

# The Burnham Review

## Muscle Energy Technique and Health

Consider Manual Therapy and Complementary and Alternative Medicine for Optimal Health

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**Kimberly Burnham, PhD Editor**

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### Muscle Energy Approaches

Postural asymmetries and pelvic pain are multiple system dysfunctions contributing to 50 million dollars in back pain in the United States. An osteopathic approach using "Muscle Energy Technique" and an Integrative Manual Therapy approach using "Muscle Energy and Beyond" can effectively address biomechanical imbalances, chronic joint pain and improve quality of life.

An integrated approach is needed to create positive, long lasting changes. Human beings are meant to move in all three planes of motion, sagittal, coronal and transverse planes with every movement. Limitations contribute to postural asymmetries, chronic pain, impingements on nerves and blood vessels, edema and other symptoms.

This issue of The Burnham Review looks at Muscle Energy and biomechanical approaches and what the research says.

### Muscle Energy Technique

Muscle Energy Technique (MET) is a direct, noninvasive manual therapy used to normalize joint

dysfunction and increase range of motion. It utilizes the patient's own gentle muscle contractions and body positioning to normalize joint motion.

The practitioner evaluates the primary areas of dysfunction in order to place the affected joints in precise positions that

enable the client to perform gentle isometric contractions.<sup>1</sup> (MassageTherapy 2007).

Another definition is "a technique that when applied directly, is based on the principle of reciprocal inhibition and when applied indirectly is based on post-contraction relaxation. The goal is the relax a muscle in spasm."<sup>2</sup>(CAT,2007).

### Muscle Energy's Effect on Edema

A non-invasive technique, MET can be used to lengthen a shortened contracted or spastic muscle; to strengthen a physiologically weakened muscle or group of muscles; to reduce localized edema to relieve passive congestion and to mobilize an articulation with restricted mobility.

MET is a direct hands-on therapy originally developed by Dr. Fred Mitchell, Sr., Osteopathic Physician, and

continued by Dr. Fred Mitchell, Jr. It utilizes the patient's own gentle muscle contractions and body positioning to normalize joint motion. When a joint doesn't have full structural potential, its function will never reach full potential no matter how many muscles are massaged!

People who have experienced trauma lately or in the past may also benefit. In general, most everyone can benefit from this method.<sup>3</sup> (DeWine,2007).

### Osteopathic Medicine MET

MET is based on the principle of reciprocal inhibition, a theory that explains that muscles on one side of a joint will always relax to accommodate the contraction of muscles on the other side of that joint when indirect pressure is applied.

Applied to a patient in order to lengthen shortened or spastic muscles, to improve weakened ligament and muscle strength, and to improve range of motion, Muscle Energy is performed when a patient

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is asked to contract a muscle for approximately 5-seconds against a resistance applied by the therapist. The muscle contraction is performed by the client 2 or 3 times in a row in the hopes to stretch the muscle further each time.

The theory behind MET suggests that if a joint is not used to its full range of motion, its function will lessen and it will be at risk of suffering strains and injuries. This form of muscular therapy makes use of a patient's own muscle energy (the force); while the therapist presents a stationary surface (resistance or anti-force) the patient will contract their muscle against in order to stretch the muscle and joint to its full potential.

Many athletes use MET as a preventative measure to guard against future muscle and joint injury. However, its mainly used by individuals who have a limited range of motion due to back, neck and shoulder pain, scoliosis, sciatica, unsymmetrical legs, hips or arms (for example when one is longer or higher than the other), or to treat chronic muscle pain, stiffness or injury.<sup>4</sup> (Amin,2006).

### **Evaluating Cervical Range**

“MET is an established osteopathic manipulative intervention often used to treat somatic dysfunctions of the spine,” said researchers in a study to “compared active cervical range of motion among asymptomatic young and middle-aged adults (n=18).

Range of motion was measured in three planes (flexion/extension, lateral bending, rotation) on all subjects (N=32) using a motion-analysis system. Multiplanar gross cervical motion restrictions were diagnosed.

