Flury

Technical Catalogue

The techniques are described outside the context of integrating the whole. They must not be used this way but only if properly indicated by that context. They can otherwise introduce disorder into the structure instead of order.

General Lengthening of the Surface of the Back on the Bench

To lengthen the back effectively, it must be long so the tissue is stretched. The posture should provide good balance for the client and involve as little effort as possible. I often use a posture on the bench with the client letting his upper body bend forward down all the way. It is essential to assure optimal conditions of the support system first. The feet should be placed slightly in front of the knees, a little apart as is comfortable, and parallel only as much as is convenient for the client. The tuberosities are as far back as possible and wide, the pelvic floor being relaxed.

The upper body goes forward down and rests on the thighs. The arms hang down lateral, drawing the shoulder blades away from the spine by their weight. They help keeping the knees in line if they tend to go apart. The head is often held back at first but must hang down freely in front of the knees. I explain that the idea is that its weight will slowly pull the whole spine long. The tuberosities far back and the top of the body hanging down in front make sure that the front contour of the trunk stays long. The back is then even longer and not bent too much.

The client should give in to the vertical pressure on the back by letting his chest and belly be pressed to the thighs. He then feels that the trunk is slightly deformed lengthwise and sideways but that it transmits the force passively to the thighs, without him helping by using his musculature. In front, the weight and the pressure are guided passively into the ground by the lower legs; the feet remain soft. In back, the pressure secures his pelvis against the bench, and he should feel if possible how his sitting bones are pushed out back more by it. This depends on complete relaxation of the abdominals and all the muscles in the pelvic area. He may need to assist in this by extending a little against the floor. The reaction solely keeps the tuberosities back and must not push up the back or posterior pelvis.

I usually work with one hand more cranial, the other distal. This hand which is lower on the back always also helps keeping the tuberosities back. It either works down and distal with the other hand keeping the tissue cranial, or it holds down and back the tissue when the cranial hand works up. The two hands so always keep a part of the back extended between them with one of them lengthening the tissue directly. The small remaining net force on the whole body is always vertically down and back on the lower back. Of course the back of the hands or the elbows may be used, too. As long as it is seen to it that the passively stable system lengthens under pressure – the tuberosities going back – the client is able to stay completely relaxed.

Of the outermost layer of the back the latissimus and the lower half of the trapezius are so available. They are stretched and spread and can easily be lengthened and taken medial or lateral as is appropriate. The erectors beneath them can e.g. be lengthened by going under them and lifting, from lateral where they are wide, from medial where they are rolled onto the spine which can't lengthen enough there.

Often clients begin to hold their head or push the back out some. This is frequently subtle but must be recognized because it makes working inefficient and presents the danger of creating disorder. But it is also a sign that the body wants to protect itself and must be heeded. One measure of safety is to keep the posture only for a short while in which working can be quick. I rarely leave clients in it for more than one or two minutes although many report that they could stay in it much longer easily.

Getting back up is tricky, especially if the back has opened a lot. I ask the client to focus on two things. First, he should come back from bottom to top like a wallpaper being unrolled up along a wall. Secondly, the force for it should come exclusively from extension against the

floor. Generally clients will bring back their head first which must be prevented. The head comes back on top last. Neither should they use their shoulder girdle or push up with their chest. The belly must stay completely relaxed. With one of my hands on the lower back I ask the client to press against the floor in such a way that my hand is at the other end of extension and is pushed back. All clients overdo this which would result in posterior tilt sitting. So I ask them to stop when the lateral midline through the lumbar segment is at about 45°. I place my hand higher up, just below the dorsal hinge, and my other hand goes to the angle of the costal arch in the epigastrium. Now both hands direct further "unrolling" in such a way that the pelvis remains tilted anteriorly, the thoracic spine lengthens in straightening, and the area around the xiphoid process goes back but not forward and up. If done this way and after releasing the weight of the body vertically down, normal sitting results.

The technique is not always possible with older clients although surprisingly many of them are able to go along with it. It is sometimes too stressful and cannot be used with clients who are not able to rest their trunk or part of it on the thighs. Usually the restriction is more functional than structural, however. It is generally contra-indicated for clients with long, slim, and soft backs. They are not short in the superficial layers of the back anyway. The most dangerous cases are those with soft sections in an otherwise hard back. Imbalance is easily accentuated. Typical examples are some locked-knee internals with a hard kyphotic upper back but a soft and hypermobile lumbar section. If the position is used with them, work should only be on the thoracic area of the back with the lower hand at about the LDH protecting the lumbar area from overstretching. For short and hard muscular backs the technique is suited best.

Hans Flury

The Lower Rectus Abdominis

The rectus abdominis, because of the direction of its fibers, its mass, and its leverage, plays an extremely important role for the relationship between the thoracic and pelvic segments as well as for the lumbar spine whether curved anteriorly or posteriorly. Not infrequently its upper part above the navel and the lower one differ as to shortness. Either one may be drawn in and in primary shortness because of permanent muscle contraction while the other bulges out, flaccid or overstretched and in compensating shortness. Diagnosis is not easy because the overlying fat tissue can be highly deceptive.

The technique presented is especially apt for the lower part of the rectus. With externals, it is more often primarily short, the pubes being high and out in front. With internals it is often stretched and tight for helping to contain the downward tendency of the pubes.

