to follow up with the stability work. 1x1, 1x2, etc. [demonstrates]

There are two ways of thinking about it. If you pick and isolate a muscle, does that change motor patterns? Post-surgical cases are different.

Let's say you have weak gluteus medius bilaterally. I could advise clam shells. But I will not because the issue is not there. [demonstrates]

My whole point is, as patients come to us, they are going to have one of the two issues, stability or mobility. Or both. And in different places. This results in a joint by joint approach. Certain joints are designed inherently to be stable, others - to be mobile.

<https://www.otpbooks.com/advances-in-functional-training-excerpt/>