

**MNZ**  
MAGAZINE

3RD QUARTER 2018

  
massage  
new zealand

# RESEARCH – DELVING UNDER THE SURFACE

## A Deconstruction of Beliefs: A First-Person Account

by **Walt Fritz, PT**

MAKING SENSE OF RESEARCH • INTERVIEW WITH PHILLIP COTTINGHAM • EVOLUTION OF A MASSAGE THERAPIST INTO RESEARCH AND BEYOND • ELEVEN STEPS TO READ A PRIMARY RESEARCH ARTICLE  
• SIX TIPS TO ACCESSING ACADEMIC RESEARCH FOR FREE • BLOGGING SCIENCE AND RESEARCH WITHOUT BORING YOUR AUDIENCE • ADAPTATION OF THE CARE GUIDELINES FOR THERAPEUTIC MASSAGE  
• A DECONSTRUCTION OF BELIEFS • FERTILITY MASSAGE – AN UNETHICAL PRACTICE?



# A DECONSTRUCTION OF BELIEFS: A FIRST-PERSON ACCOUNT

By Walt Fritz, PT

*"Lightly contact the fascia with relaxed hands. Slowly stretch the fascia until reaching a barrier/restriction...."*

Up until quite recently, Wikipedia's page on Myofascial Release<sup>(1)</sup> would have listed that exact phrase when describing how indirect myofascial release (MFR) works. Being a dynamic document, changeable at any time by anyone, this quote no longer exists on Wikipedia, but historical remnants may be found across the graveyard of the Internet<sup>(2)</sup>. Beginning in 1992, this phrase, and similar ones formed the basis of my MFR education. Many of you might look at those words and not quite understand my point, as I too would have wondered for most of my early career as an MFR-based physical therapist. They may sound quite logical and accurate, similar to what you've been taught and believe. For many years I took little interest in deconstructing ideas such as those, as the work, MFR that is, was so compelling and more than adequate for helping with pain and disorders of movement I faced in my practice. Why question what works?

Please note that by writing this I do not mean to impugn the pioneering founders, contemporary teachers, or practitioners of MFR, but instead I am encouraging you to use their successes and teachings to look deeper and grow. There is a saying that goes something to the effect of, "one cannot expect change from someone who profits from the status quo," which will often hold back change. While an entire approach was not based solely upon those two sentences posted above, MFR, as I was taught, it did sum up many of my beliefs. MFR was presented in ways that made it seem simple but full of secrets. The simplicity involved the gentle engaging of the so-called fascial barriers and allowing change to happen. The secret involved fascia's reported unknown importance in medicine

and therapy and how it was the missing piece with regards to pain and function. The entire profession of health had ignored fascia's relevance, except for practitioners of a specific style and training. The approach I learned was supported by disparate factoids that were pieced together to form a ragged science-sounding narrative, one that is presented in an environment that was open to discussion and debate which a skeptic could quickly see the flaws in, but it was one that often stood up in the closed doors of a continuing education seminar room. Some people can sell water to fish. I was a fish and quite thirsty.

Deconstructing one's beliefs can be painful; at least it was for me. My ideas were thoroughly demolished in 2005 on the forum site, SomaSimple.com<sup>(3)</sup> in the thread, "Myofascial Release: The Great Conversation". At the time of that conversation, I was still firmly entrenched in my previous MFR beliefs and camp, and a strong advocate for the work and its founder. As such, when I heard that the neuro-nuts (my slightly pejorative term for those who felt everything was explainable from nervous system explanation and who demonstrated apparent disdain for fascia fans such as myself, whom I will term fascists) on SomaSimple were doing what they called a deconstruction of MFR, I jumped at the opportunity to call them on their errors and defend my work. When ensued was 34 forum pages of bad behavior, at least on my part. Not ready for, nor interested in, the rigors of scientific debate, and as such poorly prepared to do a decent job defending what I believed to be hard scientific proof of just how and why MFR works, I was soundly thrashed on every point. I even invited some of my fascist friends, to help me in the street fight, but it mattered little. After being kicked off of the website on numerous occasions for bad behavior and then let back on, based on my promises of good behavior that I could not keep, the thread finally was closed. Like my



mind, closed. Nothing was resolved, and no minds were changed, but I felt like I had gone to the rescue of my mentor and my MFR family. (If you take the time to read the very long and, at times, embarrassing thread to its completion, please don't omit reading my postscript<sup>(4)</sup>, where I apologised for my bad behavior.

