Bowen Therapy Training & Instruction Manual

Jonathan Damonte RSHom (NA), CCH , CBT

Modules 5 & 6

Produced for
"The School of Bowen"

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Especially to Tom Bowen and his family for their continued support for this official BOWEN THERAPY TRAINING & INSTRUCTION MANUAL©

Video Instruction

www.bowen-online.com

Viceo lessons are available online at www.bowen-online.com There are 3 subscription levels and the lessons include Modules 1-4. These provide an invaluable tool for any student of Bowen Therapy.

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Bowen Therapy Training & Instruction Manual 5

by

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Endorsed by the family of Tom Bowen
Special thanks to

Barry A. Bowen

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About

In creating these manuals I have attempted to better represent the method taught to me, which was presented as the method Tom Bowen first developed by my teacher, Oswald Rentsch the founder of the Bowen Therapy Academy of Australia. There are now many and varied branches of bowen therapy methodology taught around the world and as such these manuals do not try to incorporate all those varieties nor do they claim to be the one presumptive method. They simply better present the method that I learned and use in my own practice and teaching. Jonathan Damonte

Jonathan Damonte has been involved with Bowen Therapy since 1997 after his first Bowen Therapy experience. The treatment was effective for a serious alignment and pain condition he'd suffered since his youth after a fall from a very high tree had injured his hip. He then trained with Ossie Rentsch, a long time student of the Founder, Tom Bowen, and his wife Elaine Rentsch who both came annually to Canada to teach together at the time. It was Ossie that fully resolved the hip injury and it was Ossie Rentch's style of Bowen Therapy that influenced Damonte thereafter.

In 1999, he founded the first Bowen Therapy 'Walk In' clinic, the Be Well Now Center for Bowen Technique, Homeopathic & Naturopathic Medicine in Toronto, Canada. In 2003, Damonte relocated to BC and established two clinics, one in the city center of Vancouver and the second in White Rock where he continues to practice. Damonte incorporates both Bowen Therapy and homeopathic medicine in his treatment of most chronic conditions finding that this is the best method for treating chronic disease. One of the principal reasons that he uses both Bowen therapy and Homeopathic medicine is that they're both curative therapies that don't merely treat the symptoms but reach into the patient to repair the symptoms and the cause.

In 2001, he founded Bowen Canada to help develop the therapy throughout the country. Over the next five years, he worked with The Bowen Therapy Academy of Australia, then known as Bowtech. Between 2002 and 2011, Damonte taught a large portion of Bowen Therapists in Canada and whilst teaching intensively he co-founded the Bowen Therapy Clinics, a chain of clinics that popularized the therapy throughout the country.

After several requests for video training from teachers and students alike, Damonte decided to make his training and materials available online. Results have shown that online training has proven to be as effective as one-on-one training. Further, it provides a platform for students to practice and review the methods being taught on a repeated basis, enabling them to master the method.

It was at this point that he met with Barry Ambrose Bowen, Thomas A. Bowen's son and eldest of three children. It was his encouragement and support that gave Damonte the confidence to continue and develop the only training that is in Barry Bowen's mind akin to that of his father's original work.

It is Barry Bowen's wish that all Bowen therapists come under one umbrella organization and this is why he helped found the Tom Bowen Heritage Foundation in Australia, an international body that accredits the many Bowen practitioners around the world and especially the many different trainings bearing the Bowen name. Officially endorsed by the Tom Bowen Heritage Foundation, the content of these manuals and the content of the training online at www.bowen-online.com are the truest representation of Tom Bowen's gift to the world.

Introduction

The Bowen Therapy procedures outlined in the Bowen Therapy Instruction Manuals (5 - 8) are considered for use after applying *'basic'* Bowen Therapy procedures as taught in the Bowen Therapy Instruction Manuals (1 - 4). These 'basic' Bowen Therapy procedures have not fully resolved the client's symptoms. The following *'Advanced'* or *'Specialized'* procedures are uniquely applied and do not adhere to the same protocol oriented or systemized use outlined in the Bowen Therapy Instruction Manuals (1 - 4). Instead, these procedures require thoughtful application with a deeper understanding of the underlying causes of the client's remaining symptoms. These are often clarified only after 'basic' Bowen Therapy sessions have been given and the focus of the underlying causes of the client's symptoms become clearer. Therefore, the procedures necessary to treat those symptoms become increasingly clear.

Another manner of use for the 'Advanced' procedures outlined in Manuals (5 - 8) are when the symptoms of the client at any time are deemed to be so specific to the procedure as to be obvious.

As always, if one procedure is applied and it doesn't have the required effect there is little risk of aggravation or of losing the case.

If many procedures are applied without benefit the questions of what procedures need to be applied and when they need to be applied become harder to answer.

If too many influences have been applied onto the client then the next steps are never easily decided. If the client is better or worse after a specific protocol of procedures the answer is clear.

When in doubt about a client's progress...WAIT
When a client is still improving.....WAIT
When a client is still aggravating.....WAIT

This level of patience is hard to learn and is the Bowen Therapist's most common mistake. After using the procedures taught in Modules (1 - 4) it should have come clear that the other Bowen Therapy tenet of ***'less is more'*** is quite true to practice as well as to theory.

After utilizing Bowen Therapy from the initial training provided in Modules (1 - 4), you have been able to effectively practice a repertoire of procedures and have refined it. You will by now have experienced some wonderful successes and some frustrations to the effects on some of your client's conditions. Of course, there will have been almost miraculous results seen and they are always wonderful, rewarding and enriching to have been a part of. In this next discussion we will try to understand more closely those client's that have not responded well or have even gotten worse after treatment, those client's that seem to be impossible to affect any improvement in even after many sessions.

Case 1 - The Aggravation
Mrs. A. B. age 53 has a slight build, an engaging and sweet personality and is enthusiastic to come as her husband had come for treatment for Restless Leg Syndrome, which had been effectively relieved by one application of the Hamstrings procedure. Mrs. A. B.'s only complaint at this time is of a knot of tension in the right side levator scapulae. Her intake form reveals an extensive history of physical ailments and importantly a strict regime of diet, exercise and other therapies to manage and maintain her health. Bolstered by the great response of her husband, her enthusiasm and the seemingly simple problem, you can easily take care of, you begin a Bowen Therapy session. She has bought with her a clean set of linen for her to lie on during her treatment session. You confidently apply BRM's shoulder and West. Two days after, she calls asking.

"What the $#^!(%@ **!! did you do to me!" You say, "That's great! Wait a little and you will start to feel better and remember not to take any other treatments, heat or cold applications."

Next day the call comes again and this time she states that she is not better yet and that essentially

all her symptoms from her whole life are all back!!! You instruct her that she'd better come to have a treatment to deal with these. She comes and you perform BRM's 1 & 2 only. You never see her again! What happened?

Case 2 - The Slow Responder

Mr. L. M. age 67 has been an active retiree enjoying hiking, gardening and his grandchildren. He has heard about the Bowen Therapy as a means of treating his chronic lower back pain. The symptom limits his activities and he is left debilitated by overdoing anything. He comes and on examination you observe a distinct swelling at the top of the sacrum and at L5. In the first 3 visits you provide BRM's, Sacrum, Pelvis, Coccyx, Hamstring, Kidney and Respiratory. Not necessarily in this order or only once. Overall, he says there's been no change. You see him again in 2 weeks and he reports still no change, you treat him for another 3 treatments 1 week apart. Still no change! You see him again in 3 weeks and still no change and on and on. In reflection there's as yet no change and in desperation all manner of treatments are provided around the sacrum area. By now you're offering to treat him for free as there's got to be something learned from all this. You never hear from him again! What happened?

Case 3 - The Chronic Care Client

Mrs. E. L., age 47 has come for chronic neck and jaw problems. She is also under the care of a naturopath and a psychic healer. Her chief complaint is the irritable bowel syndrome that wreaks havoc in all aspects of her health and life. She is on a strict and severe regime of diet, enzymes, supplements, herbs and homeopathics. None of which really makes a difference in the severity or frequency of her symptoms. You counsel her that you will begin by addressing her overall inflammation and particular concerns. After a few visits definite progress is made. She feels great and is excited and motivated to return to her other practitioners for further treatments with them. She comes back one month after in a terrible state with no lasting benefits from what you'd provided. You treat again and she begins to improve once more. What happened?

Case 4 - The Incomplete Case

Mr. D. B., age 44 is a physically active man who originally came in during an acute episode of his recurring lower back and sciatica. The treatment has gone very well and after only 3 treatment sessions his back and sciatica symptoms seem to be completely better. After eight months living a normal active life pain free he calls to say that he is in the same pain as when he first came. You begin again and though the symptoms seem to be improving the amazing improvement after the first 3 treatments 8 months earlier is not so amazing. What happened?

COCCYX OBLIQUE PROCEDURE

Minimum Prerequisite
BRM 1 - Moves (1 & 2)
Contraindicated in Pregnancy

Indications

Tilted sacrum
Inverted or Deviated Coccyx
Congestion or misalignment in the pelvic floor
Hemorrhoids
Ineffectual urging, inversion

Usually the choice to perform Coccyx Oblique procedure is made after other likely and well-chosen procedures have failed. This procedure is a manipulation of the inferior border of gluteus maximus, coccygeus sacrospinous and sacrococcygeal ligaments deeper to the medial inferior margin of gluteus maximus.

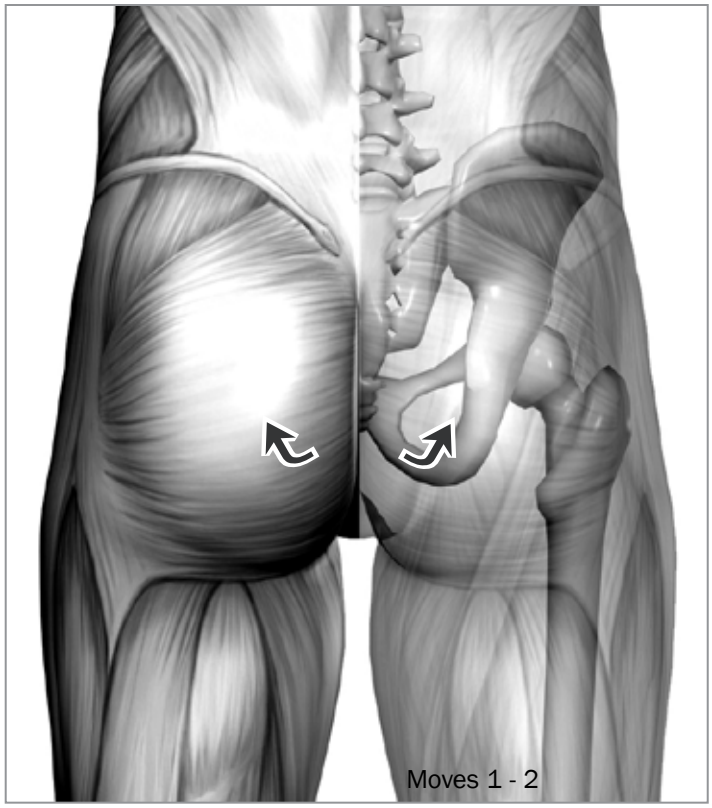
The coccyx and adjacent fascia and ligaments can sustain injuries during childbirth in both the neonate and mother. Other injuries to the coccyx can occur as a result of falls and other sustained trauma.

Assessment

As per the Coccyx procedure, decide with the client which side of the coccyx is to be addressed first by applying gentle pressure to each side. Begin on the less sensitive side. Or, if both sides are equally sensitive begin on the left.

Stand at the left side hip and face the client's feet to be balanced during the assessment of their coccyx. Place the palmar aspect of the left 2nd finger onto the distal spinous process of the sacrum, at the top of the gluteal fold, and over the fabric of their clothing or wrap the finger with tissue to work on bare skin. Palpate the coccyx distally and determine its length and alignment. Place the 2nd finger to the mid-point of the coccyx at the proximal end of the 2nd coccygeal vertebrae. Apply gentle pressure onto the transverse process and both lateral margins of the 2nd coccygeal vertebrae for approximately 3 seconds and ask the client, '...do you feel more pain, sensitivity or sensation on this the left side or this the right side...?' Repeat again superiorly or inferiorly if uncertain.

Consider the congested side and any one-sided symptoms observed or noted before deciding which side to treat this session. During follow-up sessions the side needing to be addressed will differ, be sure to note the side you treat at each session.



The following Moves (1) & (2) are strong and require balanced challenge from both 3rd fingers. The Moves are over a rounded muscle structure and the fingers need to release the challenge, the wrists drop to allow for this. There is a distinct release of ligament with muscle fibre and the client might feel quite sensitive in this area.

Move 1

Abduct the limb on the least sensitive side of the coccyx approximately 15˚ - 25˚. There is no flexing of the knee. Stand at the side of the coccyx being worked on and have the client turn to face you and the side of the coccyx being worked on.

Stand at the side of the clients hip and face their feet. Place the palmar aspect of the near side hands 3rd finger onto the inferior border of the gluteus maximus 2 -3 finger-widths lateral to the transverse process of the 2nd coccygeal vertebrae. Secure the finger with the other hand's 3rd finger if necessary or place 2 fingers to perform the move. Push skin inferiorly over the inferior border of gluteus maximus and gently hook its inferior border with the 3rd fingers. Engage firm challenge supero-laterally to the inferior border of gluteus maximus, coccygeus sacrospinous and sacrococcygeal ligaments, which lay deeper to it.

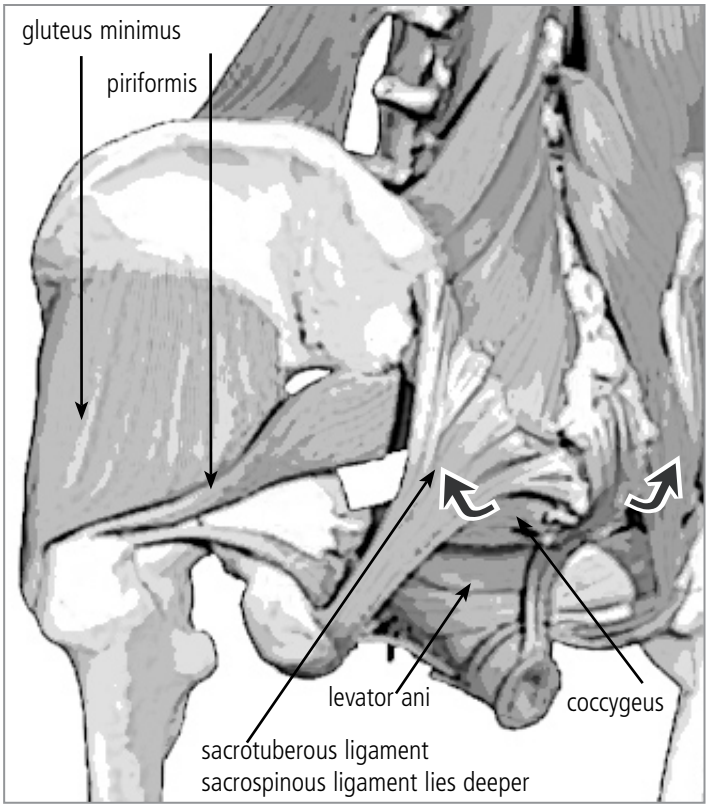
After a second deep exhalation, move supero-laterally over the inferior edge of gluteus maximus and the deeper sacrospinous, sacrotuberous and lateral sacrococcygeal ligaments. Drop the wrists and open the finger-tips to release the challenge.

Move 2

Repeat as per Move (1).

PROVIDE A MINIMUM 15 MINUTE PAUSE

Ideally, no more procedures should be applied this treatment session.



SACRAL RELEASE PROCEDURE

Minimum Prerequisite
BRM I - Lower Back Procedure

The following procedure would follow previously applied procedures indicated for sacral symptoms if the client's symptoms persist.

Indications

Long-standing lower back and hip discomfort
Arthritis
Chronic sacroiliac pain
Sciatica
Gluteal pain,

Moves 1, 2 & 3
3 ascending infero-medial moves along the lateral edge of the left side sacrum.

