Fascia Insights

How Dr. Tina Wang Applies Fascial Science to Educate and Empower

By Lu Mueller-Kaul, Certified Advanced Rolfer® and Tina J. Wang, MD

Lu Mueller-Kaul

ABSTRACT *Physical medicine and rehabilitation specialist Dr. Tina Wang discusses her appreciation for the profession of structural integration for putting fascia research on the map in this article with Rolfer® Lu Muller-Kaul. As a medical doctor also practicing manual therapy, Wang has had a first-person view of fascia research and manipulation going from obscurity to more mainstream medical domains. She offers her insights as an expert dealing with Ehlers-Danlos syndrome and hypermobility spectrum disorders.*

Tina J. Wang

Lu Mueller-Kaul: Hi Dr. Wang; thank you for meeting with me and allowing us to feature you and your fascia expertise in our Dr. Ida Rolf Institute® (DIRI) journal. Professionally, you are a medical doctor, and you are specialized in physical medicine and rehabilitation. You are an Assistant Professor for the University of California at Riverside and Loma Linda School of Medicine, where you teach resident physicians in training. People should also know that you have many publications, and have presented at conferences and seminars. Perhaps some of our readers have heard you speak.

I'm personally curious: How did you first hear about structural integration? And what did you hear about structural integration?

Tina Wang: Let me start by expressing my appreciation for your interest in my work. Structural integrators are the root of the study of fascia. Your school [DIRI] is where it all started. The Fascia Research Society came from the Ida P. Rolf Research Foundation (IPRRF); the then Rolf Institute® [now DIRI] provided the initial financing and people to organize the IPRRF, and IPRRF then hosted the first

International Fascia Research Congress in 2007 (Fascia Research Society 2023, Chaitow 2008). In those early days, fascia research had intimate ties with the profession of structural integration. And anyone who knows the story about fascia research, knows Robert Schleip, PhD who is a Rolfer, and among the visionary researchers who put this work on the map.

Ten to fifteen years ago, before fascial science started to burgeon, if you wanted to learn about fascia, you had to learn about Rolfing® Structural Integration. Structural integration is the root of the beginning of fascia research. With regard to structural integration, it is a Western practice of the treatment of fascia out of which arose fascia research. We can also go back and look at the Eastern approaches and understanding of the body; acupuncture and Chinese manual therapy also engage the body through fascia.

LMK: As a medical doctor, what's your relationship with manual therapy in general?

TW: I'm a physical medicine and rehabilitation specialist. Our board certification in the United States allows us the privilege to practice manual therapy in our scope of practice.

I started doing manual therapy quite early in my career, I trained with osteopaths. In the United States, osteopaths are trained to be physicians, in other words, medical doctors. They're called doctors of osteopathy, and they have the same practicing rights and training. So nowadays, my residents are a mixture. When I trained with osteopaths, they would do the coolest things. With their skill, they could get a post-surgical neck to move and put us all in awe.

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LMK: I know what you're talking about. With osteopathic techniques, it can look more like magic because it looks like they're barely doing anything. Especially compared to chiropractic techniques.

TW: They are influencing the system in this amazing way. When I started to learn manual therapy with my osteopathic colleagues, they had gone through so much ostracism in their early years. As I was training, they were just starting to come out of a dark and discriminatory period. Even though osteopathic techniques were on our board examination, in those days, teaching that work occurred after hours when no one was looking. Now, it's open. With one of my osteopathic colleagues, we have labs every couple of weeks. Other times, we take classes ourselves and work together to update and practice our techniques. I find I'm both learning along with the residents, as well as teaching them manual techniques. We're teaching both our osteopathic and our medical doctor physicians in training how to apply manual therapy.

LMK: I'm so happy to hear that. That's beautiful.

TW: Now, the conversation has shifted; we're expected to be able to prescribe and talk about dosing-type indications. And that's challenging because that conversation is just burgeoning.

Dr. Tina Wang working in her physical medicine and rehabilitation practice.

LMK: Yes, how are you going to define a dosage?

TW: Right. And when you do, will the therapist listen to you and respect what you ask of them?

LMK: That's already a problem. Take physical therapy for example, even when the prescription is followed and fully respected, between practitioners there is likely a difference in delivery. An exercise could be demonstrated to a patient, then they say, "Okay, now you do it. Looks good, now do three sets of ten, then I'll be back." Is the time that follows going to be uniform for each person even though they all have the same instructions?

