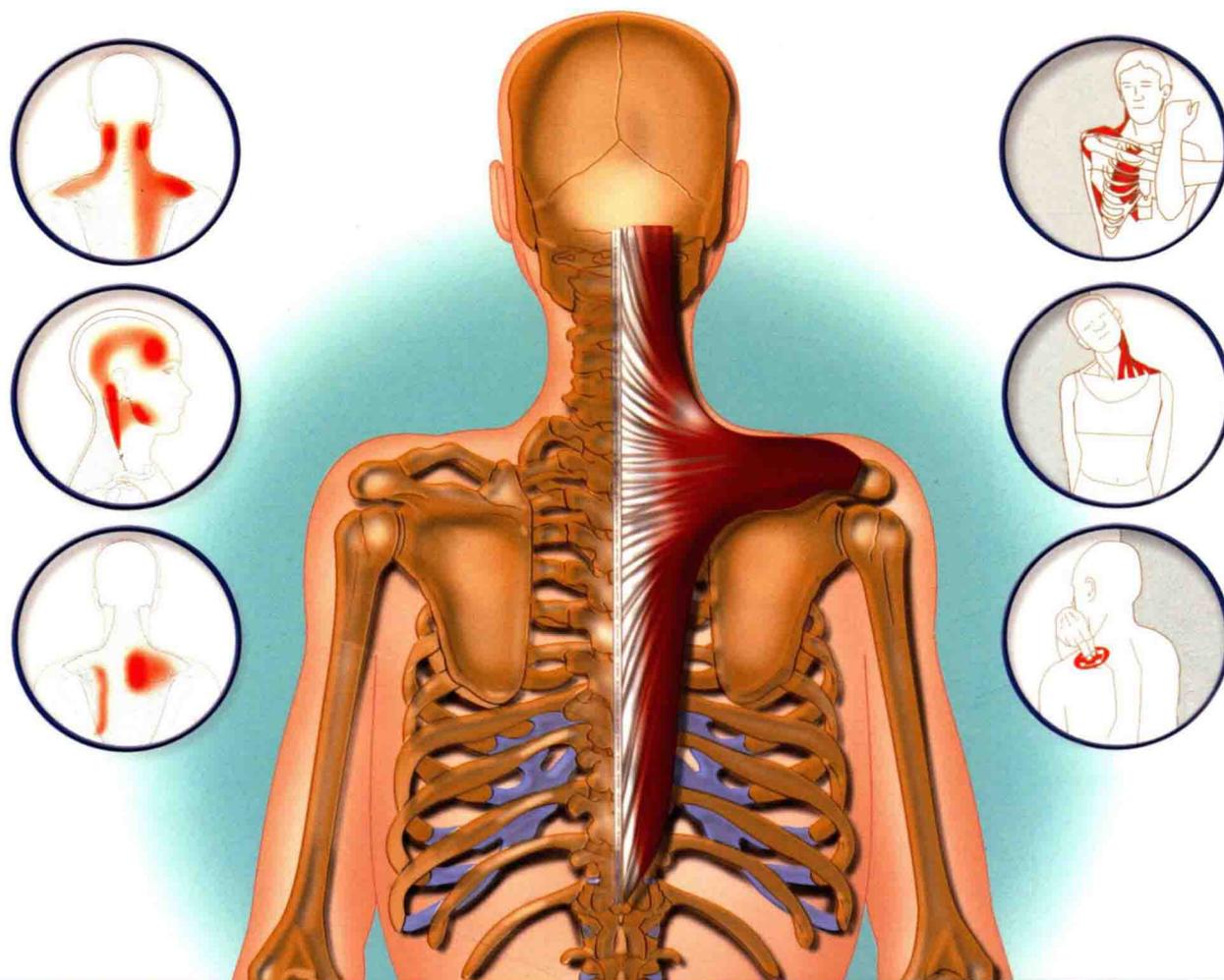


3<sup>RD</sup> EDITION

THE  
CONCISE BOOK  
OF  
TRIGGER  
POINTS

A PROFESSIONAL AND SELF-HELP MANUAL



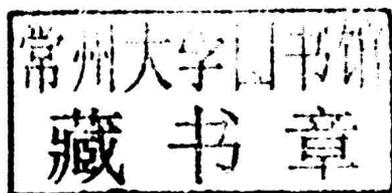
SIMEON NIEL-ASHER

# The Concise Book of Trigger Points

A Professional and  
Self-Help Manual

Third Edition

**Simeon Niel-Asher**



lotus  
publishing

Chichester, England



North Atlantic Books  
Berkeley, California

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**The Concise Book of Trigger Points** is sponsored by the Society for the Study of Native Arts and Sciences, a nonprofit educational corporation whose goals are to develop an educational and crosscultural perspective linking various scientific, social, and artistic fields; to nurture a holistic view of arts, sciences, humanities, and healing; and to publish and distribute literature on the relationship of mind, body, and nature.

#### **Dedication**

To my wife, sons, mother, friends, family, and wonderful patients.

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# Preface

Welcome to the start of an exciting journey. I know there are many books on trigger points out there and I would like to thank you for reading this one. I was asked to write the first edition of the *Concise Book of Trigger Points* in 2003 and am delighted that, since its publication, the book has been translated into over 20 languages and become a best seller worldwide. Now, over 10 years later, I have completely updated and revamped the content. I am pleased to share current research, evidence, and advanced techniques for manual therapy practitioners, as well as simple self-help protocols that can do at home.

Many of you reading this book are suffering needlessly from pain and disability. So much of this can be relieved quickly and efficiently with simple trigger point therapy. My hope and prayer for you is that you will find relief in the pages of this book.

Simeon Niel-Asher 2014  
[www.nielasher.com](http://www.nielasher.com)

# Abbreviations

ACh	Acetylcholine	NAT	Niel-Asher technique
AIS	Anterior inferior iliac spine	NLP	Neurolinguistic programming
ANS	Autonomic/automatic nervous system	NMDA	N-methyl-D-aspartate
ASC	Anterior sagittal chain	NMT	Neuromuscular technique
ASIS	Anterior superior iliac spine	OMT	Osteopathic manipulative medicine
ATP	Adenosine triphosphate	PID	Pelvic inflammatory disease