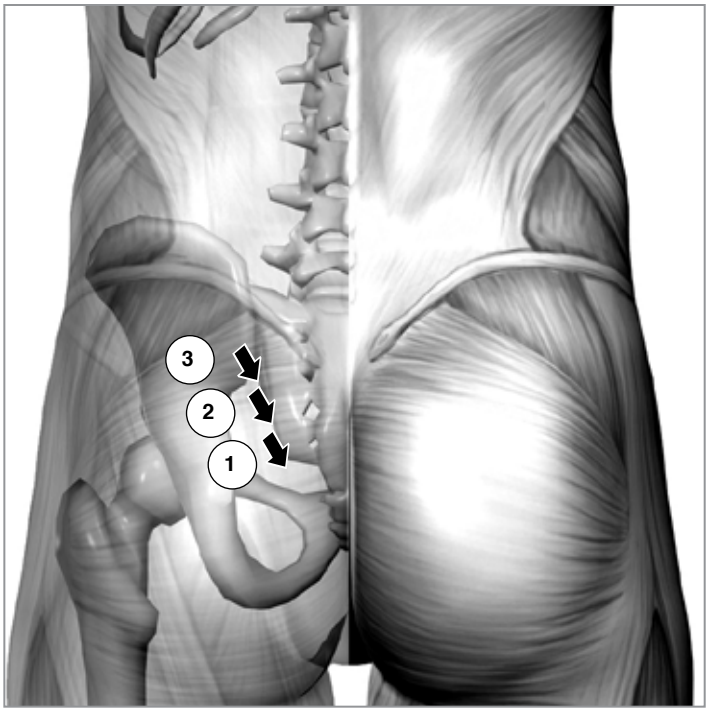
With the client lying prone stand at the left side of their hip and position the palmar aspects of both thumbs onto the inferior lateral border of the left side of the sacrum at the level of the 5th sacral vertebrae (apex). Angle the thumb pads so that the contact made is upon the lateral edge of the sacrum and the medial insertion of the sacrotuberous ligament.

(1) Draw skin slack supero-laterally along the lateral border of the sacrum, engage firm comfortable challenge. Move infero-medially along the lateral border of the sacrum maintaining the depth of the challenge. **(2)** Repeat by placing the thumbs slightly superior to Move (1) on the lateral edge of the left side sacrum. **(3)** Repeat by placing the thumbs slightly superiorly to Move (2) on the lateral edge of the left side sacrum.

The pressure of the thumbs is 50:50 onto the lateral edge of the sacrum and the sacrotuberous ligament beneath the medial border of gluteus maximus.

Moves 4, 5 & 6
Immediately repeat Moves (1), (2) & (3) on the right lateral edge of the sacrum.

PROVIDE A SUITABLE LONG PAUSE



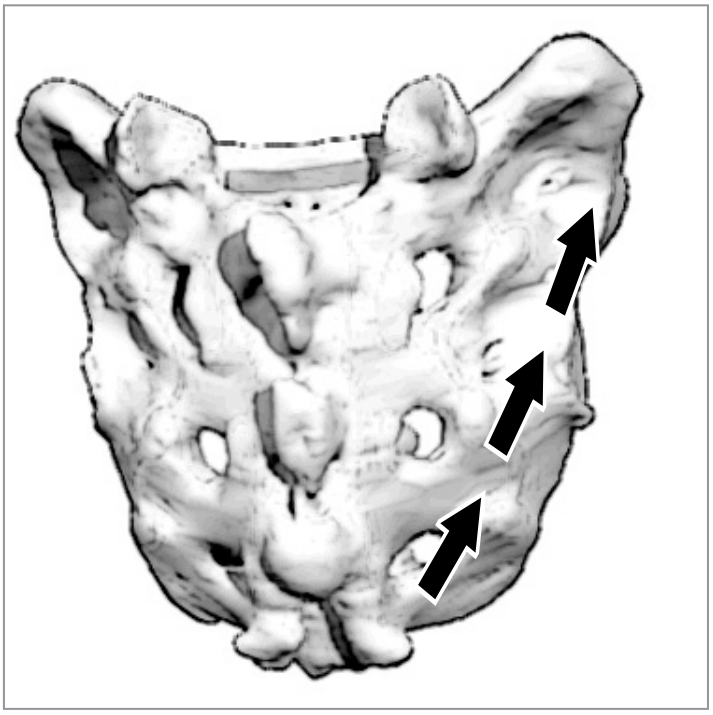
Antomy

The sacrum is triangular in shape and is typically formed from five fused sacral vertebrae. It has a superior surface (or base) that articulates with the fifth lumbar vertebrae at the lumbosacral angle, and an inferior apex that articulates with the coccyx. The apex of the sacrum is formed by the inferior surface of the fifth sacral vertebra, and has an oval facet for articulation with the coccyx via the sacrococcygeal intervertebral disc.

The pelvic surface is concave transversely and vertically. The smooth pelvic surface of the lateral mass gives attachment to the piriformis muscle. The upper part of the pelvic surface is in contact with the peritoneum, the lower part with the rectum. The dorsal surface is convex and irregular with four pairs of dorsal sacral foramina. It gives attachment to parts of the erector spinae and gluteus maximus muscles.

Pregnancy

During and immediately after pregnancy the procedure can be utilized except the Moves are performed in a superolateral direction and away from the coccyx. This is the opposite direction to the normal direction of the Sacral release.



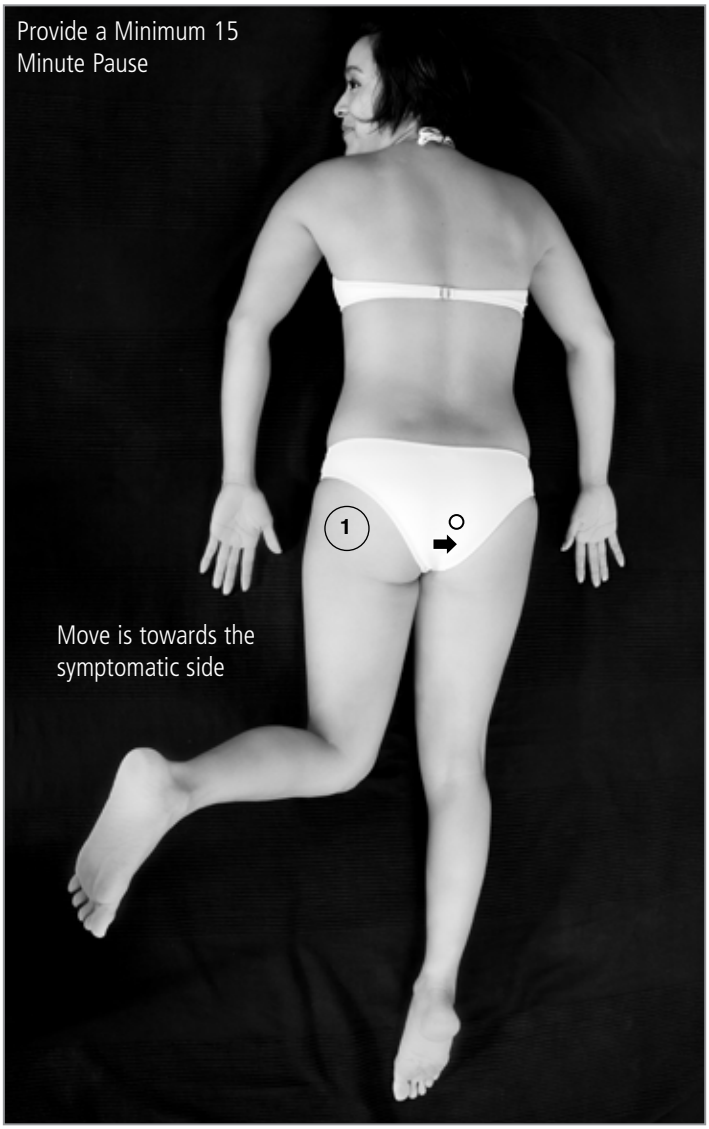
BUTTOCK PAIN PROCEDURE

Minimum Prerequisite
BRM 1 - Lower Back Procedure
Previous Procedures Applied
Pelvis, Sacral & Coccyx Procedure

Contraindicated During Pregnancy

The Buttock Pain procedure is indicated following performance of the above procedures when the client's symptoms refer less and localize into the buttock area or the sacroiliac on one side. This is especially true in sciatica cases where the neuralgic pains that referred to the lower limbs. After successful application of the above Bowen Therapy procedures the symptoms no longer refer as much and are localized closer to the source of the complaint in the lumbar vertebrae or sacroiliac joint. Or, the client remains with persistent buttock pain on one side only. Ensure the client does not use a back pocket for their wallet or phone while sitting.

The Buttock Pain procedure is a manipulation of the coccyx as in Move (1) Coccyx procedure performed on both sides with a significant pause between. There is no application of Move (2) of the Coccyx procedure.



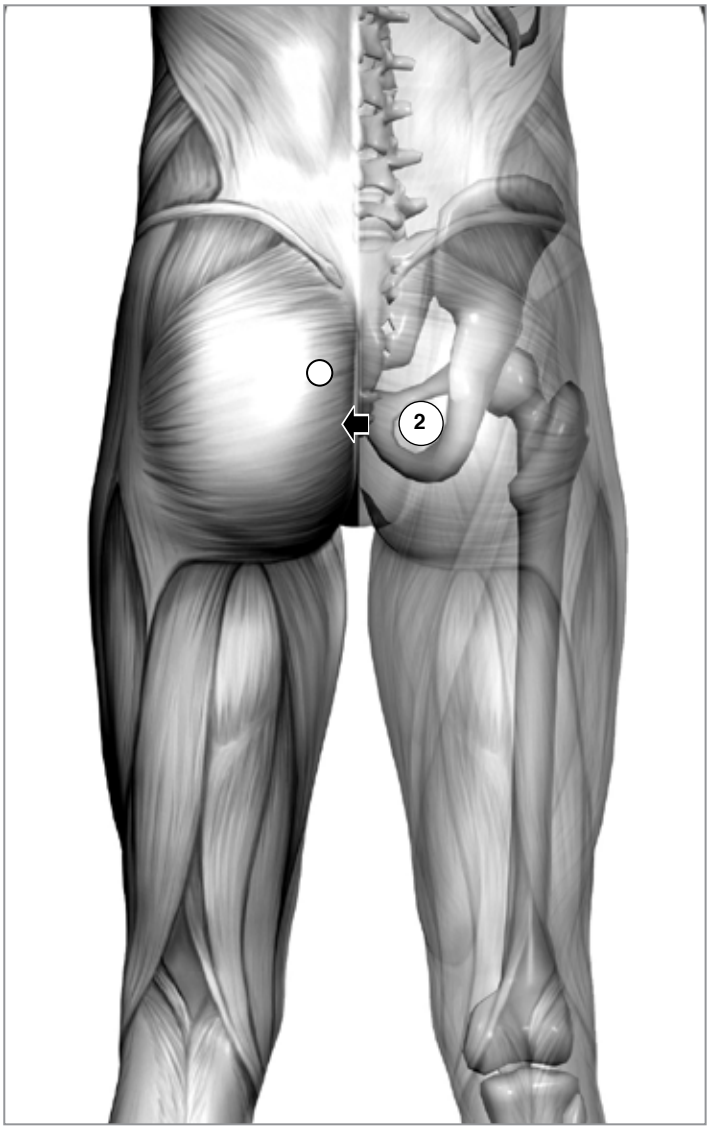
The Buttock pain procedure works best when the coccyx is moved towards the symptomatic side first followed by treatment from the symptomatic side.

Move 1 - *To the symptomatic side*
Stand at the symptomatic side flex the clients knee to 90˚ have the client turn their face towards the symptomatic side. Perform Coccyx procedure Move (1) with the palmar aspect of the 2nd finger whilst maintaining firm pressure on the 'holding point' with the 3rd finger of the same hand.

1st 15 MINUTE PAUSE

Move 2 - *Away from the symptomatic side*

2nd 15 MINUTE PAUSE



DEEP SCIATIC PROCEDURE

Minimum Prerequisite
BRM 1 - Lower Back Procedure
Plus + 5 Minute Pause

Previously well chosen procedures such as, Coccyx, Sacrum & Buttock Pain failed to ameliorate symptoms.

> *Deep Sciatic procedure is a powerful treatment that affects the body profoundly. It needs long pauses before and after for its full benefit to be realized.*

As with all Bowen Therapy procedures the potential to aggravate exists and Deep Sciatic procedure is one where caution is required especially in clients who have had long-standing symptoms, hip surgery and the frail and old-aged.

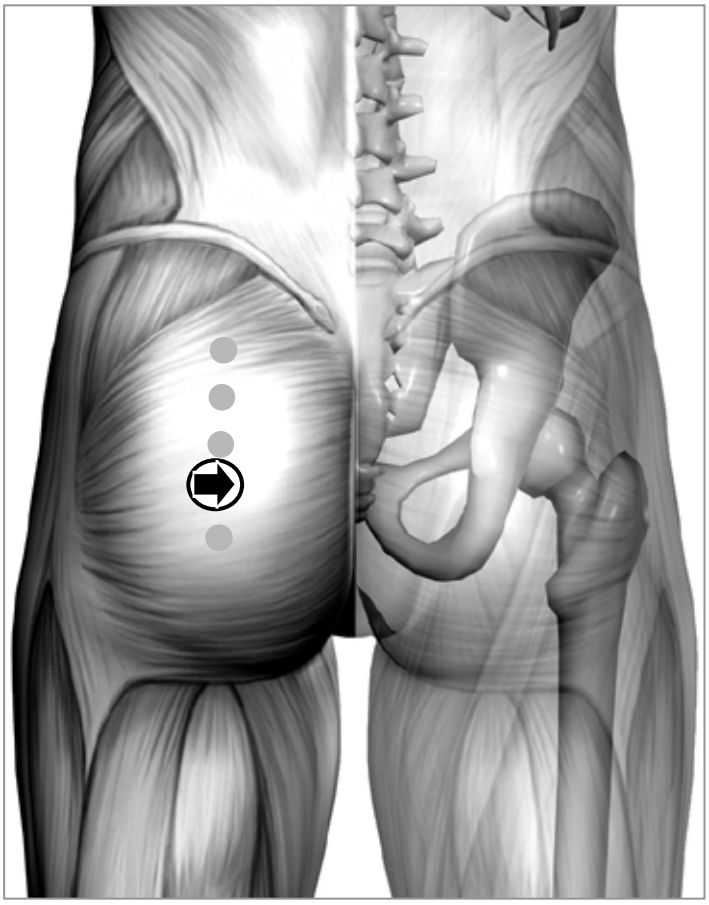
Indications

Pains originating deep in the buttock
Pain referring through the buttock
Piriformis syndrome
Sciatica that were more referred

I.e. Pain down the back or lateral side of the leg, knee pain, calf pain, ankle symptoms related to nerves and also the plantar fascia of the foot. It is especially effective for long-standing chronic conditions involving nerve symptoms. It can also be beneficial for non-resolving shoulder problems, one-sided neck pain and non-resolving headaches.

The Deep Sciatic procedure is performed only on one side, the symptomatic side.

The procedure requires the symptomatic side limb be raised approximately 6" from the treatment surface. The raising of the limb is followed by abduction of approximately 6" of the same limb to allow access onto the deepest fibres of the piriformis muscle and the sciatic nerve. To achieve the raising and abducting of a heavier limb it is necessary to have either an assistant to hold the limb or a luggage strap can be utilized.



An assistant can hold the client's limb with one hand above the knee and one hand above the ankle. A luggage strap is hung from the therapist's neck or shoulder and placed under the client's thigh, as the therapist bends and straightens over the client their limb is raised, lowered and abducted easily. Smaller client's can be treated with one hand and the other hand can be used to raise and abduct the limb.

Location

Standing at the symptomatic side. Palpate inferiorly the client's buttock at approximately the mid-point of the gluteus maximus and starting at the top of the gluteal crease. The anatomical structure is the piriformis muscle and sciatic nerve deeper than the gluteus muscles. Use the point of either thumb pressing firmly into the buttock to ascertain a point on the buttock with the most tenderness. Ask the client to give feedback with a number between 1 & 10, a reading of 5-6 out of 10 is ideal, if the reading is higher than 5-6 the procedure is likely too painful for the sensitivity the client feels in the area.

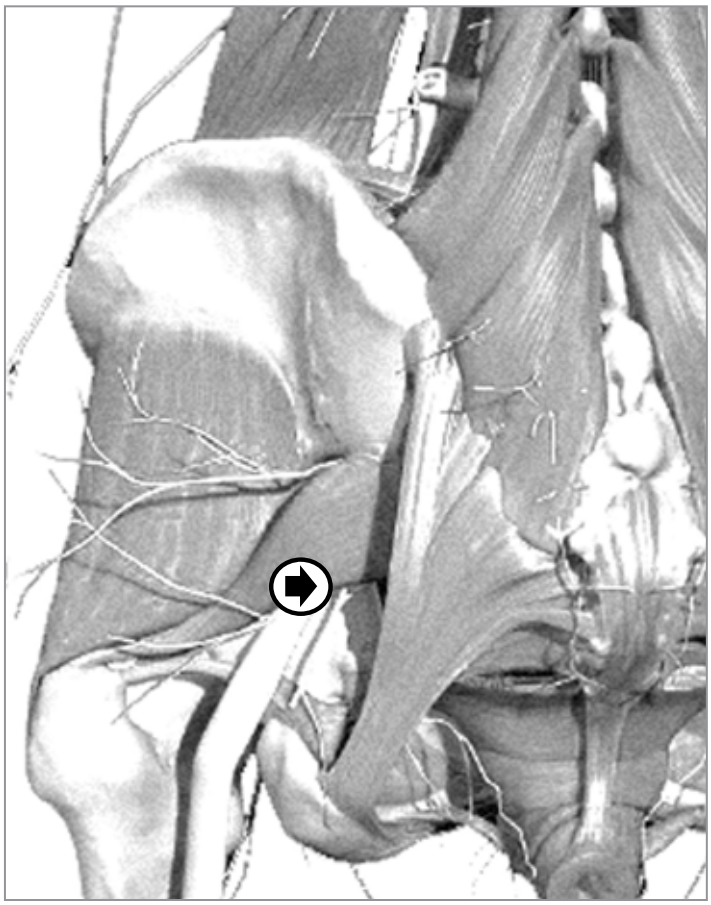
Move

Once the most sensitive point has been located place the palmar aspects of both thumbs, tip-to-tip, sink the thumb tips deeply into the gluteus maximus directly over the piriformis seeking the sensitive sciatic nerve. Elevate the client's limb approximately 6" and abduct the limb approximately 6" while sinking the thumb tips onto the sciatic nerve. Moving the client's limb in this manner allows the gluteal muscles and piriformis muscle to separate and provide the best contact for the thumb tips and sciatic nerve.