Exercises can be truly taught with attention to body schema, biopsychosocial influences on posture, and movement patterns. Ideally, the session inspires hope and curiosity.

TW: And there's a problem with perspective from the patient or client as well because oftentimes they'll say, "Why do I need to see a professional for that? When I can just watch that on YouTube and do it myself." No, you cannot. That is not how it works. The professional guides you on dosing, timing, and correct application. The interventions often look simple and are simple, but it's the correct application and the art of medicine that are complex.

LMK: Learning by only seeing is limited, this is an element I think could be done better in all education. When I was learning the work at DIRI as a student, it was a huge challenge for me. In our first lesson on 'body reading', where we looked at patterns in sitting, standing, and movements, I had no idea what to look for, and I couldn't see relevant differences for treatment.

Different learning styles are taken into account now when they teach Rolfing classes, but I believe there is an inherent bias towards visual learning because of how our first group of faculty members had been taught themselves by Ida Rolf [PhD, (1896-1979)]. Rolf trained people with just weeks of observation, so visual learners were more likely to succeed and consider the pedagogical methods they experienced as useful.

TW: Yes, it takes time. My osteopathic teachers would express that *sometimes you are meant to see what you're meant to see and not what you're not meant to see. And each of us senses in a different way.*

LMK: I like that idea.

TW: I have this happen with my patients as well, as they come through my practice, they might be early in their journey [of addressing their health]. They're still disbelieving, skeptical, searching. At this kind of juncture, it might be a one-time visit, and you can plant seeds. With one appointment, you don't see enough of the person; you don't see enough of the cultural context and body state to be able to really know in a concrete sense how manual therapy will go for them.

The Western approach to medicine is to make a diagnosis, make a prognosis, and send them on their way. Maybe there's a follow-up appointment. And the truth of what you and I are talking about is that we don't know until we have had a few visits and can see how treatment takes effect for them. Over time, you get to know the cultural context of this person's everyday life. Then you can really get a sense of their system, where they may plateau, or where we're going to see growth. With the constraints of the Western approach to medicine, we're tied to these constraints and rarely facilitate that journey. Sometimes we have a great person to refer to and maybe we hear about progress during a follow-up.

LMK: Yes. A first visit is all about establishing rapport so the work can begin.

Upcoming Book

LMK: Tell us about your book, I'm excited to hear what you're writing.

TW: This one has been in the making for years, and I seem to never finish because I have this false sense of – once it's published, then I can't update it. So finally, after many people asking, I decided to self-publish. And then at any point I can just update chapters or passages because that's how fast fascia research and our knowledge is moving. And I don't want to be tied to a book that's outdated in six months or a year.

LMK: I was wondering what concerns you have, this makes a lot of sense.

TW: And I own the rights. This way I could send a chapter to this structural integration journal where people read our words and share my ideas. My intent is to educate and empower. If a publisher owns my book, not only am I very limited in what I can share for free, but they can also challenge my ability to update the content down the road. I have very strong beliefs, I'm very opinionated, and I reserve

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LMK: That is one of the most important things about being an educated practitioner with at least some understanding of science. And I love that you have the underrated quality of being so firm about things you don't know.

TW: Yes, I am absolutely certain that we have no idea about some things.

LMK: I'm looking forward to this book. When is it coming out?

TW: Hopefully, by this fall. People can go to my website https://tupelopointe.com and sign up for the newsletter to be in the know. I'll be posting it there, as well as on Tupelo Pointe's social media.

LMK: I first came across your name when I was looking up information on Ehlers-Danlos syndrome.[1] I had more clients coming in who had this diagnosis. I found the podcast you did with Til Luchau [founder of Advanced-Trainings].[2] I have sent the link to a lot of clients and other practitioners. I, too, like to empower the client to understand themselves, and to get curious especially about physical sensations far beyond the binary, "It's fine," or "That hurts." It's important to support people to understand what feels good, what feels useful, what feels dangerous, and what their body wants to do with this sensation. Eventually, the client should see themselves and the practitioner working together as a team instead of passively expecting a repair by someone who knows everything they never will.

TW: Right, that kind of work is not for everyone. Each person is along the journey of their life, trying to discover who they are. Sometimes we get somebody who really wants to dissociate for an hour and maybe they need that in their life. And that's what you're speaking to – listening and asking ourselves, "What does this person need?" And every person is different. Every person is at a different point in their life. What they need is unique to that moment and at that place in that one person.