Relationships are tricky, especially if both sides are not interested in compromise. My relationship with my MFR family and mentor of 14 years ended in 2006 over what were seemingly trivial matters, but they were ones that neither side was willing to compromise on. Offered a choice of submissively backing down from authoritarian attempts at control or to leave, I chose to go. With my choice, I was put on a course that has brought me here today. Bloodied and a bit bruised, but a better-rounded person from a scientific understanding perspective, I embarked on a journey to find a better explanation for the work I did and would soon begin teaching. Shortly after my divorce from the MFR community, I returned to SomaSimple and started reading the articles and references that the neuro-nuts there had supplied. During the Great Debate, I never took the time to read the articles provided, as I was too busy trying

to prop up my MFR argument. Little of the new information made sense to me, as it was mostly written from neurological, behavioral, and pain science perspectives, rather than fascial perspectives. It was akin to learning a new language. However, I persevered and in the process reached out to some of my former adversaries on SomaSimple, though few had an interest in conversing with me. In hindsight I understand why, (haven't you read the thread yet?), but I needed some questions answered.

Diane Jacobs, PT, was one of the few there who took the time to guide me as I waded through the information. (My university education in physical therapy did require research literacy, but laziness had dulled my critical thinking skills, as had my MFR indoctrination.) Diane pioneered the concept of DermoNeuroModulation (DNM<sup>(5)</sup>), a form of manual therapy that relies on skin-based neurological narratives to explain the effects of manual therapy, and I was fortunate enough to participate in one of Diane's workshops. That workshop added layers of confusion but taught me many things. The confusion stemmed from how similar in appearance DNM was when compared to MFR. Similar not in the explanations, which were completely different, but similar in how the body was touched. She and I utilized nearly identical actions with our hands but were thinking quite different thoughts while treating. In MFR, I was taught that when one gently grabs hold, so to speak, we were engaging the fascia. However, in Diane's rather logical explanation, the only tissue we can have the certainty of impacting is skin, and she explained our outcomes based solely upon the neurology of skin (receptors, cutaneous nerve tunnel syndromes, and more). While deeper tissues MAY be impacted, she put forth; we can only be sure we are affecting skin. That, my friends, was a game changer. I began looking at these two sentences over and over, as well as the supposed more in-depth MFR model behind them, wondering how I had missed the omission of the skin. While a skin-based model may not satisfy everyone's needs for the explanation, it does potentially supply quite a bit.

*"Lightly contact the fascia with relaxed hands. Slowly stretch the fascia until reaching a barrier/restriction...."*



Explanations and exceptions get messy and blurred, as one can argue that skin is immediately and wholly connected to the fascia, so by stretching skin, we will directly impact fascia. However, I see these as apologist explanations, as everything is connected (how many times have you heard that one?). How can one have a reasonable level of certainty that they are contacting fascia, or any other tissue/structure beneath the skin, to the exclusion of all other tissues? Can we isolate iliopsoas for treatment, not impacting surrounding structure, when the muscle is buried beneath inches of tissue, structure, and a robust nervous system, both somatic and autonomic, all potentially ripe for impact? Therapists speak of individual muscles, pointing to them as the responsible offenders for creating pain or movement dysfunction, and how their work impacts that particular muscle. Others talk of trigger points, energy cysts, dural tube restrictions, subluxation of joints, and hundreds of other tissues and pathologies (real or metaphoric) that they believe they can detect with certainty and work to resolve those problems, all through the thick protective coating of the skin. How can one isolate one tissue/structure, to the exclusion of all other tissues, to blame as the cause of pain or movement dysfunction? Thoughts such as these were initially troubling to me, as I had never looked at MFR from this perspective, and they made me quite uncomfortable. I had just ignored all of that other stuff as less important, focusing on what I believed were fascial restrictions and their primary effects. I am guessing most other manual therapists

can relate to the troubling aspects of these views, though few may look unless forced.

A cursory look at the published research done with and on MFR allows fascial enthusiasts to cite evidence that supports their claims that fascia can be manipulated with stretching. However, a more in-depth examination of that evidence shows that most is outcome-based research, demonstrating that when an MFR style of engagement is used with various disorders, the person improves. On the research page of my website<sup>(6)</sup> I've posted dozens of such published journal articles that repeat this theme. The problem is defined, the solution is proposed, the study is done, hopefully with both a control group and a test group, and the results are discussed. When MFR is used on the test group, the authors will, at times, describe the actual hands-on sequences, while other times the intervention is vague. Most of the studies listed on my website describe positive outcomes with an MFR style of intervention. However, when defining the problem and the work, nearly all of the authors of those papers restate the historical narrative of MFR, both rehashing the older but untested views on how fascia gets restricted and how we impact it via our hands-on techniques. Few, if any, of those studies, call into question whether that historical narrative is accurate. It is true that when we put our hands on someone and act in a manner taught to us in MFR training, people feel better. But the same is true for nearly all forms of hands-on intervention. Are the hand actions of MFR that dissimilar





than the dozens of other branded forms of massage and manual therapy? I don't believe they are. Is MFR more effective than different styles of intervention? Probably not. Little has been published to support the claims made in continuing education settings and even less has been published that challenges the historical narrative of MFR, as well as massage and manual therapy in general. However, I believe that this is where our professions will grow; by looking at the evidence and working to improve the WHY of our work.

