

The sheer number of different techniques and potential structures that can be treated using the Barral method can appear very daunting to the beginner student. Knowing what to treat and in what sequence is key to being clinically effective. Understanding this has been a gradual process that has dawned slowly on me at first. However, after completing NM2 recently with Rosie, a number of clinical principles fell into place. In particular, the importance of constantly assessing and reevaluating during the treatment process, and understanding the body as a series of interconnected and integrated systems that cannot be treated effectively in isolation. The following case study illustrates some of my new found understanding of these principles.

One of the first clients I treated after completing NM2 was a woman in her mid sixties with chronic neck pain and jaw tension whom I would not have been able to treat as effectively even just a month ago.

Symptoms:

Chronic neck/jaw pain. The patient sees a chiropractor once a week who cracks her neck, but within a day, the tension is back. She has been managing her neck like this for over a year. She also gets bad jaw pain/tension. Her dentist has made a splint for her to wear at night which hasn't helped much and is now advising her to get botox injections in her jaw. She was frustrated, didn't want to get the botox, and was prepared to try anything to get some lasting relief.

Initial Assessment:

General Listening felt initially short and left, but then had a deeper and longer spiral to the right. Local listening took me to the liver, bladder, left subclavius and infrahyoids. Liver was primary. Right shoulder had both 30 degrees less internal and external rotation than the left. Right first rib was fixed. Eye movement was significantly more challenged to the left and the client reported that she often felt difficulty and a strain looking to the left. Listening at the vertex took me left. Listening at Rectus Capitis Posterior Minor, the left side was primary and pulled down. A simple mobility test confirmed this. Left lateral cervical flexion was twenty degrees, right lateral flexion was only ten degrees.

Treatment:

I began with a liver lift and then stacking into three planes. Next, I treated the right torsion in the bladder. At this point, my client informed me that she had been having issues with her right hip after an appendectomy several years ago. Before moving on to other techniques I wanted to see what changes just these two techniques had brought about and how significant they were in the overall picture. Right shoulder internal and external rotation had improved by 30 degrees and were now better than on the left which I had also assessed to get a baseline normal. Right first rib had also normalised, so no need to look at this further. Left and right cervical lateral flexion had also improved by ten degrees.

Before working the nervous system on the left from the initial assessment, I wanted to free the area. Left hyoid and subclavius release were next. Returning to listen at RCPM on the left, I still got pulled down. Inhibiting the brachial plexus took the listening away. Local listening at the brachial plexus took me up. Palpating movement of the cervical vertebrae revealed C2 and C3 to be very fixed. I found nerve buds at both vertebrae. Local listening at each, C2 took me down and C3 took me up. Inhibiting at the occipital line took away the C3 nerve bud listening. This connection then became a treatment. Next I treated the C2 nerve bud with the brachial plexus. My client reported that it felt like the tension in her neck just melted after that. A return to RCPM revealed that the listening on the left had completely gone. I also retested cervical lateral flexion and we had an additional ten degrees on both sides.

My hunch was that there was still more to this puzzle because of the eye strain and bladder fixation, so next I returned to RCPM and performed the bent knee abduction and extension for the lumbar and sacral plexus. Left knee dropped out fine, but the right knee could hardly move, and instantly there was a big pull on the right RCPM. This appeared to be a functional listening as there was no sense of this on the right with the client relaxed and lying in the anatomical position. Local listening at the right lumbar and sacral plexus both pulled up. I also performed a functional listening at the vertex that Roslyn (my mentor in Melbourne) had shown me that wasn't included in the brain class I recently did with Jean-Pierre where you get the client to put a couple of dental rolls between their teeth and bite down while you listen at the vertex. The listening took me to the left. Checking the mobility of the eyes revealed that the left had more firmness and didn't want to be mobilised left.

My final round of treatment was to treat left pterygoids and temporalis, the left eye/optic nerve with some techniques from the brain course, and to release the right sacral and lumbar plexus. Finally, I performed a balance listening at the nerves of C1 to integrate the changes. I rechecked neck movement and each side had an additional ten degrees on top of the earlier gains and eye movement had improved. All up, cervical lateral flexion on the right had gone from ten degrees at the beginning to forty degrees at the conclusion of treatment.

Conclusion:

It's no wonder manual adjustments to C2/3 hadn't lasted; there was a nervous tension from C3 pulling up and a tension from C2 pulling down, coupled with tension on the right first rib from the liver and a right torsion in the bladder. The reason that I wanted to share this case study with the group is that a number of things clicked with me as a direct result of Rosie's approach to teaching NM2. The anecdote of Jean-Pierre treating Rosie's son was a nugget of gold. In it Rosie emphasised how Jean-Pierre kept retesting and assessing to see exactly what changes he had made, never just assuming. This story, along with the extra functional listening checks not in the manual that Rosie gave us for the sacral and lumbar plexi, helped me begin to appreciate the importance of constantly evaluating, to be precise with my clinical reasoning, and to understand the relationship between general listening, local listening, extended listening, and functional listening. Overlayed on top of all this is a better understanding of the relationship between the nervous system and the viscera; when to treat which one and in what sequence.

Additionally, the lightness required to treat the nerves has also helped soften my technique for treating other areas. My client commented how light, relaxing, and comfortable it was to have her pterygoids treated. Normally when her chiropractor gets in there it's agony. In the past, I realise now that I have still been trying to push through the tension, and consequently not getting much of a change. For the first time I have felt my finger tip being drawn and almost sucked into the pterygoids while treating them. It was an amazing and completely different feeling to what I have been doing for the last six months. I have Rene, in part, to thank for this from the NM2 class. Each time that I have worked with Rene it has been when she has just completed two courses back to back, and her system has been very overworked and sensitive. Because her system has been so sensitive on these occasions, it forced me to eat some humble pie and really lighten up my touch. I can't help but think of Jean-Pierre's words here, "If you think you are being light, you are not light enough." Truly humbling words to try and live up to.

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