While the limb is raised and abducted ensure the client relaxes it while the sciatic nerve is challenged for 2 deep exhalations. At the end of the 2nd exhalation perform a deeper activation to the sciatic nerve by pressing the thumb tips medially onto the sciatic nerve.

PROVIDE A MINIMUM 15 MINUTE PAUSE

No further treatments procedures this session.



BURNING HEEL PROCEDURE

Minimum Prerequisite
BRM 1 - Lower Back Procedure
Pelvic and Knee Procedures

Indications

- Sciatica into foot
- Heel sensitivity
- Plantar Fasciitis
- Ruptured achilles
- Atrophy of calf muscles
- Difficulty flexing foot soleus

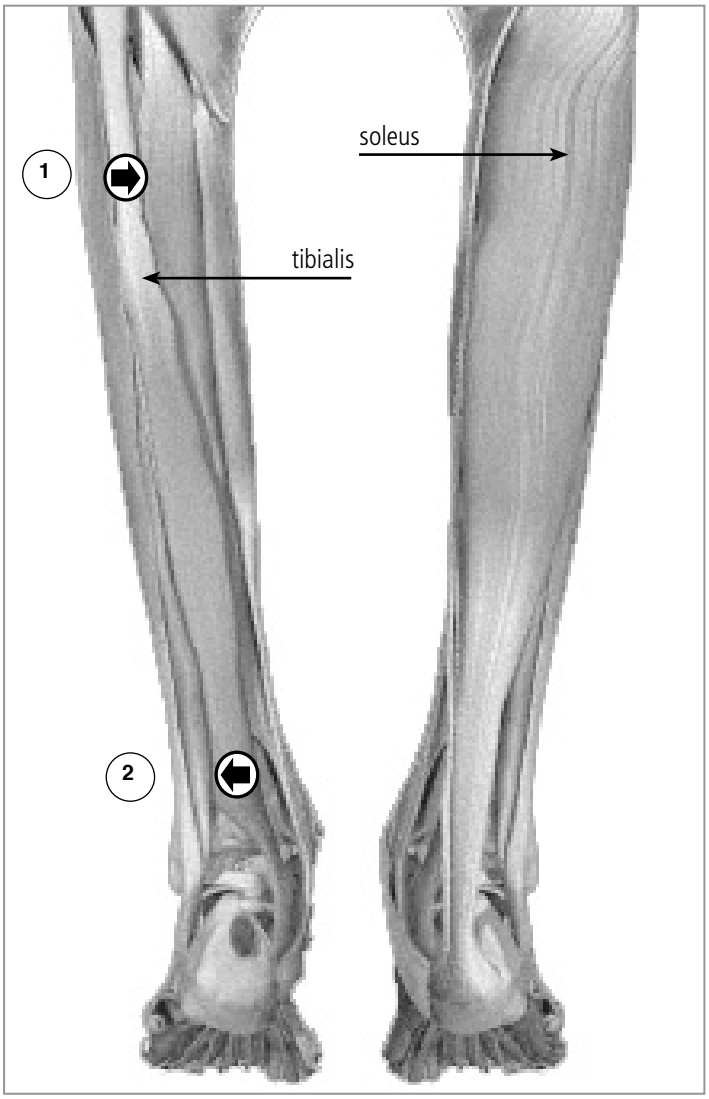
The Burning Heel procedure was termed by Tom Bowen as he developed it for client's presenting with this symptom. It is an exceptional procedure for neuralgic symptoms in the Calcaneal tendon and Heel.

Tap the heel for sensitivity. If it is painful, the fatty pad of the calcaneus may be disordered due to misalignment in the pelvis or knee causing an uneven weight distribution. Tom Bowen called this a 'split heel' and the heel may require the Heel Taping procedure. The Burning Heel procedure is not indicated for this symptom.

Perform on both limbs treating the better limb first.

Stand or sit at the client's better side foot facing their flexed knee.

(1) Position the palmar aspect of the medial hands 3rd finger onto the medial border of the lateral gastrocnemius approximately 3 to 4 finger-widths inferior to the crease of the knee. Push skin laterally against the medial border of the lateral gastrocnemius pushing aside the medial border of the lateral gastrocnemius to position the 3rd fingertip onto the soleus muscle and tibialis tendon, which lie deeper to the lateral gastrocnemius. Engage challenge anteriorly and secure the hand with the thumb on the anterior of the leg. Ask the client if the point is tender and guage a reading of between 1 and 10. If you find a point reading 5-6 out of 10 then maintain the fingertip at this point. The area is very sensitive as it is upon the tibial nerve, a branch of the sciatic nerve.

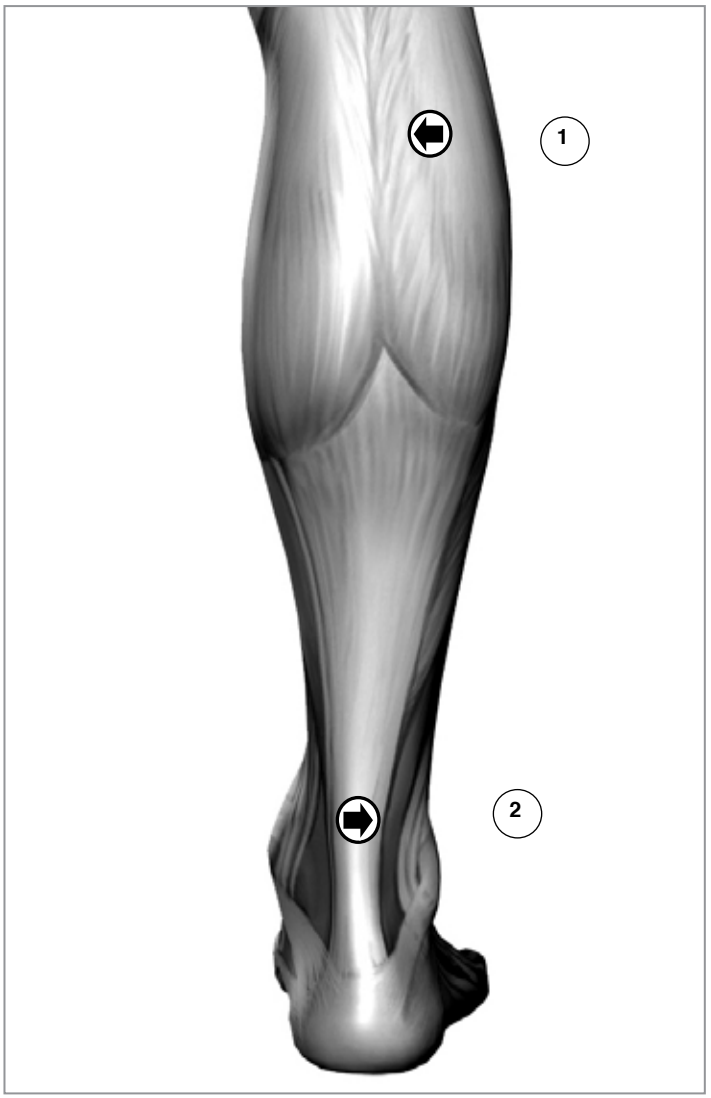


(2) Position the lateral hands palmar aspect of its 3rd finger onto the calcaneal tendon at a point 1 finger-width superior the malleolae.

Move 1 & 2 - *Performed Simultaneously*
Engage firm challenge anteriorly onto the calcaneal tendon with the lateral hands 3rd finger at the same time as firm anterior challenge is on the soleus muscle tendon with the medial hands 3rd fingertip. Have the client take 2 breaths and on their 2nd exhalation activate the 2 held tendons by squeezing tightly onto them at exactly the same moment. Focus on the mid-point of the leg at the moment of the Moves to ensure the exact timing. The client should feel a distinct increase in sensitivity at the moment the Moves are performed.

Immediately perform the same procedure on the opposite limb and return the client's limb to rest.

PROVIDE A MINIMUM 5 MINUTE PAUSE



KNEE REFLEX PROCEDURE

Minimum Prerequisite
BRM 1 - Lower Back Procedure
Pelvic and Knee Procedures

Indications

Tightness in quadriceps muscles
Difficulty to dorsiflex the foot
Patella tendonitis
Osgoode-Schlatters disease

The Knee Reflex procedure is especially useful in clients who have chronic tightness in the Quadriceps muscles, see Rectus Femoris procedure also, this affects their gait and ability to dorsiflex their foot. The patella tendons may be tight affecting the mobility of the patella. It is a potential treatment for Osgoode-Schlatters disease, osteoarthritis of the tuberosity of the tibia. It is also associated with ankle pronation and fallen arches and dropped metatarsals.

Perform on both limbs treating the better limb first. The Moves of the Knee Reflex Procedure are activations of the ligaments and extensor tendons, a signal.

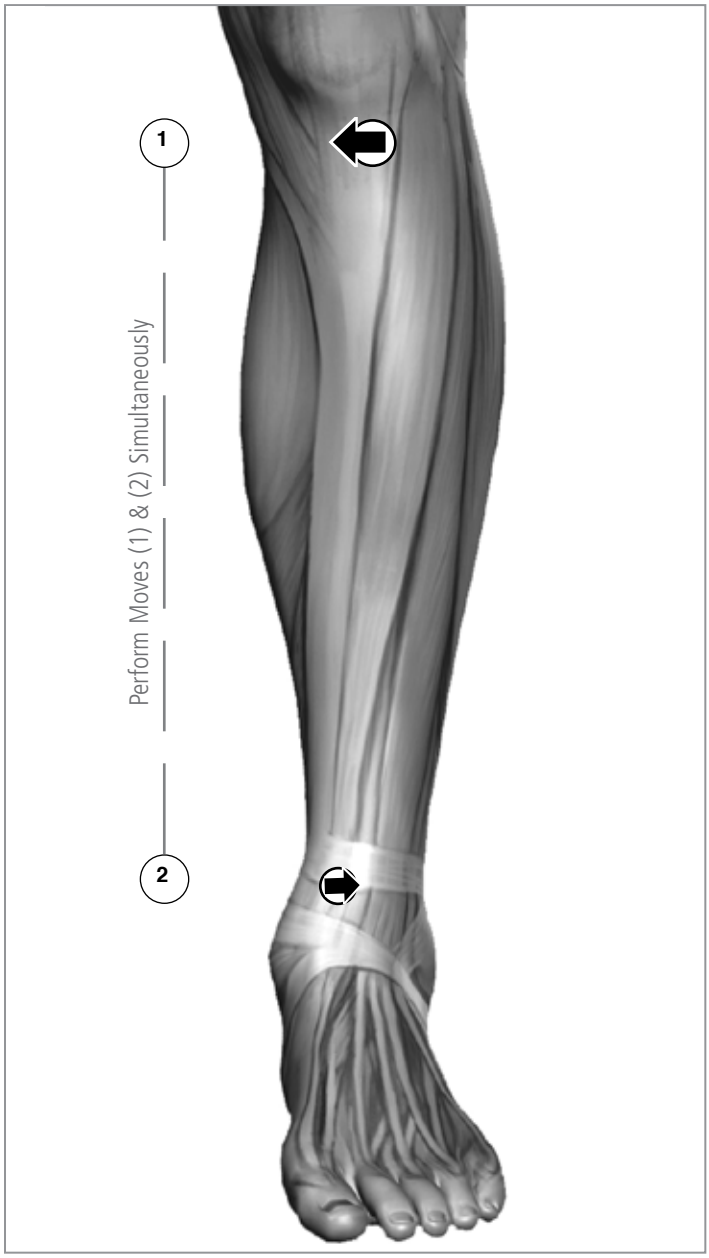
Stand or sit at the client's better side foot facing their flexed knee and support the client's foot into slight dorsiflexion and resting on its heel. Depending on left or right limb:

(1) Place the medial hands palmar aspect of its thumb onto the patella ligament adjacent and distal to the inferior border of the patella (apex). Support the thumb by positioning the fingers of the same hand onto the back of the knee.

(2) Position the palmar aspect of the lateral hands thumb onto the anterior surface of the ankle joint and over the extensor tendons of extensor digitorum longus and the inferior extensor retinaculum. Support the thumb by positioning the fingers of the same hand onto the back of the ankle.

Move 1 - *Performed simultaneously with Move (2)*

Push skin slack laterally over the patella ligament and engage firm challenge postero-medially with the palmar aspect of the medial hands thumb. Challenge for 2 breaths and on the 2nd exhalation move the patella ligament medially whilst firmly maintaining the depth of the challenge.



Move 2 - *Performed simultaneously with Move (1)*

Push skin slack medially over hallucis longus and the extensor tendons, engage firm challenge the tendons postero-laterally with the palmar aspect of the lateral hands thumb. Challenge for 2 breaths and on the clients 2nd exhalation move the extensor tendons laterally whilst maintaining the depth of the challenge.

The pressure of the challenge onto the patella ligament for Move (1) is stronger than the challenge onto the extensor tendons for Move (2). The two Moves must be synchronized and affect a signal at the same moment. To achieve this focus on a mid-point of the client's shin before the close of the 2nd exhalation.

Immediately perform the same procedure on the opposite limb and then return the limb to rest.

PROVIDE A MINIMUM 5 MINUTE PAUSE

Anatomy

Patellar Ligament (Ligamentum Patella)

The patellar ligament (ligamentum patellae) is the distal continuation of the quadriceps tendon. It extends from the apex of the patella to the upper half of the anterior surface of the tibial tuberosity. The patellar ligament is a strong, flat band to whose medial and lateral edges are attached, respectively, the medial and lateral patellar retinacula. Respectively superficial and deep to the patellar ligament are the superficial and deep infrapatellar bursae. The patellar ligament is approximately 6 to 8cms long.

RHOMBOIDS PROCEDURE

Minimum Prerequisite
BRM 2 (Moves 1-8) - Upper Back Procedure
Consider West, Back Cramp & Levator Trapezius procedures.

Indications

Chronic neck pain
Neck pain at night
Pain adjacent or beneath scapula
Immobility of scapula

The Rhomboids procedure is indicated in long-standing neck and shoulder problems involving persistent tension in the muscles adjacent to the scapula. The scapula will have some immobility as a result. Also, stabbing sensation under the scapula or down the medial border of either scapula.

Perform on both sides treating the better side first.

(1) Position the palmar aspect of the inferior hands thumb onto the rhomboideus major muscle adjacent to the midpoint of the medial border of the scapula.

(2) Position the palmar aspect of the superior hands thumb onto the tendonous belly of rhomboideus minor medial to its attachment onto the medial end of the scapula.

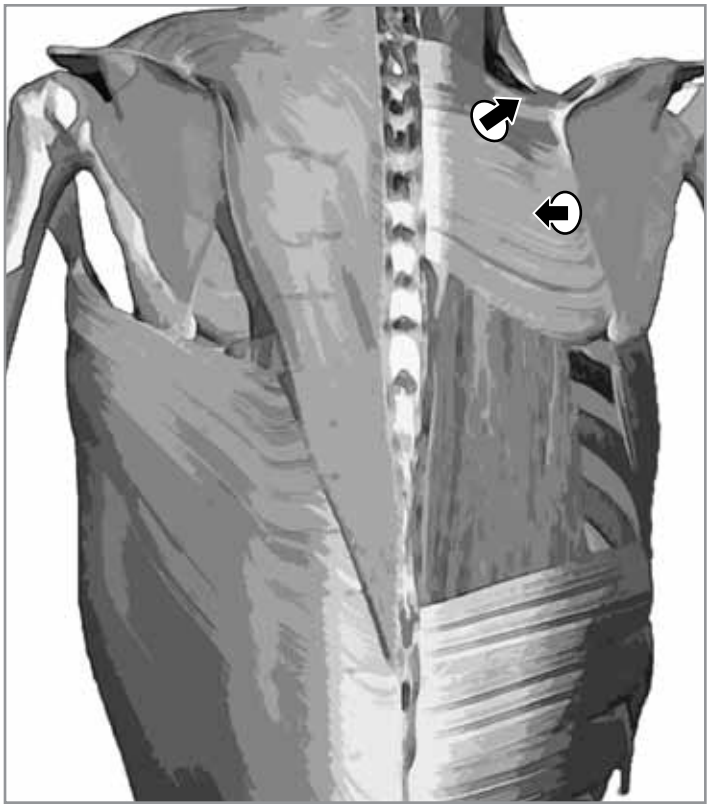
Move 1 - *Performed simultaneously with Move (2)*
Draw skin laterally laterally to the most lateral attachment of rhomboideus major with the inferior hands thumb. Rest at the medial border of the scapula and push skin slack slightly superiorly along the medial edge of the scapula towards the superior hands thumb. Engage firm medial challenge and at the close of a 2nd exhalation move medially whilst maintaining firm challenge through the Move so as to affect the ilio costallis muscles beneath rhomboideus major.