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This work requires a relationship. And it's not an algorithm. It's not, "Every time you come in here, we're going to help you dissociate." It's, "Today, this might be what you need. Tomorrow, you need something else."

As Westerners, we hate that. We want the algorithm; we want the diagnosis, the prognosis. I cannot tell you the number of times I've heard, "You just tell me all the steps I need to do. Tell me what to do. Where to do it. So I can be pain-free." To that, I ask, "You want to be pain-free so you can do what?"

Well, some people want to do all the things that they were already doing, but pain-free. Then I have a conversation about why they are here. And if it's for a state change, then we talk about the limitations of focusing on only that. It's really about listening and sensing what it is this person needs, and a lot of times it doesn't come from words.

LMK: Right, because it almost takes becoming a different person before those words can be discovered. There is a gap between the person wanting the pain to be gone, and the embodiment that is needed, even when everything is okay. There's no going back to an imaginary state of 'before'.

TW: It is so challenging. As I get deeper into my Eastern studies, this seems to be less and less challenging.

I hear this kind of sentiment echoed by people who are deeply spiritual. I don't want to say religious because we know all the trauma surrounding religiosity, but it includes people who are spiritual, no matter their belief system. What I see across all people of all backgrounds who are deeply spiritual, when they arrive, it's not about the system and how noisy it is. They are connected to this one moment with you, the practitioner, who is going to plant that seed for them. The rest is in their hands.

With some patients, there is much noise. They are engrossed with how long it took to get the appointment, they are mad at the receptionist, they yell at the scheduler and then the nurse, and when we are together, they perseverate on their anger, about the healthcare system's issues. And then I prescribe medications, but they can't afford it. And then I prescribe physical therapy, but they don't want to do it. That's all noise. We have to get past all that noise and really be present with the person to be able to sense what the real health issue is.

When the person is in front of you, you connect with that person, in that moment, and you do what you need to as a professional, as a practitioner. And then the rest is not in your hands. It's just

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that moment that you have the agency. What is your calling? Listen. Listen to the environment; listen to the person.

LMK: I opened a practice when the economy crashed in 2008. I had to somehow get people to receive massage therapy at a time when nobody was spending money, I had commitments to my practitioner employees to keep their schedules busy. Clients only wanted pain relief, nothing that seemed like a luxury. I was often doing twenty-minute sessions so that I could schedule clients every thirty minutes and offer a treatment package that people found affordable to buy. This format led me to speak and move more slowly than normal because it got me to be more intentional in that short amount of time.

What you just said about listening reminded me of these short sessions. The lesson was – you can use five minutes and make every second meaningful. You can get real results instead of being attached to the idea of not having enough time for a good treatment. If you're running out of time, slow down.

TW: Oh, I love that. You can slow down. Another phrase that I like to use is when the residents reflect on their work, and they'll say, "It's a systems issue." And I say, "Well, transcend the system."

LMK: Nice. We work with what we have right now, and time is always a limited resource. If what we truly want is to help people, then we help the person who's in front of us.

Ehlers-Danlos Syndrome

LMK: Could you share a few guidelines for practitioners of manual therapy regarding your experience with Ehler-Danlos syndrome? Are hypermobility conditions potential contraindications for some types of myofascial mobilization techniques?

TW: Yes, sure. If you want to follow rules and algorithms, you'll likely run into problems. These are complex patients. With complex patients, your algorithm is not going to work. You need to be present; you need to assess and listen. There are no shortcuts.

I do have a strong selection bias in my own clinic; I'm aware of that. I tend to see patients with many co-occurring conditions. I know the patients I see are a skewed population toward highly complex presentations.

LMK: That makes sense. Do you have a theory of why there is neurodivergence together with what we used to assume was a problem with how collagen was organized? I've heard that there may be a neurological element to this change in the connective tissues.

TW: Yes, absolutely I have some ideas that I can't prove yet. I believe that being neurodivergent is often the primary factor.

LMK: You think that comes first?

TW: There is a genetic predisposition – a potential, a possibility – of developing this disordered connective tissue trait based on genetics. With hypermobile Ehlers-Danlos syndrome (as opposed to the other subtypes), there is no specific gene variation causing a disease. The collagen molecule is not coded differently in the DNA; it's much more complicated than that. Epigenetics likely plays a strong role. Neurodivergency makes life difficult and confusing, particularly during childhood, so the whole physiologic development is significantly altered. In my opinion, neurodivergence may be a strong factor in the expression of the genetic predisposition that would otherwise have a milder clinical expression.