In the treatment group, cervical long restrictor muscles were treated

with the muscle energy technique in the sagittal, frontal, and coronal/horizontal planes.

The control group had relative restrictions addressed by means of a sham manipulative treatment protocol in which the barriers to motion were not challenged therapeutically.

The MET produced a significant increase in overall regional cervical range of motion in the treatment group (approximately 4 degrees) when compared with control subjects. Significant differences were also observed in the magnitude of change in the three planes of movement (rotation; lateral bending), with flexion/extension being the least affected. These data demonstrate that the application of the muscle energy technique can produce acute increases in the active cervical range of motion in asymptomatic subjects.”<sup>5</sup> (Burns,2006).

### **Chiropractors Use Muscle Energy**

Marc Heller describes the anatomy of the Occipital - Atlantal Joint [base of the skull and first vertebrae of the neck] and goes on to say, "Muscle energy, an osteopathic technique better described as postisometric relaxation applied to joints, has an elegant view of the C0C1 junction.

Muscle energy, by activating and then releasing the small intersegmental muscles, has a unique and powerful effect, both releasing the joint; restriction and retraining/releasing the muscles.

George Such, DC, superbly describes O-A joint restrictions in *Chiropractic Technique*.<sup>6</sup> (Such,1999)

An assessment for this area is to have the supine patient nod his head, isolating the motion to the head, not the neck. If the patient's nose ends up off-center at the end of nodding

flexion or extension, there's probably abnormal motion at the O-A.

To evaluate via palpation, cradle the base of the skull with the palm and heel of both hands. Your fingers are passive, and rest under the upper cervical. Your thenar pads rest on the temporal and parietal area. Avoid thumb pressure into the sensitive temples (greater wing of the sphenoid). Gently rock the occiput on the atlas in an A-P and P-A motion. Evaluate if the occiput resists either forward or backward glide.

Our second evaluation piece is to stack, or add another direction. When you get to the beginning feather edge of the posterior glide barrier, take the head/occiput into lateral to medial glide, first from the left, then from the right.”

The article goes on to describe some specific muscle energy techniques used within the chiropractic profession.<sup>7</sup> (Heller,2001).

Heller references a number of people involved in developing (Fred Mitchell Sr.)<sup>8</sup> or using Muscle Energy.<sup>9</sup>(Rex,1996), <sup>10</sup>(Greenman, 1996) and <sup>11</sup>Chauffour, 1986).

### **Muscle Energy Interfacing with Oriental Medicine (OM)**

In his review of Alon Marcus' *Musculoskeletal Disorders: Healing Methods from Chinese Medicine, Orthopaedic Medicine, and Osteopathy*, Robert Hayden notes the interface between manual therapy practitioners and Oriental medicine.

"The section on integrative manual therapies contains a wide-ranging overview of osteopathic methods of diagnosis and treatment such as functional technique, muscle energy, positional release, cranial technique and several more, and Marcus imparts ideas on integrating the

various techniques into OM practice.<sup>12</sup> (Hayden,2005).

### **Muscle Energy and the Sacrum**

This article discusses the biomechanics of the sacrum and different systems of naming dysfunctions are described including the W.F. Strachan's (high velocity/low amplitude system)<sup>13</sup> and Dr. Fred Mitchell, Sr. (Muscle Energy Technique)<sup>14, 15, 16</sup> models.

The types of dysfunctions described are sacral torsion, posterior sacrum, anterior sacrum, rotating dysfunctions, sacral sheer and sacral sag. Treatments mentioned include forward and backward torsions using muscle energy, unilateral flexion using respiratory cooperation, sacral sag using craniosacral technique, and sacral fulcrum sag strains using lateral sitting ischial tuberosity fulcrum method.

Descriptions of sacral or pelvic tender points (TP) (including low ilial sacro-iliac TP, iliacus (psoas) TP, inguinal ligament TP, piriformis TP, mid-pole sacral TP and high flare-out sacroiliac TP) with treatment using counterstrain techniques are discussed. There was a very brief discussion on sacral base unleveling and of the Common Compensatory Pattern<sup>17</sup>. (Janiak,2001).