Move 2 - *Performed simultaneously with Move (2)*
Push skin slack infero-medially over the tendonous insertion of levator scapula and the belly of rhomboideus minor. Nudge the skin slack towards the inferior hands thumb which has drawn the skin slack superiorly for Move (1). Engage firm supero-lateral challenge and at the close of a 2nd exhalation move supero-laterally over the rhomboideus minor muscle whilst maintaining firm challenge through the Move.

Immediately repeat on the opposite side.

PROVIDE A MINIMUM 5 MINUTE PAUSE

Moves (1) & (2) are performed simultaneously



Anatomy

Rhomboideus Major

Rhomboideus major is a quadrilateral sheet of muscle, which lies with rhomboideus minor and levator scapulae in the posterior neck and chest wall, superficial to the long back muscles and deep to trapezius, except at the Triangle of ausculation. Together with rhomboideus minor, levator scapulae and pectoralis minor it medial rotates the scapula; with rhomboideus minor and trapezius it retracts the scapula. It also acts to stabilize the scapula when other muscle groups are active.

Rhomboideus Minor

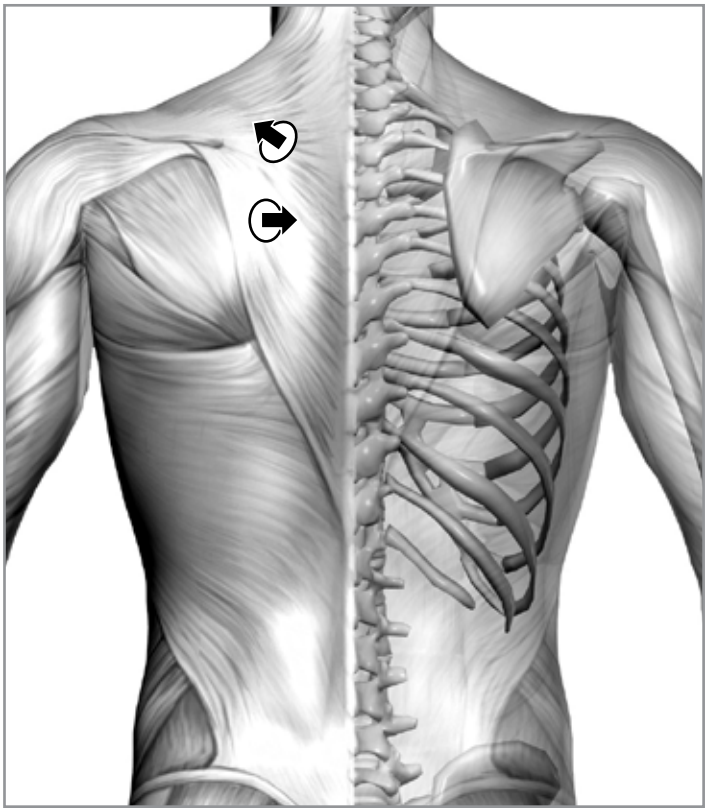
Rhomboideus minor is a small quadrilateral muscle, which lies between rhomboideus major inferiorly and levator scapulae superiorly in the posterior neck and chest wall, superficial to the long back muscles and deep to trapezius.

Iliocostalis Thoracis

The proximal attachment of Iliocostalis thoracis arises from the upper borders of the angles of the seventh to twelfth ribs, medial to iliocostalis lumborum. Its distal attachment ascends to the superior borders of the angles of the first to sixth ribs and the posterior surface of the transverse process of C7. When working on one side only, it produces lateral flexion and some extension. Both sides work together to extend the thoracic spine.

Serratus Posterior

Serratus posterior superior is a thin, quadrilateral muscle lying deep to the rhomboideus and superficial to the thoracolumbar fascia. It arises from the lower part of the ligamentum nuchae, the spinous processes of C7 to T3 and the intervening supraspinous ligaments. It descends infero-laterally ending in four digitations, which attach to the upper borders and external surfaces of the second to the fifth rib lateral to the angle. Serratus posterior superior elevates the ribs.



Perform Moves (1) & (2) Simultaneously

Bowen Therapy Training & Instruction Manual 6

by

Jonathan Damonte

RSHom (NA), CCH, CBT

Endorsed by the family of Tom Bowen
Special thanks to

Barry A. Bowen

BEDWETTING PROCEDURE 4 KIDS

Minimum Prerequisite

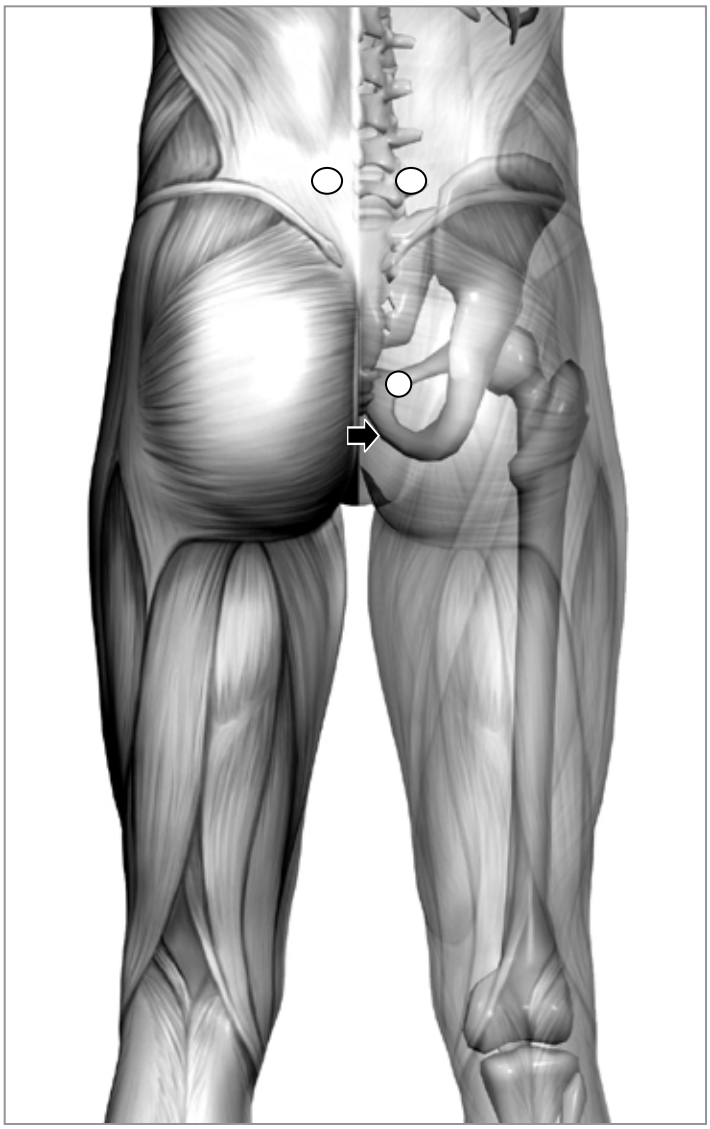
BRM 1 (Moves 1 & 2)
For adult and post pubescent incontinence perform the standard Coccyx and Kidney procedures without the additional 'holding points' described below.

This procedure utilizes a variation of the Coccyx procedure plus an additional pair of 'holding points' best provided by a parent or assistant, though these can be applied by the therapist on smaller children. The child has received prior Bowen Therapy treatments to balance any other areas of concern and there are no other causative factors involved in their symptoms such as, dietary, environmental triggers. Emotional causes can often underlie the issue of bedwetting and these should be dealt with in addition to Bowen Therapy. Bowen Therapy will effectively treat any physiological deficiency that might cause the bedwetting.

Treat the child once a week, each 7 days, to maintain the momentum of the Bowen Therapy response. Assess each time to measure any deviation in sensation or structure. The side treated will usually alternate, keep treating weekly until there are 7 dry nights observed.

Holding Points (1a) & (1b)
Place the 4th and 5th fingers onto the medial borders of the erector spinae adjacent to the spinous processes of the 5th lumbar vertebrae, this is the same level of BRM 1 - Moves (1) & (2). Or, have the parent or assistant use the palmar aspect of their thumb and 2nd finger. Apply gentle pressure antero-medially as if slightly squeezing the erector spinae towards the midline.

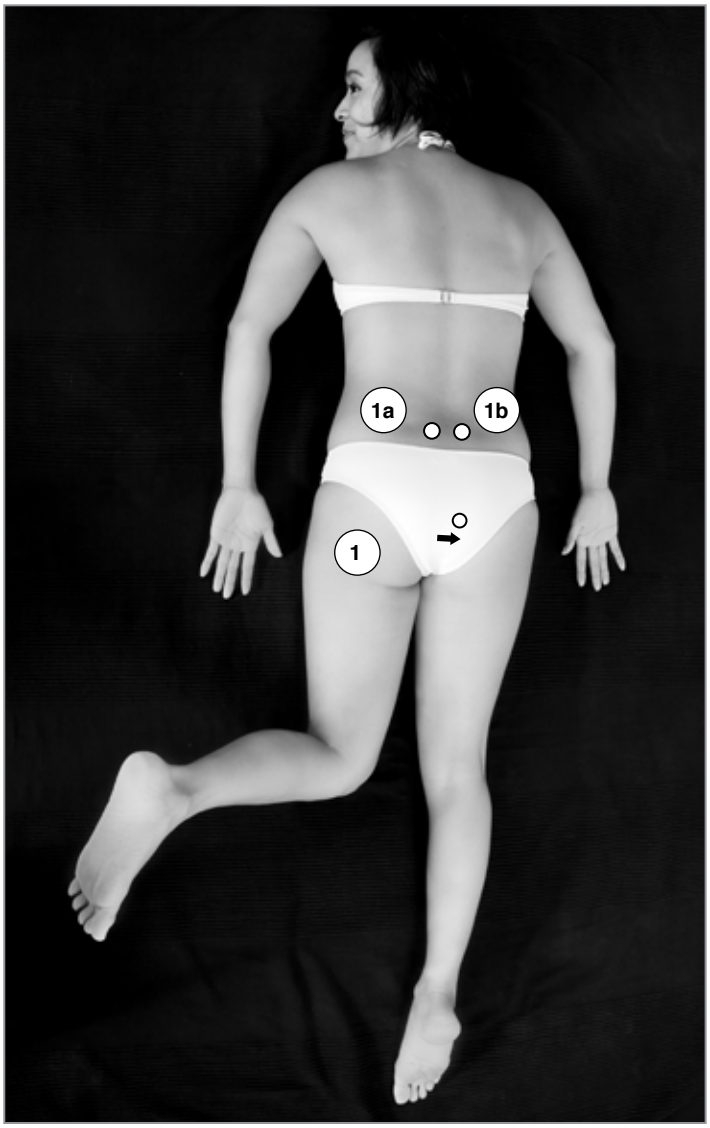
Move 1
While the 'holding points' (1a) & (1b) are held by either an assistant or by the therapists 4th and 5th fingers. Position the 3rd finger of the superior hand onto the client's opposite sacrotuberous ligament at a point adjacent to the inferior lateral angle of the sacrum and on the opposite side from the coccyx side chosen. This point is approximately 2 cm from the midline and is a firm 'holding point' during the entire Coccyx procedure, it is the same point as for Move (1) - Sacral Procedure. Place the superior hands 2nd finger against the lateral edge of the painful side coccyx, same-side as the therapist. The 2nd finger is at the mid-point of the coccyx against the lateral border of the transverse process of the 2nd coccygeal vertebrae. Comfortably



sink the 2nd finger deeply against the painful side of the coccyx. On the client's complete exhalation move over the skin and coccygeal ligament from the lateral border of the painful side of the coccyx to the opposite non-painful side. Use a rotation of the wrist and with the 3rd finger 'holding point' as a pivot point to draw the 2nd finger from one side to the other. During the move more pressure is placed onto the 3rd finger holding point than the 2nd finger as it moves over the coccyx.

PROVIDE A MINIMUM 2 MINUTE PAUSE

The client turns and lays supine to be in position for an optional Move (2) of the Coccyx procedure. To 'lock the coccyx' on the abdomen via a 'boomerang' move over the rectus abdominus muscles on the same side that was treated for Move (1) of the Coccyx procedure.



Stand beside the client's hip on the same side the coccyx was treated for Move (1). Open the client's same side lower limb to approximately 20˚ from the midline and flex their knee to 90˚ and position the inferior hand inferior to the knee or behind the clients thigh just superior to the crease of the knee. Place the palmar aspect of the 2nd, 3rd & 4th fingers of the superior hand onto the abdomen at a mid-point between the linea alba and ASIS, pointing the fingers to a mid-point of the same side inguinal ligament. Keep elbows apart and in line with the client's knee and opposite side shoulder and maintain balance to avoid straining while lifting the client's limb.

Move 2 - Optional

On exhalation lift and comfortably extend the client's flexed thigh towards their opposite shoulder using the inferior hand at the knee to support its movement. When the client's thigh begins to cover the superior hand push skin towards the inguinal crease. Comfortably challenge onto the client's abdomen with the palmar aspect of the 2nd, 3rd & 4th fingers of the superior hand and move supero-medially toward the umbilicus and over the lateral edge of the muscle then move supero-laterally over the same muscle border. The lateral border of rectus abdominus is distinctly challenged and released during the move. Finally, to the comfort of the client extend the leg in the direction of the opposite shoulder so as to stretch the thigh and hamstrings and then fully straighten it at the knee before lowering the straightened limb to rest on the treatment table.

AFTERCARE

Begin an, 'elimination diet', in which all dairy foods are avoided, followed by elimination of wheat products and then refined sugars. These food groups can be re-introduced into the child's diet one at a time to test the sensitivity to them. It is also recommended to eat from an ‘alkaline’ dietary meal plan.

CONCEPTION PROTOCOL

There are several treatment options relating to the use of Bowen Therapy for issues of infertility and symptoms relating to all stages of pregnancy.

INFERTILITY

The simple protocol for infertility is to utilize the Coccyx procedure once a month at the onset of menses.

The aim at each prior Bowen Therapy session is to address the underlying fertility issues. First restore, if needed, a regular menstruation and 28-day cycle, this once attained is the indicator that the client has reached a balanced state of health. All other physical symptoms need to be treated as a process of bringing the client into physiological balance. Various procedures are used to achieve a state of balanced hormonal function over the course of therapy.

The procedure that ultimately promotes fertility and conception is the Coccyx procedure performed monthly once balance has been achieved. It is applied only if the client is not pregnant. Other Bowen Therapy procedures that affect reproductive health include: Pelvic, Upper Respiratory & TMJ and Kidney procedures. It is also important, though not essential, to treat both partners with Bowen Therapy.

Client with *Irregular* Menses

After balancing with Bowen Therapy procedures and addressing their 'Chief Complaints' treat the woman on a *weekly* basis with the Coccyx procedure, until a regular 28 day menstrual cycle is established.

Client with *Regular* Menses

Once a regular 28-day menstrual cycle is established continue Bowen Therapy sessions *once a month* at the onset of each menstruation. The onset is established through normal signs, symptoms or an hcg test (pregnancy test) to ensure the client is not pregnant.

Perform all prerequisites and Coccyx procedure Move (1) by assessing for the sensitive or congested side of the coccyx at each session. If neither side is sensitive, address the left side. Perform Coccyx procedure Move (2) on the client's same-side abdomen. If the coccyx is sensitive on the same side for 3 consecutive sessions, perform the Coccyx procedure on the opposite side at the next session.

PREGNANCY & BOWEN THERAPY

The following list outlines a variety of care methods that can be provided during pregnancy.

During Pregnancy

Chair Bowen & Other Support
Treatment can be done with client supine

First Trimester

Nausea and Vomiting
Heartburn and Breast Discomfort
Varicosities
Insomnia
Headaches

Mid Trimester

High blood pressure in pregnancy
Carpal-Tunnel Syndrome
Back Pain
Symphysis Discomfort
Posterior Pelvic Pain

Last Trimester

Induction of Labour
Breech Presentation

Labour

Back Labour
Perineal Discomfort
Caesarian Section
Hemorrhoids

Breast Problems

Mastitis
Engorgement
Lactation problems

Neonate & Toddlers

Baby Bowen

BABY BOWEN

4 NEWBORNS & SMALL CHILDREN

The use of Bowen Therapy on children should be considered only in addition to the continued care of the child's paediatrician or other primary health-care provider.