Challenging the historical narrative of MFR, both the thought that shortened/restricted fascia can be seen to be the primary problem and that it is actually possible to singularly and selectively impact fascia, to the exclusion of all other tissues, should be questioned. These statements are in no way meant to cast shadows on the excellent research that is currently being done on fascia, and that at a point in the future there may be groundbreaking studies that confirm all that has been speculated, but at this moment, it is mostly conjecture. Fascia enthusiasts, especially those from my old MFR group, take my words as personal insults or as attempts to demean their mentor, but in truth, I have enormous gratitude for what I was taught as well as the work of my MFR peers. But gratitude does not necessitate adherence to silence. The narratives that are used to explain MFR has been critiqued, criticised, and questioned by many in the therapy and science community for decades, including my professional organisation, the American Physical Therapy Association, and with good cause. The foundational science used to support MFR is lacking, as is the science that most of us use to explain our work.

Sitting through many manual therapy continuing education workshops would make one disbelieve that previous sentence. I believe that most of us were taught in models that guide us down rabbit holes. The more workshops we take in a particular modality or from a specific educator causes us to be drawn further down into rabbit holes of thought and peer support. Look no farther than Facebook, where you will see the dozens, if not hundreds, of groups providing support and camaraderie for therapists who have trained in a specific model. Some go so far as to require a litmus

test or loyalty oath before allowing entry (yes, they do exist.). Others are less rigid, but in nearly all of the groups the members speak in a coded manner of speech, using rabbit hole-specific words, phrasing, and thought patterns native and unique to that group and modality. The hardest aspect of allowing critical thinking to flourish and possible deconstruction to occur is to separate oneself from outcomes as being proof of the narrative supplied, which is often openly discouraged in rabbit hole groups. In my original MFR family of origin I was taught that restricted fascia was to blame for the pain and that when we put our hands on someone and act in a precise fashion, we are releasing fascia. We, as budding MFR rabbit hole therapists, applied the work as taught and experience good outcomes, which seemed to fully validate the narrative, as you might do with your modality of preference. My peer group continually reinforced the narrative, and dissenting opinion was seldom heard (or allowed). This behavior allows us to fall into the post hoc fallacy, or more correctly, the logical fallacy known as the post hoc ergo propter hoc<sup>(7)</sup>. Not until one pops their head out of their existing modality rabbit hole, seeing how others are working, how they are using their hands, noticing the marked similarities in how each works but with a different explanation, will one can begin to see that our work is not so different.

Substituting certain words, many of you may recognise principle statements of your modality in the sentences at the top of the page. Is there conflicting opinion on the effects of your work that you tend to ignore? Are there alternate explanations on how your work can be explained? Is your rabbit hole peer group defensive against alternative views or questioning of the historical narrative? If so, they do so for a good reason; questioning authority often strips power and acts as the great equaliser. Educators in manual therapy continuing education have much to teach us, but most have a rabbit hole (and the income that it generates) to protect.

Becoming skeptical can cause cynicism. My apologies for what may seem to be a dark tone used in this article, and if I sound like I am disrespecting the effects or followers of myofascial release, or manual therapy/massage in general, I am not. We know

our work is good, but it is reasonable to be blinded by our biases. Such biases are not failings but are what keep us bound to our clan. Clan kinships are strong, not just in manual therapy rabbit holes, and we tend to defend our work and teachers fiercely. However, gratitude and clan behavior should not prevent one from questioning. My suggestions? Learn what you can from everyone you come in contact with, but question what is stated, including their evidence. Try not to fall into the post hoc fallacy. Learn competing theories, and work for blended narratives, incorporating all aspects of known fact. Is there a more straightforward explanation to explain your work? Don't be afraid of narratives that seem to contradict what you have been taught, as there is learning to be had in every explanation. How can one decide what is truth and what is lacking? That is not an easy answer, but a casual adherence to Occam's Razor is a start. "Of two competing theories, the simpler explanation of an entity is to be preferred"<sup>(8)</sup>.

### **Why do I continue to call my work myofascial release? Here is how I explain that:**

"Myofascial release (MFR) is one style of manual therapy that uses slow, still, prolonged stretching through clothing or directly on the skin to facilitate change in the patient. Whether having its primary effects on fascia, as historically believed, or on skin, muscle, other tissues, or the nervous system in general, it is realistically a more complex direct and indirect interrelationship of overlapping systems and effects."

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and his accompanying blog,

<http://www.waltfritzseminars.com/blog/>



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