BK	Bradykinin	PIR	Post-isometric relaxation
CRHR	Contract and relax/hold and relax	PMR	Polymodal receptor
CNS	Central nervous system	PNF	Proprioceptive neuromuscular facilitation
CNSP	Cortico neuro somatic programming	PNS	Peripheral nervous system
COPD	Chronic obstructive pulmonary disease	POL	Posterior oblique link
DAC	Deep anterior chain	PRT	Positional release technique
DSM	Deep stroking massage	PSC	Posterior sagittal chain
EMG	Electromyogram	PSLE	Primary short lower extremity
ENT	Ear, nose, and throat	RI	Reciprocal inhibition
GCA	Giant cell arteritis (temporal arteritis)	RSI	Repetitive strain injury
GI	Gastrointestinal	RTA	Road traffic accident
GTO	Golgi tendon organ	SCS	Strain–Counterstrain
HLA	Human leukocyte antigen	SCM	Sternocleidomastoideus
ICT	Ischemic compression technique	SLE	Systemic lupus erythematosus
IMES	Intramuscular electrotherapy stimulation	SNS	Sympathetic nervous system
IMS	Intramuscular stimulation	SR	Sarcoplasmic reticulum
IT	Iliotibial	STP	Super trigger point
ITPH	Integrated trigger point hypothesis	TCM	Traditional Chinese Medicine
LC	Lateral chain	TFL	Tensor fasciae latae
LTR	Local twitch response	TMJ	Temporomandibular joint
MEP	Motor endplate	TMJD	Temporomandibular joint disorder
MET	Muscle energy techniques	TPR	Trigger point release
MLD	Manual lymphatic drainage		
MT	Myotherapy		
MTP	Myofascial trigger point		

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# Introduction

## About Me

I learned about osteopathy from my great-uncle Sidney Roseneil when I was 14; he was an osteopath, acupuncturist, and naturopath in the 1960s, a time of great change in modern medicine. The notion of the body being encouraged to heal itself resonated within me even then. Osteopathic manipulative medicine (OMT) emphasizes the innate ability of the body to heal itself and teaches techniques to bring out this “semi-automatic” response. The body has self-regulatory and self-healing mechanisms that still outmaneuver and outsmart modern medicine. Through my work as an osteopath I learned to feel and understand the powerful and pre-verbal “language of touch.” When I was introduced to trigger points (TPs) in my second year of college I just knew that I had found something special. I spent the next two and a half years, along with a couple of friends every weekend, visiting, learning, and watching David Warren, D.O., “the master” at work.