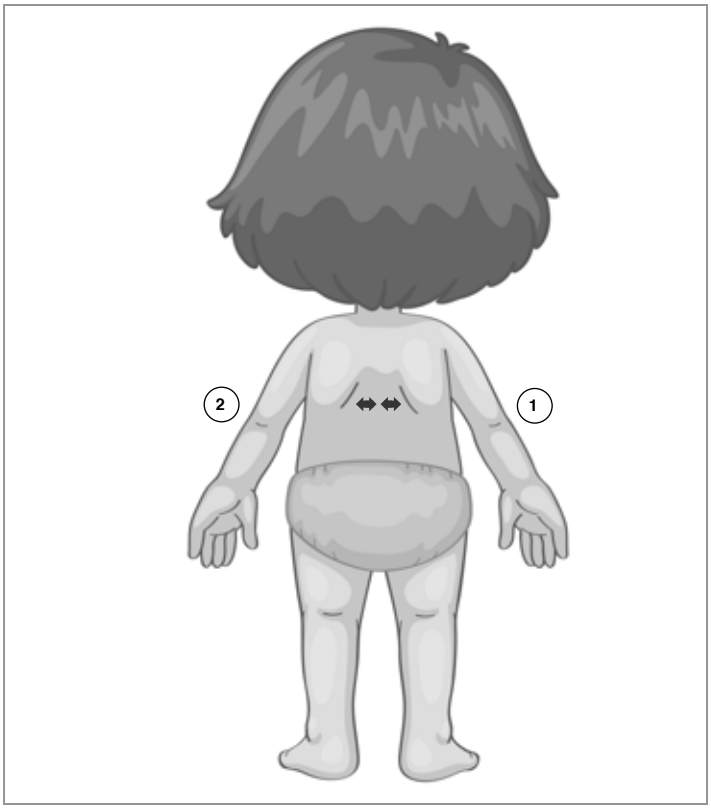
Importantly the diet and health of the nursing mother as a potential underlying factor in their child's symptoms. Advise the parents of the process you are about to undertake and ensure they are present for the treatments.

Treating newborns and small children requires thoughtful assessment and choices for an appropriate plan of action. Though not for any risk to the infant but for a speedy resolution to their concern. The treatment itself is a confirmation of the chosen plan as the positive outcome indicates a proof to the likeliest cause for their symptoms.

Most newborns will come to Bowen Therapy for Colicky Baby syndrome or infantile colic seen with either abdominal or respiratory discomfort causing their distress. The children are usually better with pressure on their abdomens and better for being carried or rocked, often vigorously.

Bowen Therapy offers an exceptional benefit and relief for these types of symptoms. It can also be taught to the parents to be used as needed.

Baby Bowen for Neonates & Infants with Colic or Asthma Symptoms uses a modified protocol of Basic Relaxation procedure (BRM 2) and the Respiratory procedure. Additionally, a modification of BRM 3 - Moves (5) & (6) might be necessary for conditions not related to digestive or respiratory complaints but are caused by congestion in the vascular supply or nervous system through the neck.



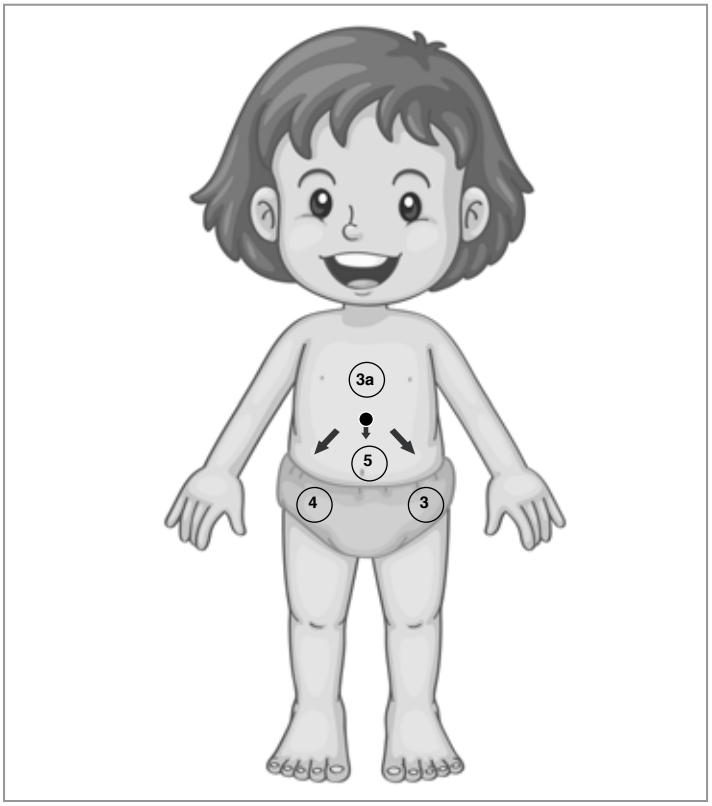
ADDITIONAL
BABY BOWEN PROTOCOLS

Step 1 - Baby Bowen
With the child securely held and positioned comfortably by a parent or therapist so as to receive Bowen Therapy moves on their upper back.

The therapist using the their 2nd or 3rd finger performs a medial move on the child's left Erector spinae at the level of the inferior angle of each scapula followed by a medial move on the right Erector spinae. Followed by two lateral moves using the same finger on the same points with out pauses.

Step 2 - Baby Bowen
Immediately following the therapist performs Moves (3) to (5) of the Respiratory procedure in the usual manner including 'holding point' (3a).

This protocol can be repeated as soon as needed in acute distress and when there is obvious and significant amelioration of the child's symptoms.



In a case that does not respond to the above procedure look for a possible neck restriction causing congestion or for other discomfort consider the following options:

Blue Sclera

It is usual for a newborn to have bluish sclera until approximately 3 months of age. After 3 months if the Sclera of one eye is bluer, there may be a neck restriction on that side.

Perform Step **(1)** & **(2)** - Baby Bowen followed by either:

- *Left Sclera* darker than right, perform Move (5) of BRM 3

- *Right Sclera* darker than left, perform Move (6) then Move (5) of BRM 3

Slow Pupil Dilation

Assess the child's response to pupil dilation using a penlight or scope. If either pupil is slower perform the following.

Perform Step **(1)** & **(2)** - Baby Bowen followed by either:

- *Left pupil* responds slower than right, perform Move (5) of BRM 3

- *Right pupil* responds slower than left, perform Move (6) of BRM 3

TMJ ADVANCED PROCEDURE

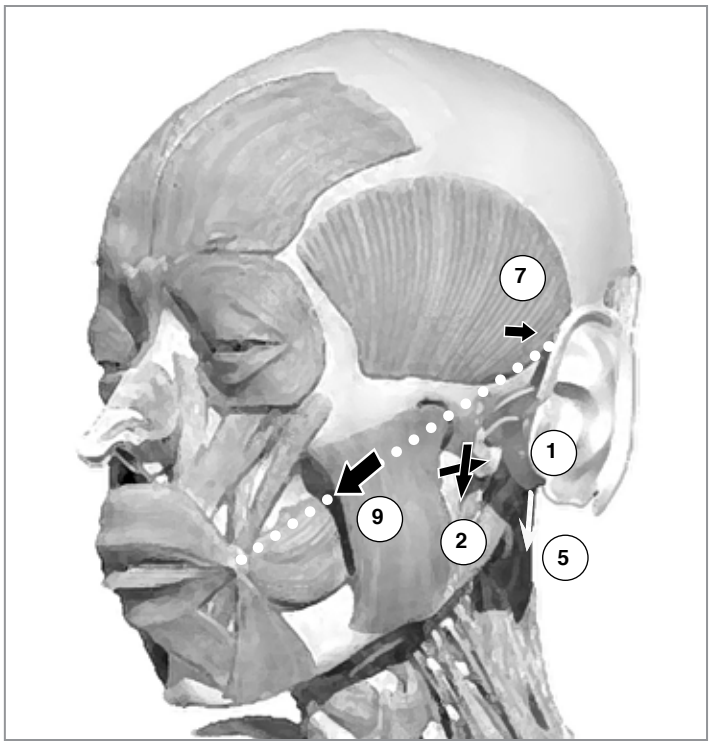
Minimum Prerequisites
Upper Respiratory & TMJ Procedures
BRM 3 - Neck Procedure
BRM 2 - Upper Back Procedure

Indications

- Sleep apnea
- Seasonal allergies
- Sinusitis
- Trigeminal neuralgias
- Bells Palsy
- Bruxism (Grinding)

Use this procedure if there's limited response or no response to other well-indicated procedures such as, Upper Respiratory & TMJ, Headache, Sinus and Eye.

The TMJ Advanced Procedure is performed immediately at the close of the Upper Respiratory Procedures and involves a repetition of the TMJ Procedure Moves (1-8) and two additional Bowen Moves (9 & 10) over the anterior border of the masseter muscle whilst the jaw separated as wide as is comfortable. The TMJ Advanced procedure is contraindicated in a client that has had surgical intervention to their TMJ joint.



While standing at the client's head place the palmar aspect of each hands 2nd finger onto the condlyes of the temperomandibular joint, with the finger-tip pointing inferiorly towards their feet, approximately 1/2 to 1 finger-width anterior to the tragus of the ear. Ensure that the palmar aspect of the 2nd finger is placed onto both the condyles of the mandible and the cranial skull.

Request the client attempt to place the first knuckle of their 2nd and 3rd fingers between their teeth, this is to make as wide a space in the temperomandibular joint capsule as possible. If the client has limited ability to open their TMJ joint the procedure can be performed with 1 finger knuckle only between their teeth.

Their fingers remain positioned for the TMJ Advanced Procedure Moves (1-4), Moves (7-10) and not for Moves (5 & 6). These moves are the same as the first 8 moves of the TMJ procedure and the opening wider of the TMJ joint provides deeper access to the capsule of the TMJ joint.

Moves 1 & 2
(1) On the left side draw skin anteriorly and engage gentle challenge medially before moving posteriorly over the condylar fossa with the palmar aspect of the 2nd finger.

(2) Return the 2nd finger to its starting point and draw skin superiorly, engage challenge and move inferiorly over the condylar fossa.

Moves 3 & 4
Repeat Moves (1) & (2) on the right side temperomandibular joint.

For Moves (1-4) the palmar aspect of each 2nd finger while moving over the ligaments at the TMJ will sink

deeply into a groove between the joints. The jaw will move fractionally under the pressure of the fingers and the movement is felt on the opposite side jaw joint as the moves are performed. When the client has two finger knuckles spaced between their teeth the joint is opened wider and the moves are deeper within it as if the finger pads would melt through the joint to affect its deepest structures.

Moves 5 & 6

The client removes their fingers from between their teeth. Position the palmar aspect of the left 2nd finger onto the left posterior border of the mandible inferior to the left side condylar process and adjacent and anterior to the left side meatal cartilage of the left ear canal. Challenge anteriorly and move inferiorly over the attachments of the left lateral temperomandibular ligaments on the posterior mandible (5).

Repeat on the right side (6).

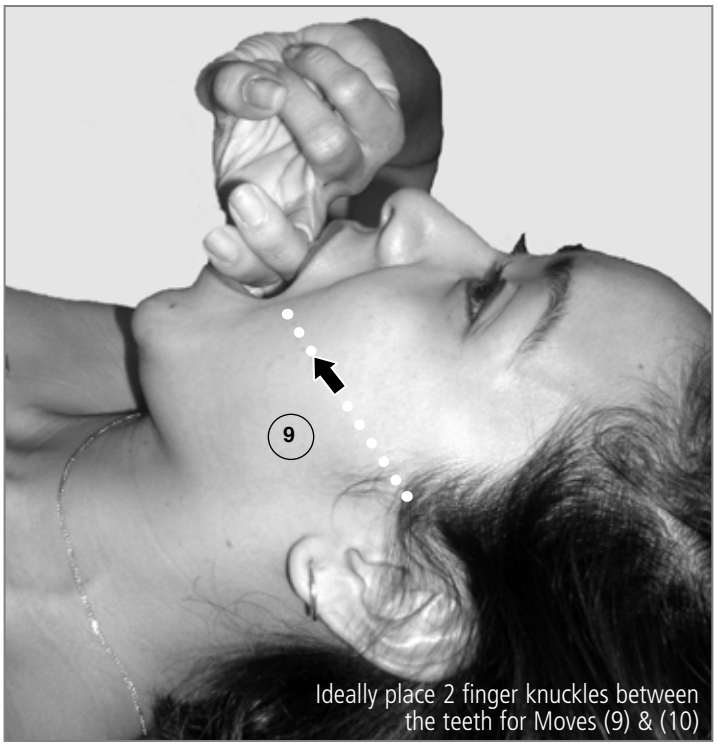
Moves 7 & 8

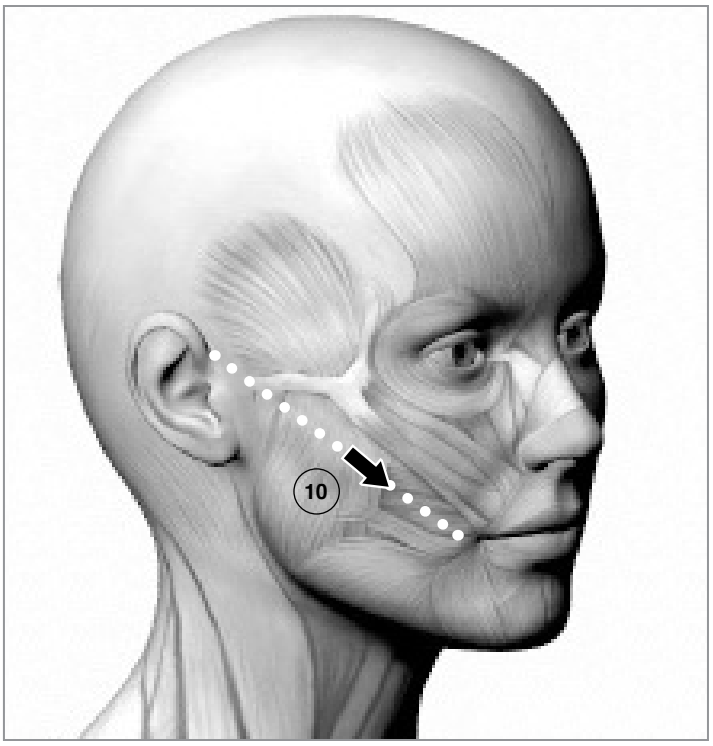
Have the client reposition ***two*** fingers, if possible, between their teeth and position the left palmar aspect of the 2nd finger onto the superficial temporal veins, arteries and nerves at a point one finger-width anterior to the superior meatal cartilage of the left ear, in the bald spot posterior to the hairline, sideburns, and in front of the ear where a pair of glasses would sit. Draw skin anteriorly, engage gentle challenge and move posteriorly over the neurovascular bundle of superficial temporal veins, arteries and nerves (7). Repeat on the right side (8).

Moves 9 & 10

With the client's one or two fingers still between their teeth landmark a point on the client's left and right cheeks by defining a midpoint between the corner of their mouth and the superior anterior insertion of the ear cartilage. This point is over the anterior border and inferior to the masseter insertion at the anterior of the lower border of the zygomatic arch. Place the palmar aspect of the left and right hands 3rd fingers onto the anterior border of the masseter muscle. Draw skin slack supero-posteriorly to the left ear engage challenge onto the left zygomatic arch. Wait for a 2nd exhalation and perform an infero-medial curved move with the left 3rd finger over the left masseter muscle (9). Draw skin slack supero-posteriorly to the right ear engage challenge onto the right zygomatic arch. Wait for a 2nd exhalation and perform an infero-medial curved move with the right 3rd finger over the left masseter muscle (10).

PROVIDE A MINIMUM 10 MINUTE PAUSE





THORACIC PROCEDURE
CHEST PAIN & SCOLIOSIS

Caution: Ensure that a competent medical opinion has been sought and provided for any chest symptoms that are new or old.

The Thoracic procedure is a simple protocol using familiar moves, it can be used to address either ***chest pain*** or ***scoliosis***. There is only one difference and that is. After using Thoracic Procedure to treat chest pain, no more treatment is given that day. Wheras, after using Thoracic procedure to treat scoliosis you can provide more treatment that day.