LMK: I know we are telling the story a little out of order, but let's back up, and please tell us more about the specific qualities of Ehlers-Danlos syndrome.

TW: Ehlers-Danlos and hypermobile spectrum disorders are a heterogeneous group of heritable connective tissue disorders. It's inherited and is characterized by skin changes. There are systemic issues that arise from this connective tissue change in stiffness and quality, including hernias, organ prolapses, fat herniations, and joint hypermobility. These are the common features that we'll see. There are thirteen different subtypes that have known genetic origins except the hypermobile subtype, which is also the most common. This diagnosis is based on the 2017 diagnostic criteria published by the Ehlers-Danlos Society (2023a).[3]

LMK: There are thirteen subtypes, and hypermobility is one of those.

TW: That is correct. It's the one where we can't run a genetic test and say, "Oh, you have the hypermobile type." And so, it's a clinical diagnosis.

LMK: And there are other hypermobility conditions that have nothing to do with Ehlers-Danlos?

TW: There are hypermobile spectrum disorders that we feel are on a continuum rather than a gradient; they're expressed differently. With hypermobile Ehlers-Danlos syndrome, there is a high number of hypermobile joints based on the Beighton criteria (Ehlers-Danlos Society 2023b). Also, there are systemic signs of connective tissue fragility and the consequences, or sequelae of that. And if someone doesn't have

sufficient numbers of these features, then they don't meet the clinical criteria for a diagnosis of hypermobile Ehlers-Danlos syndrome. But they may have hypermobile spectrum disorder.

It is so complicated. Hypermobile spectrum disorders can co-occur with autoimmune conditions that affect the extracellular matrix, and the enthesis sites, and we have to assess all of those.

LMK: I read that Ehlers-Danlos Syndrome is heterogeneous. Am I correct to say that means there is not one gene where you can say, "Okay, it's on that." There's a bunch of different genetic information that has variances that contribute to the predisposition.

TW: Yes.

LMK: Okay. And a predisposition is a difference between a person having a higher likelihood to develop the condition versus a genetic condition that has predetermined certainty that the person will develop the issues?

TW: That is correct. And to make that even more complicated, a lot of the conditions that we think of, "Oh, there's a gene for that and you're going to get it." Well, clinically, we see that it is heterogeneous too. There are certain genetic syndromes where you learn there is 100% pathogenicity with intellectual delay and physical deformities. But clinically we'll see that some of these children have very minor issues. And when we refer to the geneticist for more testing, that's when we catch these pathogenic genetic variations. It's really fascinating.

LMK: What are some phenotypes, physical characteristics, of these conditions that people who do hands-on therapies can look for? Is there something they might notice about people who may be on the hypermobile spectrum?

TW: One of the important things to look for as a structural integrator and manual therapist is the tissue quality. I did an ultrasound study with Dr. Antonio Stecco, and we found that there was a thickening of the deep fascia in people with myofascial pain (Wang et al. 2023, Wang and Stecco 2021, Wang et al. 2020). In non-Ehlers Danlos syndrome subjects with myofascial pain, their tissue stiffness differential was higher, and in Ehlers-Danlos syndrome subjects, their tissue stiffness differential was decreased; it was uniform. So when we go to palpate or feel the tissue, there's this uniform softness. People will describe it as boggy, soft, and doughy. That's one of the clinical criteria that we have in criterion two, feature A, is soft, doughy skin (Ehlers-Danlos Society 2023c).

LMK: Okay. I've noticed that. I have also noticed that underneath that texture of tissue, there can be a hypertoned muscle layer underneath. When you say deep fascia, do you mean the layer superficial to the first muscle layer, like the antebrachial fascia of the forearm, or the fascia lata of the lateral leg? That used to be called the superficial fascia, but now that term is used for the subcutaneous adipose layer. Correct?

TW: Yes, the nomenclature has changed to what you describe. People often think deep fascia means it is deep in the body. It gets misconstrued; it can be pretty superficial.

LMK: Boggy, soft, or doughy tissue is something that I also experience with people who have a diagnosis of fibromyalgia, but it's often not the whole body. Is there an overlap between people who have fibromyalgia and Ehlers Danlos?