In another set of charts, Dr. Simmons defines Muscle Energy terminology for sacral dysfunction and provides a great summary of MET approaches.<sup>18</sup>(Simmons,2002).

### **Use of OMT**

"The goal of this survey is to identify which general categories of osteopathic manipulative treatment (OMT) are believed to be most important for inclusion in the medical school curriculum by practicing osteopathic physicians.

In a survey of 91 randomly

selected members of the American Academy of Osteopathy (AAO) and 25 Osteoscience Department Chairpersons, researchers found, "based on a scale of 1-5 (1= not at all important and 5=extremely important, the mean ratings for the following OMT techniques were: muscle energy (4.4), myofascial (4.2), high velocity/low amplitude (4.1), and osteopathic in the cranial field (3.3). The mean ratings of those techniques for specific body areas were: head/cervical (4.2), sacrum, innominate & pelvis (4.1), whole body (4.1), lumbar (4.10), thorax & ribs (4.1), and extremities."<sup>19</sup> (Song,2000).

### **Muscle Energy as An Emergency Care Modality**

In this research, "osteopathic physicians who identified their practice as emergency medicine were surveyed to determine OMT use, including techniques used, graduate medical education, and factors affecting usage.

Use of OMT was common (55%), with a large minority (28%) of osteopathic physicians reporting daily or weekly usage. Techniques most often used include soft tissue treatment, high velocity/low amplitude treatment, and muscle energy treatment."<sup>20</sup> (Ray,2004).

### **Massage Therapists Use MET for Multiple Sclerosis**

"In the Northwest, where the incidence of MS is high, massage therapist, Fred Baker works with about 17 MS clients each week.

He defines his approach as eclectic: muscle energy techniques, passive-positional muscle release, Hanna somatics. Baker has found one specific approach to be especially helpful for his clients, a C1, C2 technique from Paul St. John's method of neuromuscular

therapy. The technique opens up the foramen, an area between the skull and C1 where arteries flow to the brain. "There's more blood flowing to the brain and more energy flowing down the spine to the spinal column," Baker says. "It gives them more energy and allows them to move easier."<sup>21</sup> (Vanderbilt,2004).

### **Muscle Energy and Headaches**

Another article reviews current literature on the role of manual medicine in the diagnosis and treatment of cervicogenic headache.

"Manual diagnostic procedures and treatment procedures are described for the cervical spine. Emphasis is placed on accurate diagnosis using a biomechanical model and precise localization of forces.

Muscle energy technique is suggested as a safe and effective treatment when somatic dysfunction of the cervical spine is found in association with the diagnostic criteria for cervicogenic headache."<sup>22</sup> (Grimshaw,2001).

### **MET & Nerve Compression Edema**

Luckenbill-Edds et al. recommend Muscle Energy Techniques and other Osteopathic Manual Therapy techniques for nerve compressions. "Experimental and clinical studies of nerve compression syndromes show that ischemia or edema, singly or combined, causes responses in nerves that lead to alterations in impulse conduction and to commonly observed clinical signs.

Because osteopathic manipulative treatment (OMT) is thought to affect microcirculation and anatomic positioning of structures, nerve compression syndromes appear ideal as models for studying how OMT accomplishes results. We recommend that researchers develop experimental protocols or clinical

studies of nerve compression syndromes that will use anatomic, histologic, and physiologic criteria to monitor the effects of OMT. Techniques such as soft tissue, muscle energy, counterstrain, or myofascial release are appropriate for study in nerve compression syndromes. Such studies are necessary to understand the biologic basis of OMT.<sup>23</sup> (Luckenbill-Edds,1995).