Since graduating in 1992 I have been working as a busy osteopath, researcher, student, and teacher. For over 22 years I have been privileged to meet and help many thousands of patients. I have been blessed with many gifts, a great family, great friends, and a wonderful, international career. I have met amazing people and been a part of their healing journey. I have been flown all around the world and worked with pop stars, Hollywood actors and actresses, gurus, politicians, and Olympians. In 1999 I developed and pioneered an advanced trigger point technique called the *Niel-Asher technique* (NAT). All this because I learned and understood one of the best kept secrets in pain medicine—*trigger point therapy*.

## About You

Acute and chronic pain are highly motivating signals. When we are in pain we are vulnerable and will often try anything that is suggested. You may have been to the doctor and had MRIs and blood tests only to be given medication and sent away or told there is nothing wrong with you! Or worse—it is all in your mind. You may have tried physical therapy, nutrition, diets, acupuncture, chiropractic, osteopathy, massage, Bowen technique, Pilates, and so on, all to no avail. In the information age we are all increasingly bombarded with a bewildering array of new drugs, fad diets, therapies, and therapists, all “selling their wares.”

Trigger point therapy is the *real deal*: it works fast, it is low cost, it is reproducible, it is evidence based, and it is easy to master. So why do all doctors and manual therapists not practice or know about it? The truth is that in time they all will. Many practitioners use trigger points every day in their work one way or another, even if they do not know it. Learning how to use them properly increases the efficiency, speed, and efficacy of treatment.

## About Pain

Muscular (myogenic) pain and dysfunction can arise from many factors, such as trauma, chronic postures, sports injuries, and systemic disease. Muscular pain is a key part of our protective and defense mechanism. Pain is a valuable alarm bell to tell us something is wrong.

Furthermore, trigger points have been implicated in a range of conditions and they can often mimic others. Conditions ranging from headache, earache, and toothache, to back pain, tennis elbow (lateral epicondylitis), and even dizziness often have a trigger point at their very core.

In this book you are going to learn how to identify the source of your pain and apply effective and simple home relief. For those therapists already working with trigger points, I hope you will find this guide concise, practical, clinically relevant, and useful. In Chapters 4 and 5 I have included advanced techniques, such as dry needling, spray and stretch, proprioceptive neuromuscular facilitation (PNF), advanced hands-on positional release techniques (PRTs), and basic NAT protocols.



### A Note About Peripheral Nerve Supply

The nervous system comprises:

- The central nervous system (CNS)—i.e. the brain and spinal cord.
- The peripheral nervous system, including the autonomic nervous system—i.e. all neural structures outside the brain and spinal cord.

The peripheral nervous system consists of 12 pairs of cranial nerves and 31 pairs of spinal nerves (with their subsequent branches). The spinal nerves are numbered according to the level of the spinal cord from which they arise (the level is known as the *spinal segment*).

The relevant peripheral nerve supply is listed with each muscle presented in this book, for those who need to know. However, information about the spinal segment\* (Figure 2) from which the nerve fibers emanate often differs between the various sources. This is because it is extremely difficult for anatomists to trace the route of an individual nerve fiber through the intertwining maze of other nerve fibers as it passes through its plexus (plexus = a network of nerves; from the Latin word meaning “braid”). Therefore, such information has been derived mainly from empirical clinical observation, rather than through dissection of the body.

