



When setting up and performing low back joint mobilization, it is critically important that the client's spine is torqued as little as possible. Make sure that the client's shoulders and hips are as stacked as possible.

joint mobilization of the low back

When addressing the musculoskeletal system, perhaps the number one objective of massage therapy is to restore motion to taut soft tissues. Muscles and tendons, ligaments, joint capsules, and other dense and loose fascial tissues can accumulate fascial adhesions and become inflexible. Muscle tissue can also become tight because of increased muscle contraction tone. In turn, these taut soft tissues result in decreased joint motion. In the spine, decreased motion at a specific joint level, for example the L1-L2 level, is called a “segmental hypomobility.”

To improve soft tissue flexibility and joint range of motion, massage therapists can use a combination of bodywork techniques, including massage strokes, heat and stretching. However, there are times when massage and heat followed by broad stretching is not effective—especially when the taut tissue is located at a segmental hypomobility because adjacent segmental levels compensate and become hypermobile by increasing their range of motion. As a result, broad stretches result in further stretching of these hypermobilities instead of

the hypomobility.

In these cases, joint mobilization is an extremely effective technique. Joint mobilization can be viewed as being a form of pin and stretch. However, instead of aiming to stretch large muscles, muscle groups and myofascial meridians, the aim of spinal joint mobilization is to stretch the smaller intrinsic muscles, ligaments and other fascial tissues at a specific segmental joint level. This is accomplished by pinning/stabilizing one vertebra while the adjacent vertebra is pre-stretched and then mobilized, thereby stretching the intrinsic soft tissues between them.*

The Low Back

When performing joint mobilization of the low back, stabilizing the spine can be challenging. It is usually best accomplished by positioning the client so that her body weight stabilizes the upper lumbar spine while the lower lumbar spine or pelvis is mobilized. The client should be placed in a side-lying position. The figures in this article demonstrate the client in a left side-lying position

*Joint mobilization of the spine should not be performed on clients who have a pathologic disc, spinal stenosis, and/or marked degenerative joint disease (osteoarthritis) of the spine at that level, unless approval is given by their physician.

Before practicing any new modalities or techniques, check with your state's massage therapy regulatory authority to ensure that they are within the state's defined scope of practice for massage therapy.

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Figure 1



Figure 2

so that the pelvis and lumbar spinous processes (SPs) can be mobilized into right rotation (note: rotating an SP to the right is technically termed left rotation of a vertebra).

Figure 1 demonstrates the client starting in a left side-lying position near the edge of the table. Figures 2 and 3 show how to place the client's arms. In Figure 2, the client's left (table-side) arm is gently pulled outward to roll her onto the back of her shoulder. Figure 3 shows that her left hand is then placed on the side of her body wall, while her right arm is relaxed and hanging off the side of the table. It is extremely important that the client's upper back is not torqued (twisted), and her shoulders remain as vertically stacked as possible.

To position the client's right lower limb, the therapist flexes the client's hip and knee joints, first with his hands and then with his left (rear) thigh. This is done until the therapist can feel tension in the soft tissues of the client's low back/pelvis with his left hand (Figures 4 and 5). Note that the therapist is facing the cephalad (head) end of the table.

The next step is the most challenging aspect of this joint mobilization procedure: the therapist lifts his left (rear) foot off the floor until he can contact the client's right knee with his left thigh (Figure 6). The method is

the client where her pant pocket would be.

When doing this, the therapist rests his left hand on the client's posterior pelvis, stabilizing her upper trunk by placing his right hand over the hand she has on her body wall. When pressing on the client's hand/body wall, be sure you press in a cephalad direction, not a posterior direction, so that the client's spine is not unnecessarily torqued. The challenge in performing this step is to maintain the stretch/tension in the client's low back/pelvis. It's also critically important that the client's lower spine is not torqued. When done properly, there will be no twist in the client's upper or lower back. Her shoulders will remain essentially stacked, and her hips will also be stacked. You should look for her posterior superior iliac spines (PSISs) and anterior superior iliac spines (ASISs) to be vertically stacked.

The therapist now gently but firmly lets his body weight sink down onto the client's right thigh, bringing her right thigh down off the side of the table. Movement of the thigh pulls on the client's right pelvic bone, creating a stretch tension at her right sacroiliac joint. Movement of her thigh and pelvic bone can be assisted by the therapist's left hand, positioned on the client's pelvis. Once done, for proper balancing and body mechanics, the therapist stands at the head of the table, upper trunk

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