### **Bell's Palsy and Muscle Energy**

Bell's palsy is caused by a lesion of the facial nerve and results in unilateral paralysis or paresis of the face. In this report, researchers noted "the case of a 26-year-old woman with Bell's palsy, whom they treated with osteopathic manipulative treatment that was focused on the enhancement of lymphatic circulation. The osteopathic manipulative procedures used involved reducing restrictions around four key diaphragms (thoracic outlet, respiratory diaphragm, suboccipital diaphragm, cerebellar tentorium), as well as applying the thoracic pump, muscle energy, primary respiratory mechanism, and osteopathy in the cranial field. The authors, who were guided by the four principles of osteopathic philosophy, report that the patient's symptoms resolved within 2 weeks, during which two sessions of osteopathic manipulative treatment, each lasting approximately 20 minutes, were held. Patient recovery occurred without the use of pharmaceuticals"<sup>24</sup> (Lancaster,2006).

### **MET and Acute Low Back Pain**

In this study to examine the outcomes of Muscle Energy Technique in patients with acute low back pain, researchers worked with, "10 men and 9 women diagnosed with acute low back pain.

The control group received

supervised neuromuscular re-education and resistance training while the experimental group received the same exercises coupled with MET."

Using the Oswestry Disability Index to evaluate the effect of the selected treatment (8 times over a 4-week period, researchers concluded, "MET combined with supervised motor control and resistance exercises may be superior to neuromuscular re-education and resistance training for decreasing disability and improving function in patients with acute low back pain."<sup>25</sup> (Wilson,2003).

### **Muscle Energy and Lumbar Spine**

This study examined whether the application of a muscle energy technique (MET) to the lumbar spine could significantly influence lumbar extension range of motion in an asymptomatic population. Twenty-six volunteer subjects, with limited range of motion in lumbar extension, were randomly assigned to either a control group or a treatment group.

"Thirteen subjects in the treatment group underwent eight sessions with the muscle energy technique, two times per week for 4 weeks.

Statistical significance was found indicating that the MET group significantly improved in lumbar extension range of motion."<sup>26</sup>(Schenk,1997).

### **MET Increase Knee Extension**

In a study "to investigate the effectiveness of MET in increasing passive knee extension and to explore the mechanism behind any observed change," researchers took "40 asymptomatic subjects who were randomly allocated to control or experimental groups.

Subjects lay supine with their thigh fixed at 90 degrees flexion, and the hamstring muscle stretched to the

onset of discomfort by passive knee extension. Knee range of motion was recorded with digital photography and passive torque recorded with a hand-held dynamometer.

The experimental group received muscle energy technique to the hamstring muscle, after which the resistance to stretch and the range of motion were again measured. The knee was extended to the original passive torque and the angle at the knee recorded. If the onset of discomfort was not produced at this angle, the knee was further extended and the new angle was recorded."

Researchers said, "a significant increase in range of motion was observed at the knee following a single application of MET to the experimental group. No change was observed in the control group."

Researchers went on to note, "a single application of MET produced an increase in passive stretch of the hamstring muscle. When the post-test torque applied to the muscle remained constant (the same as used in pre-testing), no significant change in length occurred. This suggested that a single application of MET produced no biomechanical change to the muscle, but created a change in tolerance to stretch."<sup>27</sup> (Ballantyne,2003).

### **Muscle Energy Helps Eliminate Urinary Incontinence**

In this research, Physical Therapist, Diane Douglas describes, treatment techniques which helped eliminate urinary incontinence and stimulated bowel and pelvic function.

"I began treating Judy based on techniques presented in Integrative Manual Therapy for the Autonomic Nervous System and Related Disorders. Initially, I used positional releases on the diaphragms of the

body to decrease treatment reactions. Next, I used procedures from Muscle Energy for the Pelvis, and incorporated mobility templates to correct Judy's descended sacrum.

Then, I switched gears to address visceral dysfunction. I found that Judy's transverse colon had attached to her pelvic bowel, and her bladder had adhered to the uterus. Again, we used multiple therapeutic tools to solve this problem, including visceral manipulation to assist the body in self-correction. I also applied myofascial release to help the pelvic region regain proper function.

To increase Judy's pelvic stability, I educated her in the basics of a functional exercise program. In addition, Judy used a transcutaneous electrical stimulation unit at night to assist pelvic floor muscle growth. After 15 sessions, Judy's urinary incontinence resolved and her pelvic range of motion improved in all planes. Her bowels began eliminating once or twice a day, and she rated her occasional back pain at pain scale levels of one or two."<sup>28</sup> (Douglas,2005).