TW: Having Ehlers-Danlos syndrome doesn't exclude a person from having fibromyalgia. They're both syndromes, there can be co-occurrence.

LMK: My mother used to say you can have lice and fleas.

TW: That is really true. As I think about it, the myofascial literature about fibromyalgia seems to address the superficial fascia. And Ehlers-Danlos definitely affects the superficial fascia as well. We didn't look at that specifically in the study, but I am doing a study right now where we are looking at the superficial fascia, the adipose layer, and looking for changes in certain conditions like lipedema and angiolipomas.

You know, when I look at the protocols and the literature on structural integration with my Western scientific lens, it always fascinates me how much these older systems, these founders, these great thinkers like Ida Rolf, through their experience, noticed where they had to work first. It aligns with where the science is heading. Starting with the diaphragm working centrally, for example, which is vagal, which is sympathetic, which is breathing, and which is neurodiversity.

LMK: Yes, that's fascinating. I heard that at first, Dr. Rolf started the series of treatments with a session for the feet, which today happens in the second session. Of course, we still think a foundation and awareness of grounding is important before we work on the alignment and movement possibilities of the rest of the body. But it quickly became clear to Rolf that we can't start that foundational work before addressing breath and the relationship between practitioner and

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TW: I'm a serious student of meditation. I study in the lineage of Krishnamacharya. It's an Eastern healing approach. Part of studying spirituality in this framework is understanding, not finding, but rather understanding one's dharma, one's role in life.

client. Rolfers are anchored in thinking about the basic function of breathing.

TW: Exactly, with manual therapy, people feel light, and they won't know what their practitioner just did, but they feel hope, trust, and a belief that they are going to get better.

LMK: Beautifully said. To recap, what I hear you saying is you're excited about fascia and it has become part of your specialty. You're a specialist on this hypermobility spectrum and particularly Ehlers-Danlos syndrome. But in looking at how best to help those people, you treat the whole person.

Study with Everyone

TW: Absolutely and I'm always learning. I go everywhere to study. I study with everyone. I'll end up in a massage therapy class somewhere, I'll end up in an osteopathic class, at a physiotherapy class, a psychology class, all over the place. And it's because I'm trying to piece together a path to seeing the bigger picture.

LMK: I'm sure your patients appreciate that a lot.

TW: With my patients, we engage in all these things that we discussed. But at the end of the day, when I listen carefully, I hear my patients say, "I trust you. Treatments X, Y, and Z may be the gold standard suggested by experts for the condition, but I trust you. Will you take a look and tell me what you think?"

Oftentimes I will say, "Well, the science says A, B, and C regarding your medical condition. These are the risks and benefits." And then I end with, "But what does your gut tell you?"

LMK: And that's why they trust you; you're not talking over them. You want to lift them up to make their own decisions about what is ultimately their concern. It's their life, it's their body. They need to get the information and you want to help them gain that information, but you're not making the decision for them.

TW: Right. And to really drown out that noise, that fear of the unknown, losing health, and losing life. I want people to be able to access what they know is best for themselves because everyone has intuition. It's just whether or not they want to listen to it.

LMK: I often ask clients, "Does this make sense to you? Does this feel beneficial to you? What is your body telling you? Or what is your innate response? Do you feel like you want to get away from this touch or move towards it?" And they might be confused about these questions in the beginning, but they do find out that there is a clear sensation if they listen for it.

TW: With hypermobility spectrum disorders and the Ehlers-Danlos syndrome population, don't let them talk you into applying pressure that you do not feel is appropriate. If you are listening to the tissue and the tissue says, "No, no, no," but the client is saying, "Oh, I want you to go hard." In these cases, trust your hands and yourself. You may lose the client, but it's even worse to cause a severe reaction.

LMK: Right. Do you feel that within these populations there's a tendency towards no pain, no gain?

TW: It's a really type A population. They want to get things done quickly. And they have specific ideas of how it's going to get done – all or nothing. But it's also about getting to know the client if I want to affect their tissue to make a change. I think about, what is the relationship, do I know this body, do I know this person, do I know the capacity that this person and this tissue can handle? In the first session, I do not.

LMK: I'm always curious about what motivates people who are doing extraordinary things. Why do you do so much?

TW: I'm a serious student of meditation. I study in the lineage of Krishnamacharya. It's an Eastern healing approach. Part of studying spirituality in this framework is understanding, not finding, but rather understanding one's dharma, one's role in life.