The client lies supine on the table. This usually means for internals that their pelvic shift is reversed – the pelvis is in front of the legs and the lumbar segment – and the anterior tilt is increased because the weight of the legs which are behind the pelvis in this position drag down on it in front additionally. The lower rectus is so stretched already, which is favorable to the technique. With externals the situation is different. The anteriorly shifted pelvis is congruent for them. Often their lumbars and iliac crests drop back and so increase the posterior pelvic tilt, which makes the move more difficult. With many it is completely impossible because the mass of the adductors, the medially collapsed hamstrings behind, and the narrow tuberosities prevent the pubes from going down and back between the thighs which is the essence of this move.

The client is first asked to rotate the knees internally so they face each other a bit. There should be no strain, and just a little bit on the internal side of neutral usually suffices. The knees can be apart some. Care must be taken that the back is completely relaxed, and also the tonus of the rotators and gluteals should be reduced consciously. In effect, the hips in back where they lie on the table should be felt to go wide. This movement should be intrinsic and not engage the abdominal wall in any way. One should be able to observe a minimal passive downward movement of the pubes, in the direction of the anterior tilt. If they move up instead, the reason can be functional or structural. With the first, the clients must be instructed to release all extrinsic musculature. Guiding by the pubes or the anterior superior iliac spines – pressing them together medially slightly and holding them distal – can help them to get the feel of it. If this is not successful the obstruction is probably structural and the move is impossible.

I now go in on both sides of the rectus, lateral to its edges and a little above the pubes, gathering the superficial fascia with my fingertips from lateral to medial. This eliminates tension behind and beside the rectus and allows to go under and behind its edges. I now turn my hands so that all the fingertips (except for the thumbs) go in the direction of facing forward, lifting the rectus from behind. Often they only look medial, but anything will do which serves the intention of lifting the rectus off from the tissue behind and making it go over the fingers. Sometimes the fingers almost meet, sensing the linea alba, at other times one has to be satisfied with just being able to lift the edges.

Now the client is asked to let his knees rise straight up, keeping them internal. The feet are felt to remain on the table with their weight. The movement should not be done extrinsically by contracting the belly and the rectus femoris. In this case the pubes would move cranially. With the movement intrinsic it is exclusively the iliaci which work. When they begin to tense, at first the weight of the legs prevents the knees from rising up. Instead, the ilia are drawn forward down, taking the pubes along: the pelvis very distinctly rolls into a marked anterior tilt. The pubes go down considerably and back between the legs. If the back is kept relaxed completely, no harm is done even with strongly anterior lumbars. The iliac crests in back don't move up but actually detach a little more distally. So because the back doesn't shorten and the front lengthens the midline also lengthens.

With my hands I follow the movement of the pubes and augment it at the same time. The fingertips slide

some, lifting the rectus and separating it from the underlying fascia. Usually I arrive with them at the angle where the rectus attaches to the pubic bone. They lift the rectus there and at the same time take the pubic bone more distal and back, continuing its movement a little beyond the point it has reached by itself. The thumbs on the superior edge of the pubes may help from in front.

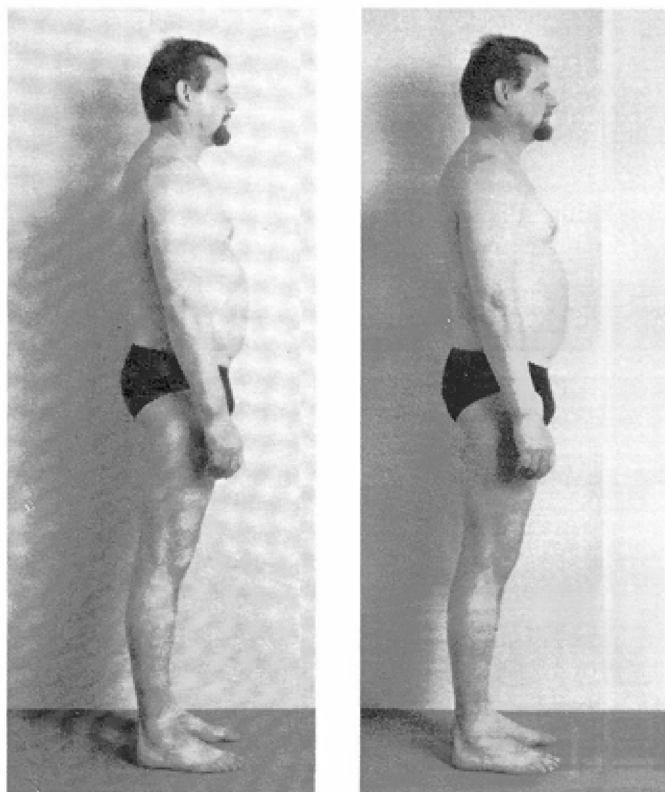
Now the client is asked to let the knees sink back again, still keeping them internal. The pubes now want to go forward and up but are kept where they are by my fingers. This is when the rectus lengthens, assisted by my fingers. At the end, I ask the client to relax the legs which then roll out. Still keeping the pubes down and back for a moment adds some more space to the area.

The initial internal rotation of the legs is essential. It sends an impulse into the pelvis to tilt anteriorly to be congruent, probably transmitted along the fascia of the sartorius and gracilis. Furthermore, it prestretches the iliaci which find optimal conditions for "working" and at the same time refrains them from wasting their effect on external rotation and adduction.

At the beginning, when the fingertips have found their hold on the backside of the rectus, it is useful to shift attention momentarily. When the pubes descend and my hands pick up the movement to lead it farther, I focus on the anterior side of the lumbars, imagining that by pulling down the rectus and pubes I first take care that the lumbar vertebrae open and come apart in front. This assures that any resistance from the musculature of the back is sensed immediately and can be remedied.

Hans Flury

Ill.1 Before and after backwork.



Ill.2 Before and after lower rectus method.