It combines variations of the following:

BRM 2 - Moves (1-8)
Respiratory Procedure Moves (1-5)
BRM 3 - Moves (1), (3) & (2), (4)
Or, Moves (2), (4) & (1), (3)
*Moves (5) & (6) are **NOT** performed*

CHEST PAIN

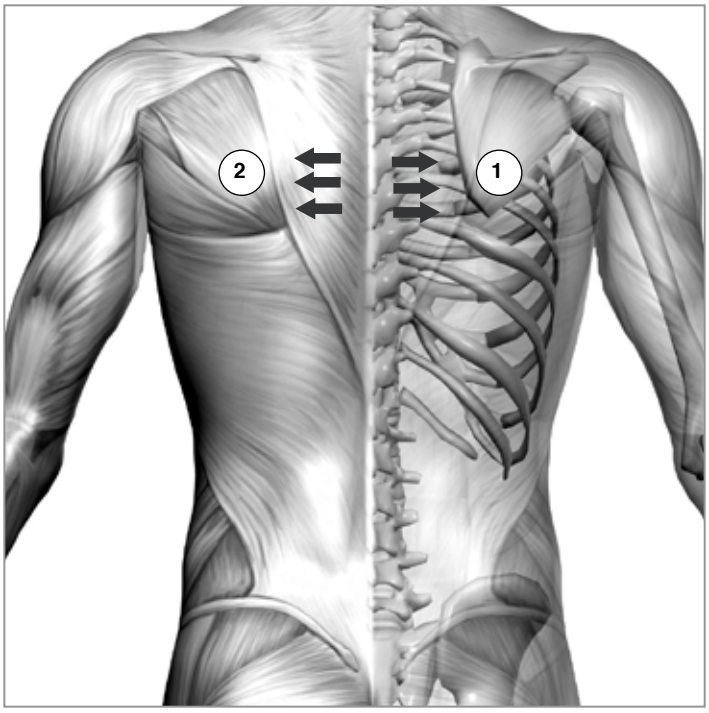
Minimum Prerequisite

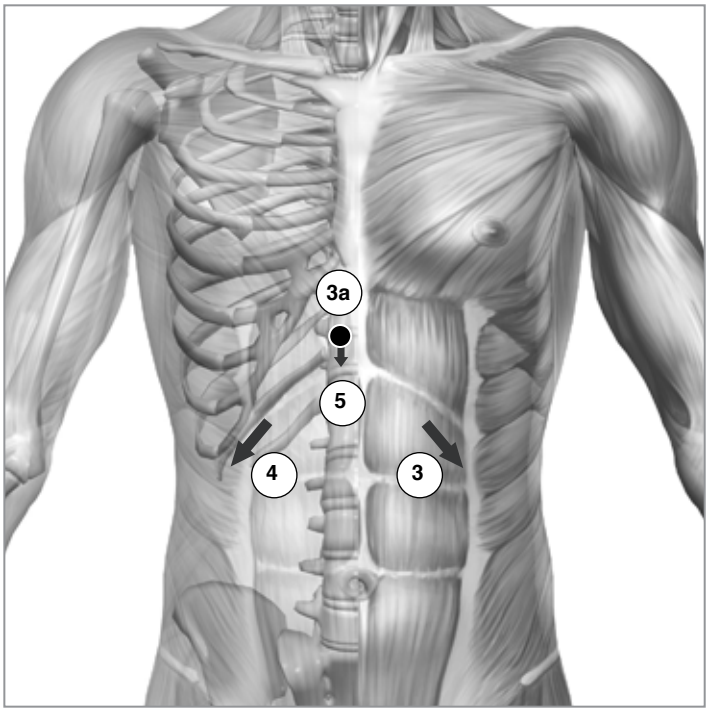
General 'balancing' Bowen Therapy treatment performed 1 Week prior, at this session minimally perform BRM 2 - Moves (1-8). BRM 1 (1-10) can also be applied if needed to help a client fully relax.

Indications

One-sided chest pain. The nature of the pains can be muscular, nerve, intercostal or related to respiration. The client should be under the care and medical supervision for any cardiac related disorders and the client must be stable before performing the following procedure.

If indicated for chest discomfort and one-sided chest pain the Thoracic procedure used to treat chest pain would complete treatment for that session and it should ***not*** be combined with any other Bowen Therapy procedures.





CHEST PAIN

Step 1

BRM 2 - Moves (1-8)
PAUSE

Step 2

Respiratory procedure - Moves (1-5)
PAUSE

Step 3 for *left* sided symptoms

Perform BRM 3 Moves (1) & (3) ~ (2) & (4).
Moves (5) & (6) are NOT performed.

Step 3 - for *right* sided symptoms

Perform BRM 3 Moves (2) & (4) ~ (1) & (3).
Moves (5) & (6) are NOT performed.
PAUSE

SCOlIOSIS

Step 1

Perform the prerequisite BRM 2 - Moves (1-16)
PAUSE

Step 2

Perform the Respiratory procedure - Moves (1-5)
PAUSE

Step 3

Perform BRM 3 Moves (1) & (3) ~ (2) & (4)
Moves (5) & (6) are NOT performed.
PAUSE

Alternate Each Visit the Left & Right Sides. In other words, choose to treat with BRM 3 Moves (1) & (3) ~ (2) & (4) the first weeks visit and then on the next use BRM 3 Moves (2) & (4) ~ (1) & (3), and so on.

If treating for chest pain or discomfort no further Bowen Therapy procedures should be applied after.

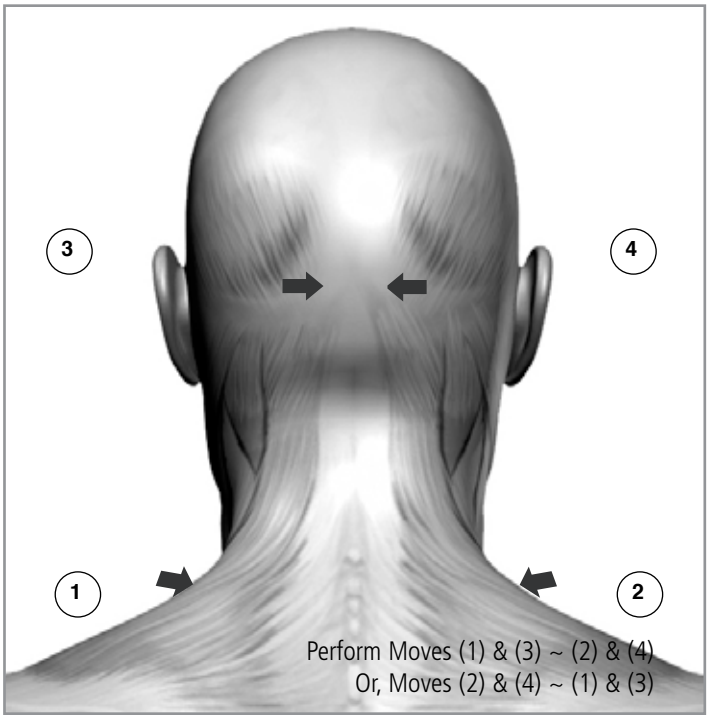
In treating scoliosis or other curvatures of the spine it is possible to perform additional procedures that are indicated for the client this session if the minimum prerequisites for them have been performed.

SCOLIOSIS PROCEDURE

Minimum Prerequisite

BRM 2 - Moves (1-16) at this session. BRM 1 (1-10) can also be applied if needed to help a client fully relax.
Respiratory Procedure Moves (1-5)

Following the use of Thoracic procedure for scoiliosis other clearly indicated procedures can be applied. Excepting those that require BRM 3 as a prerequisite, as BRM 3 (5) & (6) have not been used.



CHEST PROCEDURE

Minimum Prerequisite

None. The Chest Procedure can be performed in isolation or as part of any Bowen Therapy Session.

Indications

Lymphatic congestion
Breast discomfort, Cystic tissue
Mastitis
Shoulder problems and chest area discomfort

The procedure can be taught to clients to perform on themselves on a regular schedule to ease chest area congestion.

Contraindication

It is recommended that the Chest Procedure not be performed on anyone with pectoralis or breast implants. Or, on any client with a concern about or any client with breast cancer.

Discuss the Chest procedure with your client and gain their consent before performing it. It's advised to have a third party present and it is not necessary to expose the breast as the moves can be performed through clothing and even a padded bra.

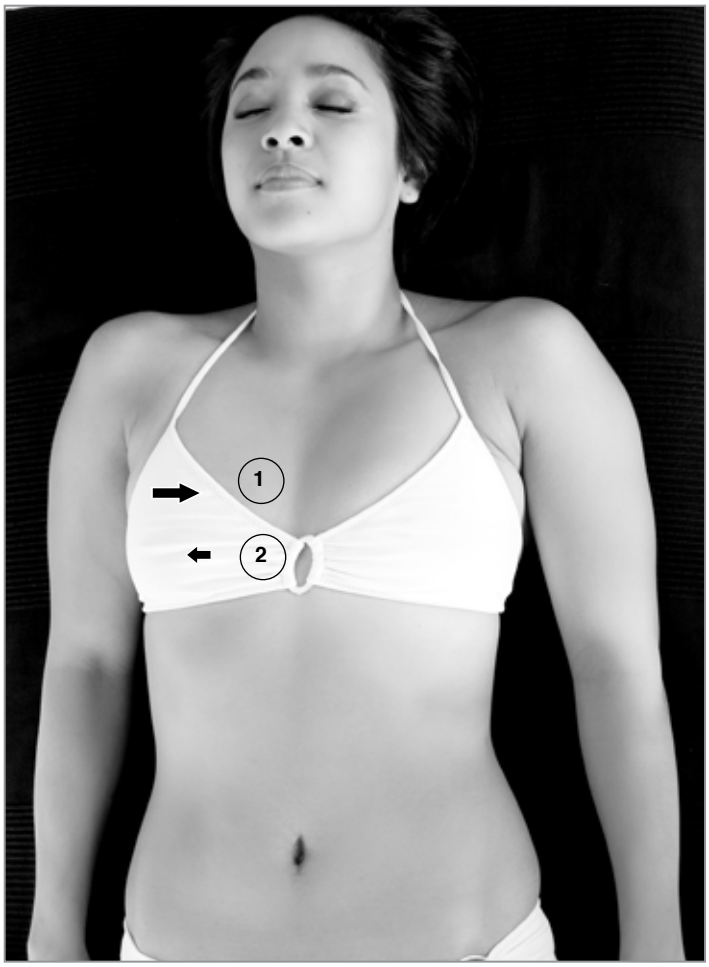
Treat the better side first. With the client lying supine stand at their right side to perform the procedure on the left side and stand on the left side to perform the procedure on the right side.

It is useful to guide the taking of slack while performing the moves by placing a marker such as a pen under the clients arm approximately two finger-widths distal to the axillary crease.

Note: Mr. Bowen performed this procedure with his hands back to back, his thumbs flexed into his palms, and his fingers extended, with the radial border of his index fingers resting on the body to perform the moves.

Move 1

With both hands back-to-back move the breast tissue inferiorly from a point inferior to the mid-clavicle. Use the inferior hands 2nd finger on its radial side to draw the breast tissue and skin slack inferiorly to the level of the marker. With the palmar aspect of the superior hands 2nd finger placed on the anterior fibres of the lateral border of pectoralis major, pectoralis minor and serratus anterior, located on line with the coracoid process. Push skin slack laterally with both hands and engage comfortable postero-medial challenge onto the lateral fibres of pectoralis major. While maintaining the depth of challenge using the palmar aspect of the superior hands 2nd finger move both hands medially over the lateral border of pectoralis major, pectoralis



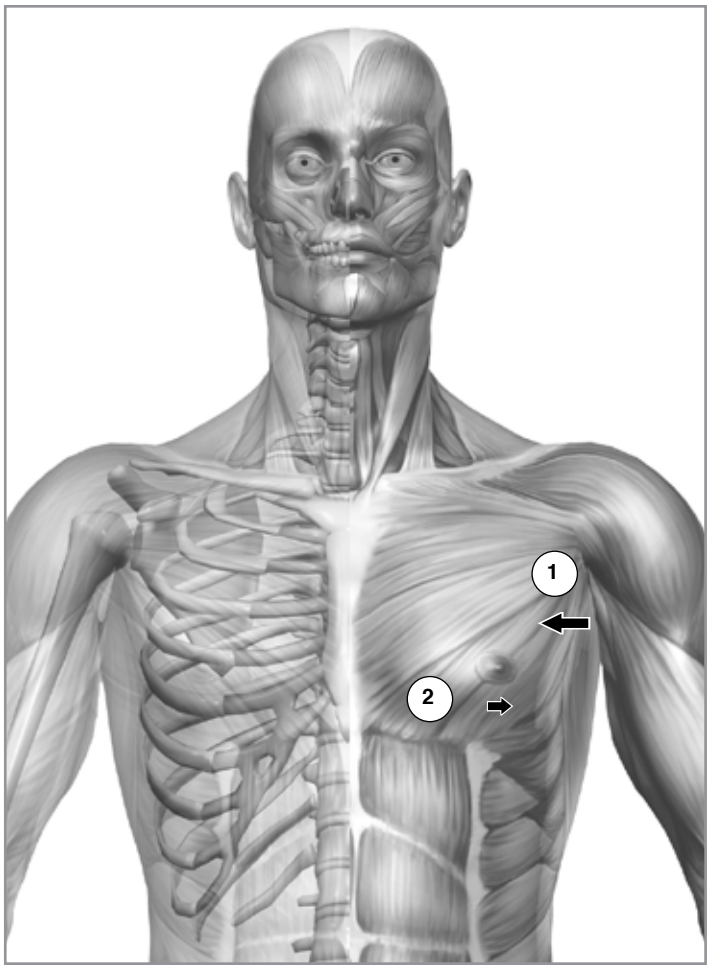
minor and serratus anterior beneath to release the muscle edge.

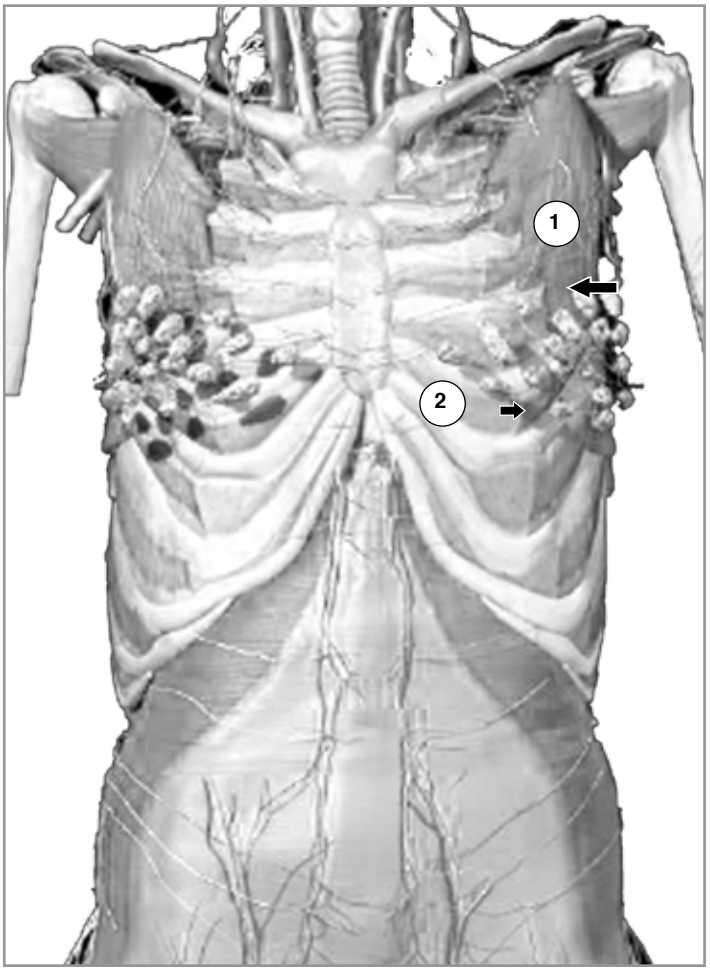
Move 2

With both hands back-to-back positioned at a point inferior to the breast and in line with the mid-clavicle move the breast tissue and skin slack superiorly. Use the radial side of the superior hands 2nd finger to push the breast tissue and skin slack superiorly to the level of the marker. Palpate for a depression or groove between the 5th and 6th ribs in line with the mid-clavicle with the palmar aspect of the tip of the inferior hands 3rd finger. Draw skin slack medially with both hands and engage comfortable posterior challenge with the inferior hands 3rd finger tip and move laterally through the groove of the ribs as far as the skin slack allows.

Stand at the opposite side and repeat Moves (1) & (2) on the opposite side.

PROVIDE A MINIMUM 5 MINUTE PAUSE





VAGUS NERVE PROCEDURE

Minimum Prerequisite

BRM 1 - Lower Back Procedure
BRM 2 - Upper Back Procedure
BRM 3 - Neck Procedure

Indications

The Vagus Nerve Procedure is indicated for the following symptoms:
Stomach and cardiac spasm
Low libido
Breathing difficulties
Difficulty swallowing
Chronic pain in rib cage
Diaphragmatic pain especially on left side
Pancreas, gallbladder and liver problems
Rapid heart beat
Tingling in first 3 fingers
Liver region sensitivity
Anxiety

Ensure that the client has received a clear medical diagnosis for any chest related symptoms and is under the care of a qualified medical practitioner.