In order to give the most accurate information possible, I have duplicated the method devised by Florence Peterson Kendall and Elizabeth Kendall McCreary. Kendall & McCreary (1983) integrated information from six well-known anatomy reference texts, namely those written by Cunningham, deJong, Foerster & Bumke, Gray, Haymaker & Woodhall, and Spalteholz. Following the same procedure, and then cross-matching the results with those of Kendall & McCreary, the following system of emphasizing the most important nerve roots for each muscle has been adopted in this book.

Let us take the supinator muscle as our example, which is supplied by the deep radial nerve, C5, **6**, (7). The relevant spinal segment is indicated by the letter [C] and the numbers [5, **6**, (7)]. Bold numbers [e.g. **6**] indicate that most (at least five) of the sources agree. Numbers that are not bold [e.g. 5] reflect agreement by three of four sources. Numbers not in bold and in parentheses [e.g. (7)] reflect agreement by two sources only, or that more than two sources specifically regarded it as a very minimal supply. If a spinal segment was mentioned by only one source, it was disregarded. Hence, bold type indicates the major innervation; not bold indicates the minor innervation; and numbers in parentheses suggest possible or infrequent innervation.

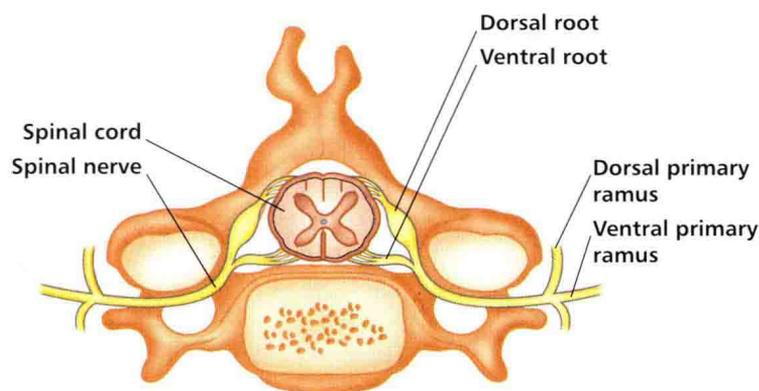


Figure 2: A spinal segment, showing the nerve roots combining to form a spinal nerve, which then divides into ventral and dorsal rami.

\* A spinal segment is the part of the spinal cord that gives rise to each pair of spinal nerves (a pair consists of one nerve for the left side and one for the right side of the body). Each spinal nerve contains motor and sensory fibers. Soon after the spinal nerve exits through the foramen (the opening between adjacent vertebrae), it divides into a dorsal primary ramus (directed posteriorly) and a ventral primary ramus (directed laterally or anteriorly). Fibers from the dorsal rami innervate the skin and extensor muscles of the neck and trunk. The ventral rami supply the limbs, plus the sides and front of the trunk.



# 1

## Healing Yourself through Self-Help Techniques

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### A True Story

Let us begin with a true story about John, who, according to his mother, was a “very, very sick little boy”; he nearly died of scarlet fever just before his third birthday. By the age of five he had developed whooping cough and chicken pox, and he was left with shaky health. In his teens, even though he played lots of sports and tried to stay healthy, John developed digestive problems; at age 14 he weighed 95 pounds. He was (eventually) diagnosed with colitis and celiac disease. John also suffered from back pain. At age 17 his father was so concerned that he sent John to the Mayo clinic in Rochester, Minnesota, where he was eventually diagnosed with Addison’s disease of the adrenal glands (hypothyroidism).

In the course of time, John developed muscular pain. His problems started after a spinal accident during military service, as a result of which John underwent major back surgery. This was only partially successful, so he was treated with drugs and a back brace, but his pain got worse and worse; according to his brother it was a “constant source of difficulty.” As time went on, he could not touch his toes or even do up his shoelaces. Sometimes he had to use crutches, and he was on constant medication. This medicine helped him temporarily but also left him with unwanted side effects, such as depression, osteoporosis, chronic constant muscular pain, and muscle spasms.

