**Phase 2 Treatment: Reach**

*Release new options for movement, teach self-treatment and management strategies. Build strength, endurance and capacity for daily function and goals.*

We achieve this goal by identifying the underlying Driver for the problem and addressing dysfunction of the Driver in the multiple interactive systems; Musculoskeletal, neuromuscular (motor control), fascial, neural, articular etc.

**Objective Assessment: Key Points**

*Part A: Identify the Driver*

* Use Corrections now to determine the impact of one area on another
  + Start with your correction of the region you have been treating - find regions that get worse. Hint: these will likely be regions that are not responding to current treatment
* Use the ConnectTherapy Drivers Diagnostic Chart and algorithm for this
* Use an appropriate **Screening Task** to be able to determine the NOLT in the region you are assessing – for example Squat is good for Pelvis and Thorax, BAL can be used for rings and neck as well. Heel raise/back foot in step forward and squat is good for assessing NOLT in feet.
* When you have what you think is the Primary Driver, correct it and use your **Tests for Pain and Improvement** to determine the impact on the client experience.

**Treatment Techniques**

*Part B: Treat the Driver – Phase 1*

The goal here is to release the Driver enough so that you can train better ‘core control’ in the deep and superficial muscles that control the Driver. This is the process:

1. Perform a pre-treatment Movement Test as appropriate.
2. Assess NOLT of the Driver – in movement test and in Screening Task
3. Correct the Driver:
   1. Determine how easy/hard correction of the Driver is – can you get a full correction or is there too much resistance?
   2. Use your screening tasks or your Release Goals (see below) to inform what you need to release. If there is increased resistance through these movements, you will need to perform release that allows you to access the muscles causing the increased resistance in that particular range. You may have to reposition the patient to be effective in reaching the muscle and having it sufficiently relaxed
4. You can try a cue to see if the client can activate a better pattern (prior to release). If they can, you will require less release and you should be thinking immediately of Phase 2 Release Goals.
5. Release the non-optimal patterns around the Driver. For example, in the upper rings, this includes muscles attaching directly to the rings (intercostals, serratus anterior, obliques) and those that have become dysfunctional because they are associated with the Driver being non-optimal for (sometimes for a long) which changes length-tension relationships and causes compensatory movement patterns (commonly lats, posterior deltoid).

After every release (remember to balance the forces 3D all the way around the Driver structure) – repeat steps 1 – 4 until you can find a cue that allows the client to better control the Driver.

**Release Goal**

Phase 1: Release enough to achieve the following:

* Client to perform low load, ADL’s
  + 50% head rotation+
  + Arms to 90d elevation
  + Some trunk rotation (pelvis/trunk dissociation)
  + Sitting / squat
* Client to be able to find a cue that controls the Driver better

Phase 2: Target exercises

* Simple – single joint, uniplanar, saggital
* Low load – low resistance, low challenge
* Do not challenge the Drivers direction of greatest neutral zone
* A well-rounded program includes exercises from each of the following categories. Find the easiest category of exercise to start.
  + Lower extremity + Open Kinematic Chain
  + Lower extremity + Closed Kinematic Chain
  + Upper extremity + Open Kinematic Chain
  + Upper extremity + Closed Kinematic Chain
* Consider the strength deficits that are there

**Release process**

Plan your release so that you can get to all the structures 3D on the Driver with the muscles relatively relaxed. Good release positions include:

|  |  |
| --- | --- |
| Rings | * Supine for ant scap vectors and Trunk/pelvis dissociation * Sitting, standing (with arms supported) for posterior shoulder girdle vectors * Prone for segmental massage and DN to Tx paraspinals and posterior ring vectors |
| Neck | * Supine for all levels * Sitting to release into head rotation |
| Hips | * Supine for release into flexion and abd and rotation * Sidely or end of bed to release into extension |
| Pelvis | * Crookly with support under legs |
| Knees | * Supine |
| Feet | * Sitting, foot hanging (hindfoot) * Prone (midfoot) * Crookly (forefoot) * Sitting with foot on floor (to release from foot flat to heel raise or sliding forward on floor |

**Education and Empowerment**

*Connect the client to the overall picture of what is possible and where they are.*

* What you released is the client’s compensatory muscles – show the the client how they can effectively identify when they need to and how to release this area
* Demonstrate on the Movement is Medicine Pathway where the client is now and highlight the strategies you are using to move them forward