Move 1

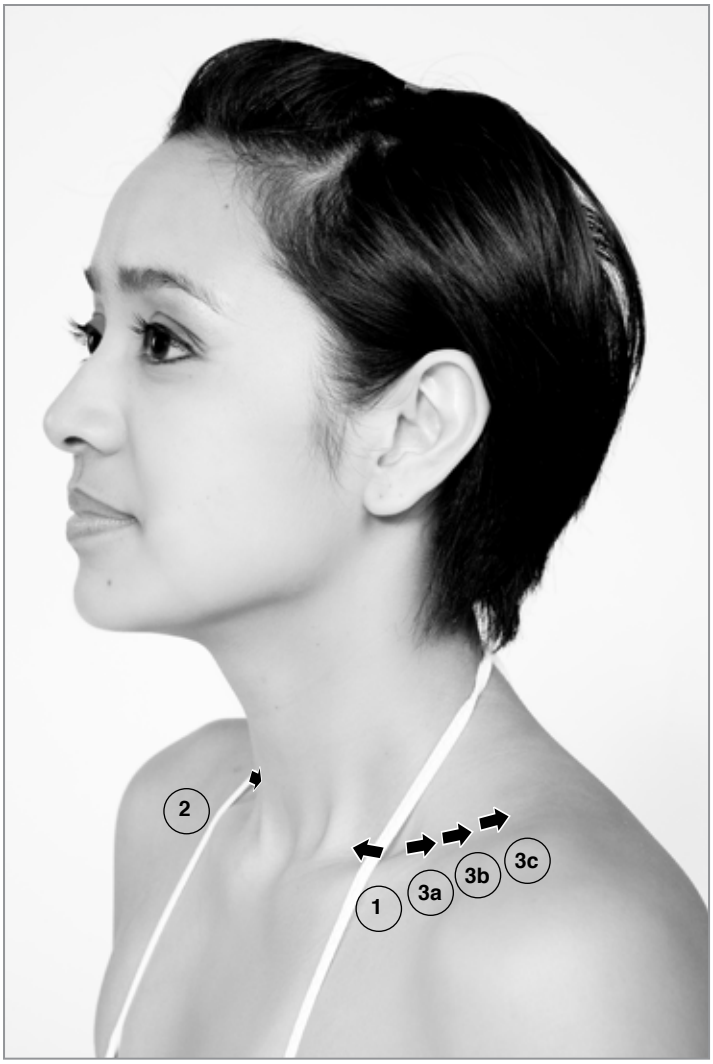
With the client lying supine stand at their left side position the palmar aspect of either hands 3rd finger onto a point adjacent and superior to the left clavical and the tip of the 3rd fingertip lateral to the sternal attachment of the sternocleidomastoid (SCM). Draw skin slack laterally along the superior border of the clavicle engage very gentle challenge and move medially over the omohyoid tendon and vagus nerve. The 3rd fingertip stops at the sternal attachment of the SCM.

Move 2

With the client lying supine stand at their right side position the palmar aspect of either hands 3rd finger onto a point adjacent and superior to the right clavical and the tip of the 3rd fingertip lateral to the sternal attachment of the sternocleidomastoid (SCM). Draw skin slack laterally along the superior border of the clavicle engage very gentle challenge and move medially over the omohyoid tendon. The 3rd fingertip stops at the sternal attachment of the SCM.

Moves 3a, 3b & 3c

Stand at the left side of the client and position the left 3rd finger supinated onto the posterior border of the clavicle adjacent and lateral to the omohyoid tendon. Perform 3 gentle lateral moves each one-finger width lateral to each other along the posterior edge of the left clavicle. The 3rd fingertip gently moves laterally with the belly of the inferior omohyoid muscle.

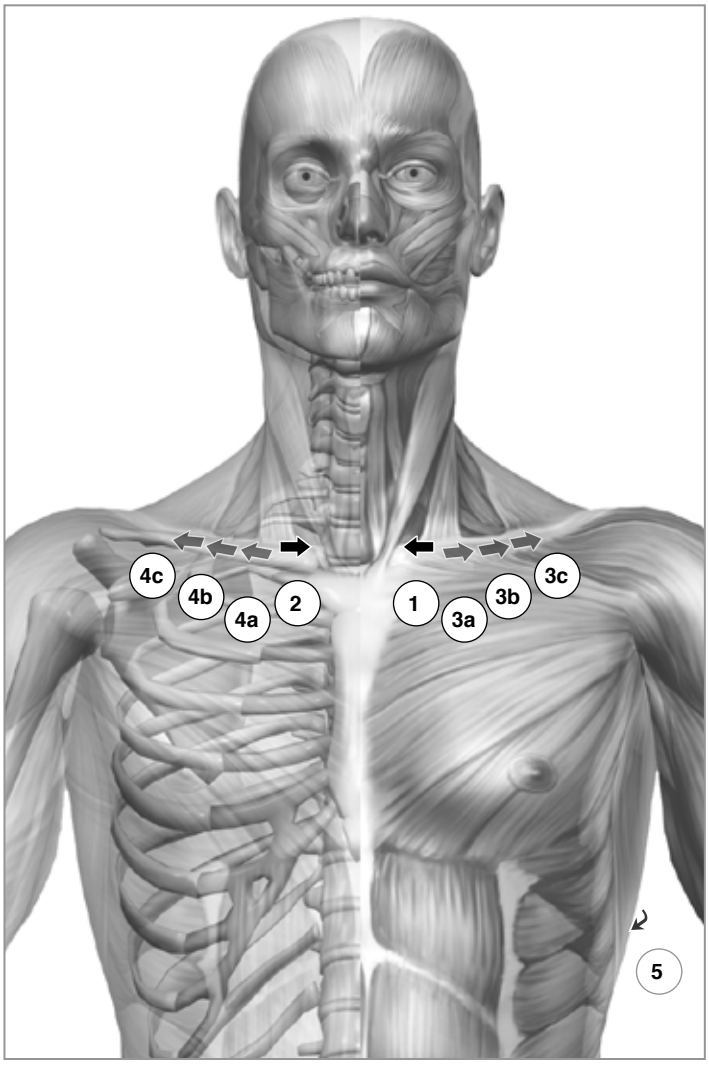


Moves 4a, 4b & 4c

Stand at the right side of the client and position the right 3rd finger supinated onto the posterior border of the clavicle adjacent and lateral to the omohyoid tendon. Perform 3 gentle lateral moves each one-finger width lateral to each other along the posterior edge of the right clavicle. The 3rd fingertip gently moves laterally with the belly of the inferior omohyoid muscle.

Move 5

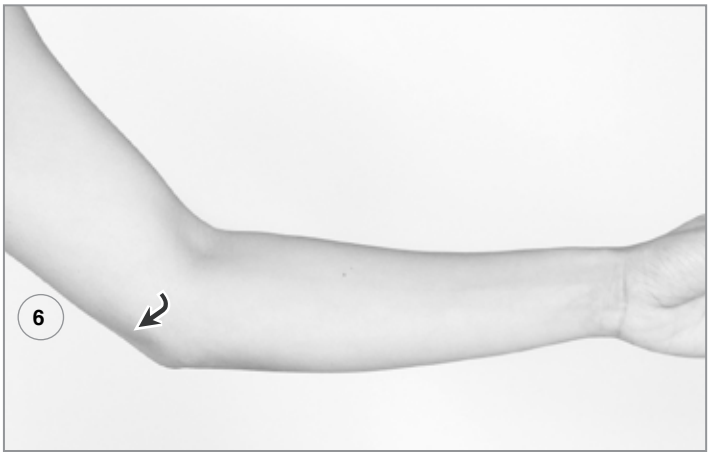
Stand at the client's right side and reach across to the left side with the right hand thumb touching the axilla and the fingers extended the 3rd finger should be approximately on a small neurovascular bundle located between the lateral margins of the 6th and 7th ribs. The bundle is sensitive to touch and it is acceptable to ask the client for feedback on the most sensitive spot. When located perform a gentle anterior move over it with the palmar aspect of the 3rd finger.



Move 6

Stand at the clients left side and perform Move (3) of the Elbow/Wrist Procedure. Position the right hands intermediate phalanx of the 3rd finger onto a point adjacent and proximal to the medial epicondyle. Bend the fingertip into the elbow crease and gently challenge the anterior border of the biceps brachii and neurovascular bundle. Move gently over the median nerve, neurovascular bundle and biceps brachi posteriorly.

PROVIDE A MINIMUM 10 MINUTE PAUSE



VAGUS NERVE ANATOMY

Vagus' means 'wanderer' - and that is indeed what these nerves are. Attached to the brain stem, and emerging through the base of the skull into the neck, the right and left vagus nerves innervate through their branches a widespread range of body parts, from the head down to the abdominal organs.

These nerves contain fibres that are both incoming to the central nervous system (the majority) and outgoing from it. Sensory information comes from the external ear and its canal, and from the back of the throat (pharynx) and upper part of the larynx. Longer fibres travel in the branches of the vagi from the organs in the chest and in the abdomen: from the lungs and the heart, and from the alimentary tract, including the oesophagus and right down to half way along the colon. The incoming signals lead to many reflex responses, mediated at cell stations in the brain stem, and entailing either autonomic or somatic motor responses. For example: irritants in the airways stimulate vagal sensory nerve endings and lead to a cough reflex; information on the state of inflation of the lungs causes modification of the breathing pattern; distension of the stomach leads to reflex relaxation of its wall. The outgoing, motor fibres in the vagus nerves represent most of the cranial component of the parasympathetic division of the autonomic nervous system.

Cardiovascular

Vagal stimulation slows the heartbeat, and excessive stimulation can stop it entirely. We know now that vagal nerve endings act on the heart's pacemaker by the release of the transmitter acetylcholine; this modulation of the heart rate is continuous, counterbalancing the action of the sympathetic nerves at the same site. The vagus nerves also provide a pathway for reflex reduction of the cardiac output if the blood pressure tends to rise.

Respiration

In the lungs, they stimulate the smooth muscle in the wall of the bronchial tree, tending to increase the resistance to airflow (by causing bronchoconstriction), again counterbalancing the sympathetic effect which tends towards relaxation.

Digestive

In the alimentary tract they stimulate smooth muscle in the walls of the stomach and of the intestines, acting through the nerve networks between the layers of smooth muscle, but they have the opposite action on the smooth muscle sphincter that tends to prevent the stomach contents from moving on.

Endocrine

They stimulate glandular secretions of stomach acid and of the digestive enzymes that are released into the stomach and intestine, and the ejection of bile from the gall bladder. They also influence the release from the pancreas of the hormones that promote the storage of absorbed nutrients.

All these effects add up to support of activity in the alimentary system during and after eating, when the parasympathetic effects predominate over the opposite quietening effects of the sympathetic nerve supply.

The term 'vaso-vagal' attack refers to fainting, when from a variety of causes ranging from emotional shock to the pain of injury - there is a strong parasympathetic outflow in the vagus nerves, causing slowing of the heart that leads to a fall in blood pressure sufficient to cause unconsciousness.

BURSITIS, CYSTS & OSTEOPHYTES

BURSA

There are hundreds of bursa scattered throughout the body. The function of a bursa is to decrease friction between two surfaces that move in different directions. Bursa can be thought of as a Ziplock bag with a small amount of oil and no air inside. Imagine rubbing this bag between your hands; movement of your hands would be smooth and effortless. A Bursa functions as a smooth, slippery surface between two moving objects.

Bursa are found at points where muscles and tendons glide over bones. Without the bursa between these surfaces, movements would be painful.

Bursitis is the inflammation of a bursa. Normally, the bursa provides a slippery surface that has almost no friction. A problem arises when a bursa becomes inflamed. The bursa loses its gliding capabilities, and becomes more and more irritated when it is moved. When the condition called bursitis occurs, the normally slippery bursa becomes swollen and inflamed. The added volume of the swollen bursa causes more friction within an already confined space. Also, the smooth gliding bursa becomes gritty and rough.

Bursitis can result from any repetitive movements or due to prolonged and excessive pressure. Similarly in other parts of the body, repetitive use or frequent pressure can irritate a bursa and cause inflammation. Another cause of bursitis is a traumatic injury. Following trauma, such as a car accident or fall, a patient may develop bursitis. Usually a contusion causes swelling within the bursa. The bursa, which had functioned normally up until that point, now begins to develop inflammation, and bursitis results. Once the bursa is inflamed, normal movements and activities can become painful. Systemic inflammatory conditions, such as rheumatoid arthritis, may also lead to bursitis. These types of conditions can make patients susceptible to developing bursitis.

Trochanteal Bursitis

Commonly a result of misalignment, injury or inflammatory processes of a hip joint, this painful inflammation is an inflammation between the bursa at the greater trochantor.

CYSTS

A cyst is an abnormal, sac-like structure that can be found anywhere in the body. Cysts usually contain a gaseous, liquid, or semisolid substance and have an outer wall, known as the capsule. Cysts may be small and visible only under a microscope, or they may grow to a very large size and displace normal body structures.

Cysts occur commonly in numerous tissues and organs and are often named according to their particular anatomic location.

Baker's Cyst

A swelling in the space behind the knee (the popliteal space) composed of a membrane-lined sac filled with synovial fluid that has escaped from the joint. Baker cyst is named after the British surgeon William Morrant Baker (1839-1896). Also called a synovial cyst of the popliteal space.

Ganglion Cyst

Is a tumor or swelling on top of a joint or the covering of a tendon attachment or insertion. It looks like a sac of liquid (cyst). Inside the cyst is a thick, sticky, clear, colorless, jellylike material. Depending on the size, cysts may feel firm or spongy. One large cyst or many smaller ones may develop. Multiple small cysts can give the appearance of more than one cyst, but a common stalk within the deeper tissue usually connects them. This type of cyst is not harmful and accounts for about half of all soft tissue tumors of the hand.

Ganglion cysts, also known as Bible cysts, are more common in women, and 70% occur in people between the ages of 20-40. Rarely, ganglion cysts can occur in children younger than 10 years. They most commonly occur on the back of the hand (60-70%), at the wrist joint and can also develop on the palm side of the wrist. When found on the back of the wrist, they become more prominent when the

wrist is flexed forward. Other sites, although less common, include:

- ~The base of the fingers on the palm, where they appear as small pea-sized bumps.
- ~The fingertip, just below the cuticle, where they are called mucous cysts.
- ~The outside of the knee and ankle the top of the foot

The cause of ganglion cysts is not known. One theory suggests that trauma causes the tissue of the joint to break down forming small cysts, which then join into a larger, more obvious mass. The most likely theory involves a flaw in the joint capsule or tendon sheath that allows the joint tissue to bulge out.

The ganglion cyst usually appears as a bump (mass) that changes size. It is usually soft, anywhere from 1-3 cm in diameter and doesn't move. The swelling may appear over time or appear suddenly, may get smaller in size, and may even go away, only to come back at another time.

Most ganglion cysts cause some degree of pain, usually following acute or repetitive trauma, but up to 35% are without symptoms, except for appearance. The pain is usually nonstop, aching, and made worse by joint motion. When the cyst is connected to a tendon, there may be a sense of weakness in the affected finger.

Bone Spurs

A bone spur (osteophyte) is an outgrowth of bone that can occur along the edges of a bone. It is also called an osteophyte. Bone spurs are can form in any bone, but are most commonly found in joints, where two or more bones come together. They also occur where muscles, ligaments, or tendons attach to the bone.

Some of the most common parts of the body affected by bone spurs are the neck (cervical spine), low back (lumbar spine), shoulder, knee, foot, and heel.

Bone spurs typically occur because of continued stress or rubbing of a bone for a prolonged period of time. This can be due to osteoarthritis or inflammation such as tendonitis. Normally there is a layer of cartilage along the edges of bones where they come together to form a joint. With osteoarthritis, this cartilage layer becomes worn away, and the bones can rub directly against each other. New bone forms in response to the stress or inflammation. It is the bone's method of trying to stabilize or protect itself.

There are other medical conditions that are commonly associated with bone spurs. These include a condition known as plantar fasciitis. This is an inflammation of the fascia or connective tissue where is attaches to the heel or calcaneus. Diffuse idiopathic skeletal hyperostosis (DISH) and ankylosing spondylitis are both inflammatory disorders that affect the body's ligaments and causes bone spurs in the spine.

Bone spurs do not always cause symptoms. Many people have bone spurs but do not know it. However, if bone spurs rub against other bones they can cause pain or a loss of normal motion in a joint. This is most common in the hips, knees, hands and feet.

If the bone spurs rub against tendons or ligaments they can cause pain or a tear. This is common in the shoulder and can lead to a rotator cuff tear.

