# WHEN THE BODY HAS AN IMBALANCED WORKLOAD THE HIDDEN COST

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So your knee or hip or back is stiff or painful, ranging in severity from "I can't move or exercise like I used to," all the way to "it's hard to walk." Drugs, manipulation, physical therapy, may have provided some short-term relief, but it really hasn't gotten better. Surgery may have been recommended or already completed to repair or replace the joint, the disk, or fuse the vertebrae.

Often there is no history of major trauma to that particular area. So, what is the cause of this chronic ongoing problem? Aging? Obesity? Arthritis? If these were the root causes, all seniors would eventually require joint replacements or spinal fusions. And why do so many younger, healthy, exercising, non-overweight patients need them as well?

The answer lies in the end result of years of an imbalanced workload in the body. Chronically contracted, or underused muscles; shortened ligaments and tendons; stiffened, immobile fascia all abnormally compress or pull on bones. These habitual, but abnormal, forces cause joints to move in ways that damage the bone and surrounding soft tissue, resulting in inflammation and deterioration of cartilage and bone. Compromised soft tissues makes ligaments more vulnerable to shredding and tearing as in ACL, rotator cuff and elbow injuries.

Muscles need to lengthen or shorten efficiently to perform their functions and cannot because they are held in habitual constant contraction which requires neighboring or counterbalancing muscles to work harder, eventually causing problems in those new areas.

So you can blunt the pain with drugs. You can repair or replace the joint or fuse the area (causing greater demand for movement above or below the fused joint). But what good is it, if in the long run, the old, dysfunctional patterns of moving that joint in walking or reaching remain the same?

Surgical skill and trouble free hardware do not ensure a long term successful outcome if the same stress factors that contributed to the original problem remain unchanged after recovery. It is not uncommon to need a second hip replacement, on the same side several years later.

After broken bones, sprained ankles, car accidents, sports injuries, or falls, we press ourselves to return to function as soon as possible, although there are areas that do not yet move efficiently. So we shift the workload to other muscles and joints. These compensations become habitual and operate "invisibly" beneath our awareness.

In addition, many of us favor one leg over the other, or overwork one shoulder, because of a long-forgotten childhood injury. You may habitually hold your neck because of present pain or an old fear response. Often we habitually overuse one arm, leg or wrist, or crunch one side of our ribs at home, in the work place and while playing sports.

A restriction in your neck, back, ankle, sacrum or rib may not hurt. They don't grab your attention. But they are not performing their full share of the workload. So other joints, especially the weightbearing ones, are working extra hard, moving in ways for which they were never designed. These abnormally loaded areas quietly deteriorate after years under this increased workload. They become symptomatic, painful, inflamed — damaged.

The goal of post-surgical rehabilitation is at best to return to previous movement capacities. But the old compensatory patterns still remain. The overloading continues; and the wear patterns begin anew on the same areas.

If the new joint is now metal or ceramic, a greater, not lesser, work load has been transferred to the opposite hip, knee, or ankle. These areas along with the back or neck now experience an increased demand for turning and twisting. There is a reduction in the subtle nuances of weight bearing and other sensory information to the brain from the replaced joint or fused area. You loose movement possibilities, especially in the complex interplay of rotation, which asks for increased stabilization on the other side. This then becomes the next surprising, but seemingly unconnected, problem to surface. Thus the frequent need for an eventual hip replacement on the other side.

There is an efficient way to rebalance the joint workload before tissues become so compromised they require surgery, or to enhance the results of surgery or to upgrade the recovery after surgery. Rehabilitation comes to include not just short-term relief, but the long-term prevention of new damage.

This alternative to traditional rehabilitation is non-invasive and very effective. Proper workload distribution can be relearned using neuroplasticity. The brain can choose new patterns of movement through exposure to novel information via the sensorimotor system. But first **habitual movement patterns must be brought back into awareness before they can be changed.** Otherwise, we are just superimposing new ways of moving that still incorporate the old, faulty ones.

This learning from self-observed kinesthetic sensation arising from small non-habitual movements occurs during CFR floor work and individual table sessions.

**The nervous system is amenable to change. But in order to truly upgrade habitual movement patterns that are out of awareness, it needs to be reminded of a past, more efficient self usage in a way that gets its attention and in the unique language it understands.**

Dr. Moshe Feldenkrais, the genius with whom I originally trained, said about healing, "It is not a question of finding and fixing the afflicted area. It is a question of upgrading the intention that executes the action."

**Functional movement heals.** With the release of habitual patterns, injured areas are no longer constantly stressed by excess workloads, freeing the body's innate ability to repair and heal.

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