### Janet and John

Finally, when John was in his late 30s, a friend introduced him to the “controversial but brilliant” MD Dr. Janet Travell, who was pioneering a new type of treatment called *myofascial trigger point therapy*. She treated him regularly and also recommended him heel lifts and a rocking chair to ease his pain. After only a few weeks John started getting better: for the first time in his life he was able to manage and reduce his pain. In fact, her treatments were so “profoundly successful” that she helped John to achieve and sustain his wonderful career—a career that changed the world!

John finally found the relief from his pain that had eluded the most eminent of doctors; his problems were mechanical—his muscles had developed trigger points. Dr. Travell's treatment was 'natural', mechanical, and simple; she had found a way to release hidden pain-codes locked within his muscular system. John publically acknowledged Dr. Travell's work and soon after he became the President of the United States, he appointed Janet as his "Personal Physician", the first woman and one of the few civilians to hold that post. Dr. Travell continued to explore and develop her theories and the science behind trigger points until her death in 1997 at the age of 95. Over time her legacy has been extensively researched, expanded and validated. Now it is time for you to benefit from these simple but powerful techniques.

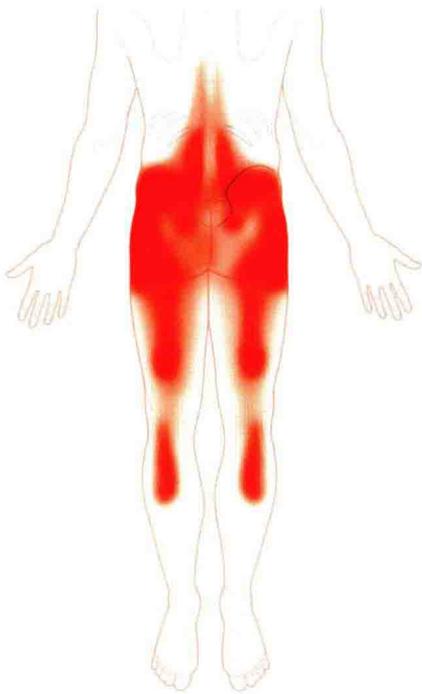


Figure 1.1: John F. Kennedy's pain map (suggested). Erector spinae bilateral lower, gluteus maximus, minimus and medius both sides; tensor fasciae latae both sides; gastrocnemius both sides.



Figure 1.2: Photograph of Janet Travell and John F. Kennedy; her most famous success story. <http://www.janettravellmd.org>

## A Few Words Before You Start

There are many reasons why you might have trigger points, so it is important to consider your trigger point pain in the context of the rest of your body. It must be stressed that the techniques offered in this book are not a substitute for therapy from a qualified practitioner; although aches and pains from trigger points are common, there can sometimes be an underlying pathology. *It is advisable to always seek a proper diagnosis from a qualified medical practitioner or experienced manual therapist.*

### Acute and Chronic Pain

Authorities estimate that in 75–95% of muscular pain cases, myofascial trigger points are a primary cause! Therefore there is a high probability that understanding what trigger points are, and learning how to "switch them off," will help you overcome your pain.

Trigger points may arise for many different reasons; some of the most common factors to be aware of are:

- Head-forward posture (upper crossed pattern)
- Round shoulders (upper crossed pattern)
- Head to one side—telephone posture
- Occupational/ergonomic stressors
- Slouched standing (lower crossed pattern)
- Slouched sitting (e.g. computer screen/ergonomics)
- Cross-legged sitting
- Habitual postures and/or habits
- Driving position
- Scoliosis
- Joint hypermobility
- Lifting/carrying
- TMJ syndrome
- Whiplash
- Primary short lower extremity (PSLE)
- Repetitive activity or sport
- Chronic vitamin and/or mineral deficiency
- Iron deficiency and hypothyroidism
- Medication induced (iatrogenic)

With any long-standing or chronic pain, there will be compensations and adaptations in a range of muscles locally and even remotely from the pain area.

Trigger points can be active (painful) or inactive (latent); they can also manifest in secondary muscles or as satellites in and around the vicinity of the primary pain. They can mimic angina, bursitis, prostatitis, appendicitis, cystitis, arthritis, esophagitis, carpal tunnel syndrome, pelvic inflammatory disease, diverticulosis, costochondritis, sciatica, and pain from a heart or gall bladder attack.