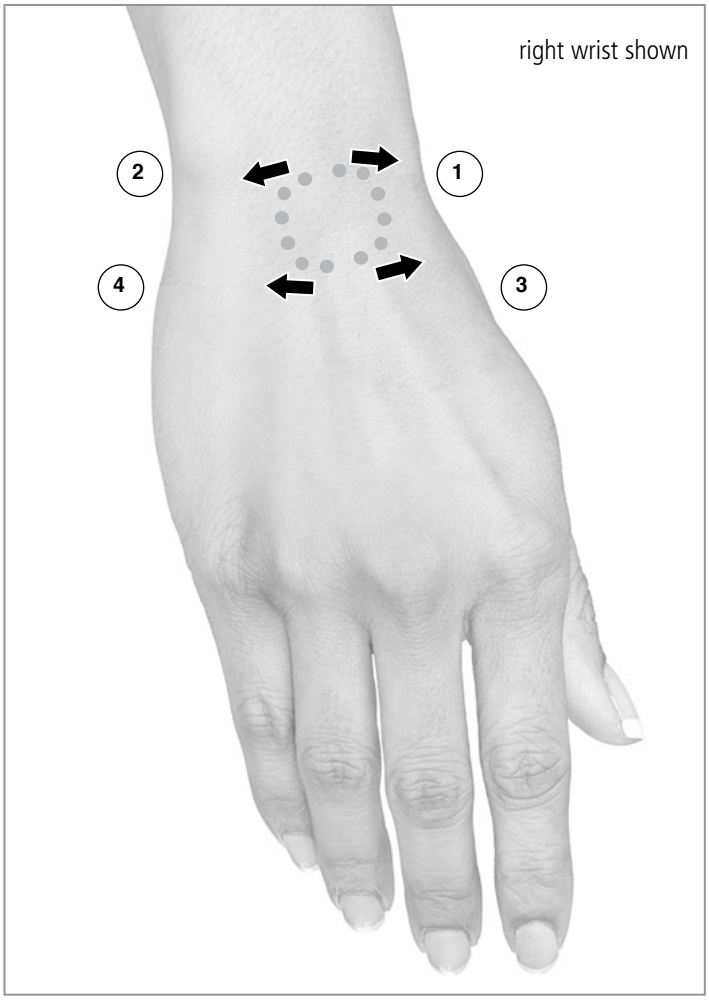
If bone spurs occur in the spine, they can cause pain and loss of motion, but they can also pinch the nerves or spinal cord. When nerves in the spine are pinched, it is known as radiculopathy. It can cause pain, numbness, tingling, or weakness in the arms or legs. If the spinal cord is compressed, it is called myelopathy. This can cause problems with balance, weakness, and pain.

BURSITIS PROCEDURE

Minimum Prerequisites
Perform the adjacent joint procedures with their appropriate prerequisites as well as the procedure for the joint in question.

Indicated for soft, hard, medium and small pockets of inflammation resulting from repetitive strain, injury or inflammatory processes elsewhere in the body such as, Ganglion cyst, Baker's Cyst, Osteophytes (Bone Spurs) & scar tissue or adhesions in the fascia. The Bursitis Procedure is used for the treatment of inflammatory processes adjacent to joint structures wherever there has been repetitive strain, injury or inflammatory process elsewhere that affects the structures causing even further pain and inflammation.

Ensure the client has received a competent medical diagnosis for any lumps they bring your attention to especially if they are not adjacent to a joint and tendon attachment.



The Bursitis Procedure can be repeated once weekly or more frequently if indicated. The procedure releases the congestion around the inflamed area and reduction of swelling and pain is clearly observable in more recent conditions, in long-standing symptoms the procedure may need to be repeated persistently.

The Bursitis Procedure utilizes two paired Bowen Moves away from the midline of the swelling and performed bi-laterally at the distal and then the proximal ends of it.

Move 1
Palpate the superior border of the bursa or cyst. Position the palmar aspect of either a thumb or finger onto the supero-medial border of the swelling, draw skin slack medially to the midline of the swelling and apply comfortable lateral challenge. Move laterally over the superior medial border of the swelling to the comfort of the client (1).

Move 2
Position the palmar aspect of either a thumb or finger onto the superior lateral border of the swelling, draw skin slack laterally to the midline of the swelling and apply comfortable medial challenge. Move medially over the supero-lateral border of the swelling to the comfort of the client (2).

Move 3 & 4
Perform a lateral and medial move at the distal margin of the swelling as per Moves (1) & (2) described above.

PROVIDE A MINIMUM 2 MINUTE PAUSE

AFTERCARE & EXERCISE

The application of anti-inflammatory ointments such as, Iodex ointment and apple cider vinegar and soaks in Epsom salts and Washing Soda are essential to continue the benefits of the Bowen Therapy procedure.

PSOAS PROCEDURE

Minimum Prerequisites
BRM 1- Lower Back Moves (1 & 2)
BRM 2 - Upper Back Moves (1-4) & Moves (9-16)
Kidney & Respiratory Procedure Moves (3-5)

If this procedure is indicated, attempt to resolve the condition with other appropriate procedures during previous sessions

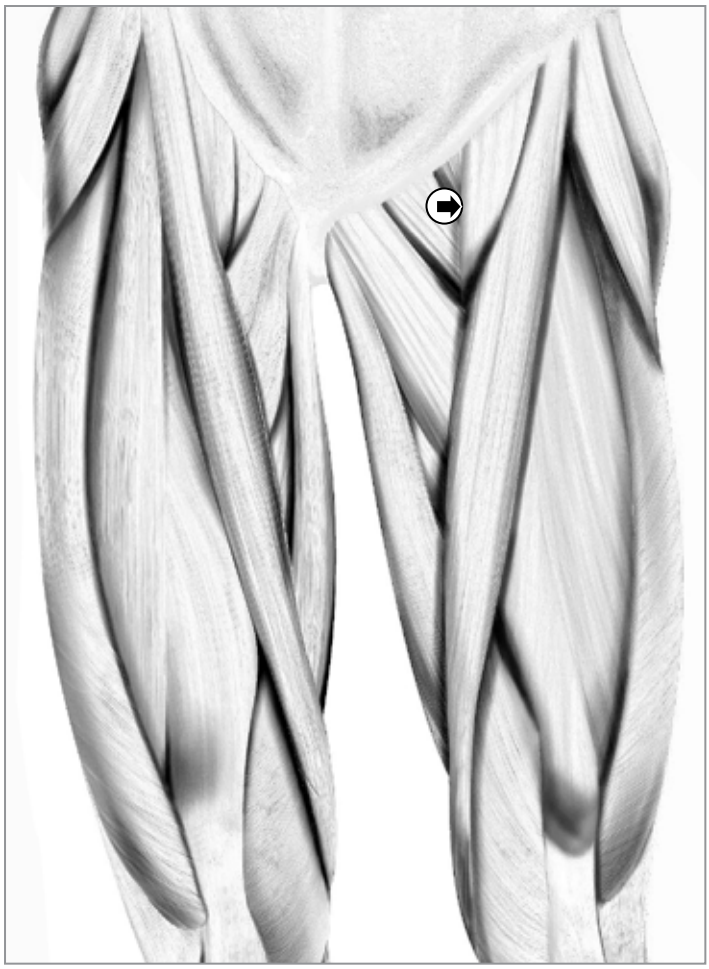
The Psoas Procedure is indicated for the following symptoms: Leaning forward at pelvis or lumbar lordosis, difficulty standing upright & unresolved groin pain and chronic relapsing Sciatica & Herniation. Observation of the client's free hand position at their thigh when standing as any asymmetry can indicate unevenness in the psoas group of muscles.

Anatomy
The psoas muscle originates from the transverse processes of all the lumbar vertebrae and the intervertebral discs above each lumbar vertebra from T12 to L5. It inserts and receives with the iliacus, the majority of the fibers of iliacus on its lateral side. The conjoined tendon of iliacus and psoas major attach into the lesser trochanter of the femur. With the origin fixed, it acts with iliacus to flex the hip joint.

Bend the clients knee and rotate it laterally to access the Psoas muscle. Support it with a pillow or on your own knee.

It is a major postural muscle and is a prime hip flexor. Its origins explain why this procedure may be of benefit to low back problems. This procedure is also beneficial for people who spend a lot of time seated or bending forward at the hips.

Immediately after completion of Respiratory Procedure Moves (3-5) and all other prerequisite procedures stand at the first side being treated or begin with the left side. Discuss the Psoas Procedure with the client or have a third party present when working on younger clients.



Move

Position your flexed knee onto the treatment table to support the client's flexed and externally rotated thigh. Using the 3rd finger of the superior hand palpate medially the inguinal crease to the medial 1/3 where a soft hollow adjacent and inferior to the inguinal crease gives access onto the insertion of the iliacus and the conjoined fibres of psoas major deeper to it. While challenging these fibres postero-laterally ask the client to define the sensitivity or pain they feel from the challenge on a scale of 1-10. The pain level needed to confirm location and depth of challenge is at a level of between 4-6.

The 3rd finger can be over the femoral artery while palpating and challenging for pain sensitivity, if the pulse of the femoral artery is felt re-position the medially and deeper while challenging more laterally to avoid it.

Use a second finger to secure the challenging 3rd finger and maintain the level of pressure at between 4-6. Gently turn the fingertip and challenge the psoas and iliacus muscles supero-laterally. After a second exhalation perform a supero-lateral activation. The activation will feel as if the 3rd finger slips over one or more of the fibrous insertions of iliacus and psoas major. The client will feel an increased level of sensation after this.

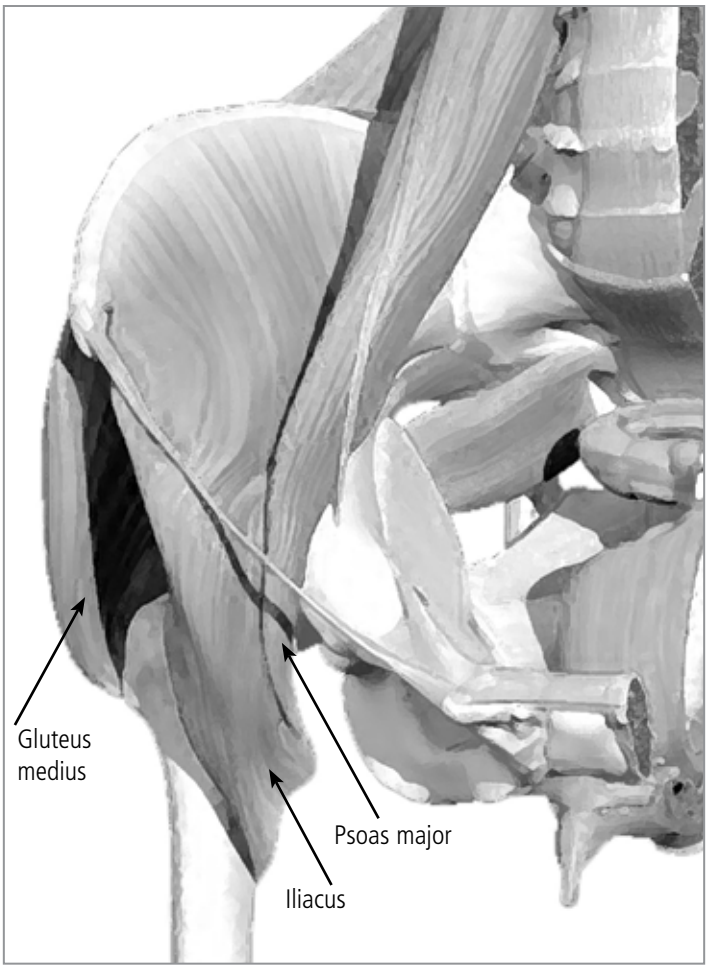
Return the clients limb to the treatment table and stand at the client's other side to perform the Move on the opposite limb.

PROVIDE A MINIMUM 15 MINUTE PAUSE

No other procedures should be performed this session

AFTERCARE & EXERCISE

Have the client sit comfortably upright on a chair or bed and position a firm pillow or exercise ball between their knees. Stand the feet onto the toes to raise the knees above the level of the hips and squeeze the pillow or ball together for a few seconds, the effort is focused at the groin where the psoas, iliacus and adductor longus are exerted. Relax and repeat 6 X once daily.



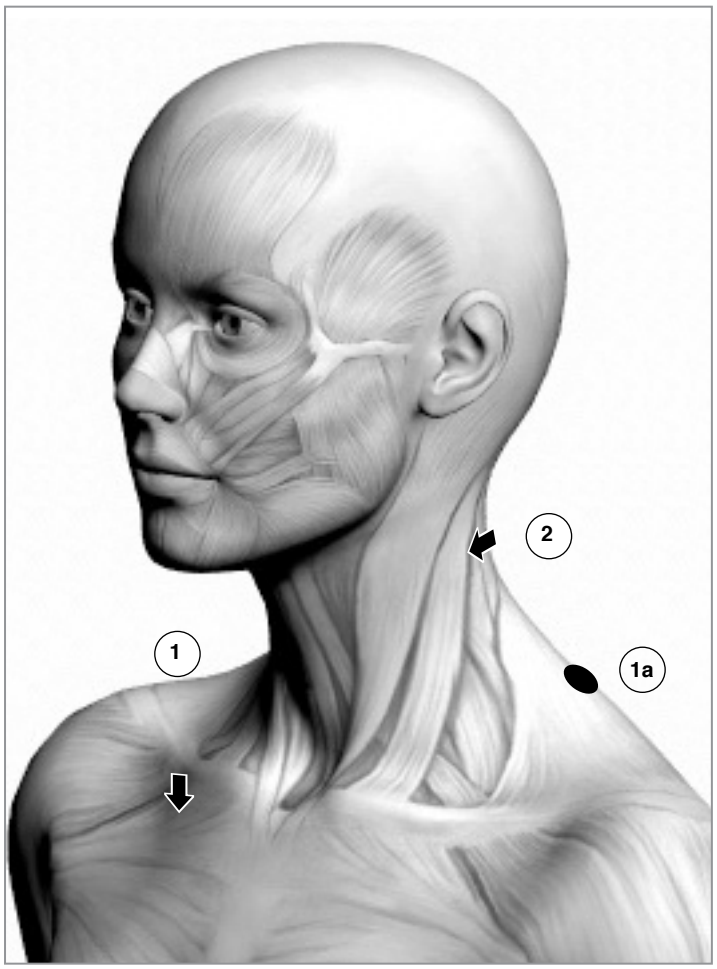
LEVATOR TRAPEZIUS PROCEDURE

Minimum Prerequisites
BRM 2 - Upper Back Procedure
BRM 3 - Neck Procedure

This simple and effective procedure is an essential tool in the treatment of the chronically tight necks and shoulders of people who come for Bowen Therapy. The Levator Trapezius Procedure is usually indicated for use at follow-up sessions when there has been little or no effect to the tension in the trapezius muscles and the levator scapulae deeper to them, often one side is worse than another. The procedure can be used on one side only but is chiefly indicated for use bi-laterally.

Symptoms indicating its use are quite clear as the client will complain of tightness in the top of their shoulders, be sure to ask the location of their symptoms, or the tension is felt when performing other moves. The pain in this area can be extreme and there is often a palpable inflammation in the levator scapulae when performing BRM 2 Moves (6) & (8). The tension is sometimes unchanged until this procedure is performed, even after many visits and many well-indicated procedures have been utilized.

Holding Point (1a)
With the client sitting or standing face the anterior side of the shoulder being addressed first. With the palmar aspect of the lateral hands 3rd finger palpate the trapezius muscle at a point superior to the medial angle of the scapula and at a mid-point between it and the anterior border of the trapezius. Ask the client for feedback as you palpate for the point of maximum inflammation and sensitivity (1a). Once this point is found rest the 3rd finger on it and position the palmar aspect of the medial hands 3rd finger onto the deltopectoral triangle of the opposite shoulder at a point inferior to the clavicle and adjacent and medial to the coracoid process (1).



Move 1

Re-secure the lateral hands 3rd finger onto the trapezius muscle and the levator scapulae deeper to it and engage firm and focused inferior challenge (1a). Push skin slack with the medial hands 3rd finger superiorly over the superior border of the pectoralis major to its superior insertion adjacent and inferior to the inferior border of the clavicle and ask the client to take 2 deep breaths. Engage inferior challenge and on a second exhalation move inferiorly over the superior border of the pectoralis major muscle insertion, the move is short and precise. At that moment there should be a release of tension that is felt in the 'holding point' (a). Repeat if it is not clearly felt.

Repeat on the opposite side.

PROVIDE A MINIMUM 5 MINUTE PAUSE

Move 2 - Optional

Position the palmar aspect of the 3rd finger onto the posterior margin of the levator scapulae approximatel 2 finger-widths inferior to its insertion or approximately at the level of the mandible (jaw line) on the side of the client's same side neck. Push skin slack posteriorly and engage anterior challenge on the client's exhalation move anteriorly over the levator scapulae.

Consider: North, Rhomboids, Sternum, Chest, West and various Shoulder Procedures.