### **Restoring Biomechanical Function After Amputation**

Therapists treating a 32-year-old woman after left traumatic above-knee amputation report, "the patient presented 10 weeks after amputation with a complaint of inability to use her prosthesis because of severe groin pain.

She reported that her prior therapist had the prosthetist adjust the prosthesis multiple times, but the groin pain did not abate. Her pain did not appear to relate to a prosthetic fitting issue.

The patient's pelvis was assessed and her left posterior superior iliac spine was 1½ inches higher than the right side. Her left anterior superior

iliac spine was lower and outflared excessively. She had a positive standing forward flexion test. Her left quadratus lumborum had markedly increased tissue density and was shortened.

These findings were consistent with left anterior ilial rotation, out-flare, and up-slip [Muscle Energy dysfunctions].

Treatment included inferior mobilization with traction, muscle energy, strain and counterstrain, and posterior mobilization.

The treatment resulted in the "patient's anterior groin pain resolved after manual medicine treatment. No further prosthetic modifications were needed."

The researchers noted, "to our knowledge, this is the first published case of treatment of sacroiliac dysfunction after posttraumatic amputation. For this patient, proper prosthetic fitting was impaired because of pelvic dysfunction. We also noted some minor pelvic issues in other patients after traumatic amputations."

They concluded, "a pelvic assessment should be done in all patients who have had traumatic amputations to optimize prosthetic fit and function."<sup>29</sup> (Rosenberg,2003).

### **Muscle Energy Use Among Athletic Trainers**

Muscle Energy Techniques require "more active participation by injured athletes than other manual therapy techniques, in that the athletes actively contract affected muscles against a counterforce. Isometric, concentric, and eccentric contractions are all used in restoring muscle and joint function"<sup>30</sup>(Houglum, 2000).

MET techniques are often used in the treatment of lower back problems<sup>31</sup> (Denegar, 2000).

The primary benefits are provision of stretch to hypertonic muscles and fascia, strengthening of weak muscle, and increased mobilization in restricted joints.<sup>32</sup>(Woerman, 1989).

Thus, the two primary functions of modality application, reduction of pain and increase in range of motion, are directly addressed through the application of muscle energy as a therapeutic modality.<sup>33</sup> (Holt,2004).

Denegar concluded, "although manual therapies are more extensively used in later stages of rehabilitation, they have definite uses as modalities to reduce pain and increase range of motion in injured tissues. Especially, the use of therapeutic massage, myofascial release, joint mobilization, muscle energy, and strain-counterstrain are important for modality application. These therapies are usually used in conjunction with other modalities such as TENS or other non-mechanical techniques,<sup>34</sup> (American Academy of Orthopaedic Surgeons, 1991) but are often used by themselves in the early rehabilitation of injuries<sup>35</sup> (Denegar, 2000) and<sup>36</sup>(Lunn, 2001).

However they may be used, it is certainly the case that the athletic therapist's hands have become much more widely employed modality tools in recent years.<sup>37</sup> (Holt,2004).

### **Muscle Energy Used in an Integrative Manual Therapy Approach to Fibromyalgia**

This case study focuses on a 46 year old woman with complaints of total body pain and diagnosis of Fibromyalgia Syndrome (FMS) and illustrates the benefits of Integrative Manual Therapy (IMT)<sup>38</sup> and an integrated approach to care.

With a focus on the immune system and lymphatic drainage and<sup>39, 40</sup> Endermologie, researcher noted

that, “after therapy was completed, the woman had significant improvement including a decrease in her medications and a significant improvement in levels of fatigue”

The treatment plan was developed after reviewing the evaluation and included multiple techniques.