I laugh at how I ended up where I am. If I were in control of this life, I would be an astrophysicist doing computational work in a room by myself, not talking to anyone. But I am in one of the most hands-on interpersonal professions.

Another way to look at it would be as a series of fantastical lifetime occurrences. If I hadn't met my mentor in the park with his sick dog, if I weren't a dancer, or if my research mentor hadn't responded to me when I was a medical student - if none of these things had occurred . . .

My first "D" in my life was on my first histology test in medical school. I went in to talk to the professor, and I said, "Oh, I'm so sorry. I'm going to study even harder." And he looked at me and said, "Stop studying, stop studying." I said, "No, I have this plan. I'm going to work even harder." He said, "Absolutely not." Instead, he asked me, "What do you love doing?" "I'm a dancer. I love dancing." And he said, "Well, I want

you to stop studying and go dance." I resumed dancing and did fine on every test since then.

It's this series of events that led me to where I am. When I look back, I see I have a hard time interacting with people. Absolutely. I am neurodivergent. I have an exceedingly hard time. And it means that when I go into the room with a patient, I have to be really present. A positive aspect is that I see through all the social constructs that people put up as a defensive barrier and I can see the insecurity.

This is my dharma; all these things conspired for me to really understand that. I may be interacting with neurotypicals, and it may make me very uncomfortable teaching and doing interviews. But I truly understand that this is my life's calling – this is my dharma. I am showing up and doing the best work I can deliver with integrity and intention. And it's gifted me with many blessings like getting to meet amazing people and to have opportunities like this to connect with someone so like-minded and passionate about the work you do.

LMK: Thank you so much. It always makes me feel less insane when I meet like-minded people.

TW: There's a couple of us out there.

Endnotes

1. Ehlers-Danlos syndrome is a genetic condition that weakens the body's connective tissue, it has a variety of symptoms including joint hypermobility, and there are several forms of the disorder (Mayo Clinic 2023).

2. Dr. Tina Wang was the featured guest on *The Thinking Practitioner Podcast* with Til Luchau and Whitney Lowe on November 16, 2022, episode 79, "Hypermobile Ehlers-Danlos, Fascia, and Pain (with Tina Wang)." The audio and video are available from https://advanced-trainings.com/thinking-practitioner-podcast-ep-79-hypermobile-ehlers-danlos-fascia-and-pain/.

3. The Ehlers-Danlos Society website says that people with this syndrome "face a diagnostic odyssey: years, sometimes lifetimes, fighting for recognition, diagnosis, and care. The Ehlers-Danlos Society is working towards a time when geography and wealth no longer determine your quality of life" (2023d). The clinical diagnosis of hypermobile Ehlers-Danlos syndrome is assessed through three specific criteria checklists (Ehlers-Danlos Society 2023c).

Tina J. Wang, MD is a board-certified physical medicine and rehabilitation physician specializing in fascia. Dr. Wang practices a unique blend of osteopathic medicine, integrative medicine, and regenerative medicine at her private practice, Tupelo Pointe (https://tupelopointe.com), in Upland, California. Her focus is not just treating musculoskeletal ailments, but also facilitating health by meeting her patients' functional, nutritional, and unique needs. Also, Dr. Wang is an Assistant Professor at the University of California at Riverside and Loma Linda School of Medicine, where she teaches resident physicians in training, physician, assistants, and medical students. She is among the core faculty teaching the musculoskeletal curriculum. Dr. Wang frequently guest lectures at local universities, schools, and programs.

Lu Mueller-Kaul is a Certified Advanced Rolfer and coauthor of The Rolfing® Skillful Touch Handbook *(2022) with Bethany Ward and Neal Anderson. Mueller-Kaul began her journey as a licensed naturopathic physician in Germany in the 1990s. Along the way, she practiced acupuncture, chiropractic adjustments, and traditional Chinese medicine before coming to the United States to study Rolfing SI. She would love to read your thoughts and feedback, and she's happy to offer a free phone call, schedule via the contact link on www.QforLu.com or email Lu@QforLu.com.*

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Keywords

fascia; physical medicine; rehabilitation; structural integration; fascia research; manual therapy; osteopathy; body reading; Ida Rolf; Western medicine; Eastern medicine; self publishing; Ehlers-Danlos syndrome. ■