With significant Myofascial Mapping noted over the lymph tissue, thoracic and abdominal regions, Disruption of Membrane technique<sup>41</sup> was completed over these areas<sup>42</sup> (Weiselfish-Giammatteo,2000).Lymph node Advanced Strain and Counterstrain<sup>43</sup> techniques were done in areas of major lymph nodes and near major organs. Aberrant motilities in the lower extremities, abdomen and thorax were addressed to include Immune Deficiency Motility<sup>44</sup> and Eruption Motility.<sup>45</sup>

In another article on Osteopathic technique and pathogenic processes, Hruby takes a Muscle Energy and Osteopathic Manipulative approach to viral infections in "Avian influenza: an osteopathic component to treatment."<sup>46</sup> (Hruby,2007)

Koch and Lunn continue, “Muscle Energy and ‘Beyond’ Techniques were used to address pelvis and sacrum mechanics.

In attempts to decrease the client’s pain, Bone Bruise technique and Advanced Neural Tissue Tension of the sensory nerves were completed in areas of intense discomfort. With supervision from her MD, the client was able to decrease her medication dramatically secondary to improved comfort.

As soft tissue protection was relaxed through the aforementioned techniques, the biomechanical range of motion potential was maximized through Muscle Energy and ‘Beyond’ Technique of the pelvis, sacrum and spine.<sup>47, 48, 49, 50, 51, 52, 53,</sup>

<sup>54</sup>. This allowed for improved ease and comfort with function, which was evident in ROM testing pre and post treatment.

With IMT, each client’s condition is unique, and subsequent treatment plans which focus on the pathoanatomical landmarks involved in that client’s condition can help to improve their health, and ultimately, their quality of life.<sup>55</sup> (Koch & Lunn, 2004).

### **Muscle Energy for Extremity Jts**

While MET has traditionally been done by osteopaths and has been used to correct spinal and pelvic bone dysfunction, innovated researchers and clinicians are using muscle energy to improve biomechanics throughout the body. Developed by Sharon W. Giammatteo, there are muscle energy techniques for the extremity joints.<sup>56, 57, 58, 59</sup> (Weiselfish-Giammatteo).

### **Muscle Energy for Animals**

Wetzler includes MET and other manual therapy approaches in her treatment of animals. She notes, "our purpose as animal care givers is to appropriately evaluate and suggest the combination of treatments that will support the animal to optimal health. Integrating the skills and knowledge of conventional medicine, chiropractic, acupuncture, physical therapy, homeopathy, herbs, and other forms of energy medicine is where health care is going in the 21st century.

Supportive modalities as ultrasound, electric therapy, laser, heat, cold and magnets are excellent for localized soft tissue dysfunctions.

Manual Therapy procedures consist of Muscle Energy techniques, Craniosacral Therapy, Strain-Counterstrain techniques, Visceral Manipulation, Mechanical Link, Lymphatic Drainage, Myofascial

Release, Movement Re-education.”<sup>60</sup> (Wetzler,2003).

### **Pelvic and Lower Extremity Pain**

There are a number of books that promote the use of muscle energy and other Osteopathic Manual Therapy techniques for pain syndromes and lower extremity dysfunctions.<sup>61</sup> (Lewitt, 1991).<sup>62</sup>(Chaitow,2005) and<sup>63</sup>(Lowe,2003).

Another article discusses the concepts of the vertical dimension of a joint space and other concepts developed by Sharon (Weiselfish) Giammatteo, PhD, PT, IMT,C. Hegarty presents “a case study of a 39 year old woman who received treatment with Integrative Manual Therapy for pain in her right knee that she experienced during running. On initial evaluation, her greatest postural dynamic dysfunction was a severe limitation of her spinal mobility.”<sup>64</sup> (Hegarty, 2001).

Kempel presents a case study is on “a patient with sciatica who complained of pain and numbness radiating down his right hip and leg. Patient presented with decreased range of motion and function of his right leg with gait deviations. He was treated for four sessions with Integrative Manual Therapy (IMT) with a focus on muscle energy and biomechanics. After treatment was completed, patient presented with normal gait, increased range of motion of his right leg, and a total elimination of pain and paresthesia in his right leg. The patient was now able to return to his normal daily routine.”<sup>65</sup>(Kempel, 2001).

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