

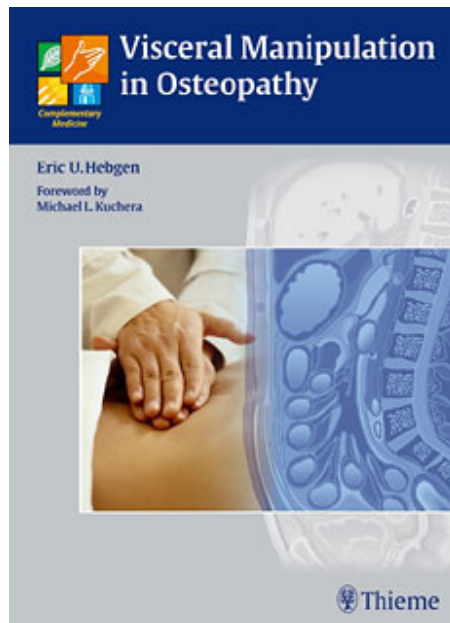
Eric Hebgen

Visceral Manipulation in Osteopathy

Reading excerpt

[Visceral Manipulation in Osteopathy](#)
of [Eric Hebgen](#)

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Introduction

Explaining the Concepts of Jean-Pierre Barral, Georges Finet and Christian Williame, William and Michael Kuchera, and Chapman

The following chapters offer a description of the osteopathic manipulation of the internal organs. I will introduce you to four treatment concepts that have one feature in common: all of them use the anatomy of the body as the foundation for the development of each particular concept. In the following paragraphs, I would like to explain the differences between these concepts.

The manipulation of the internal organs according to **Jean-Pierre Barral, DO**, is the standard method of visceral osteopathy in Europe. In this method, Barral views the organs from a mechanical perspective: organs form visceral joints with another organ or a part of the locomotor system, e.g., the diaphragm. Similar to joints in the locomotor system, the partners of a joint move against each other in fixed directions and ranges. To ensure that this movement is executed with as little friction as possible, the partners of a parietal joint are characterized by a smooth surface and by the synovium, which produces small amounts of joint fluid. Likewise, the organs have a smooth surface as their external surface is sealed off by a layer of serous skin. This layer is the peritoneum, the pleura, or the endocardium. Furthermore, we find a small amount of fluid in the serous cavities between the organs. The organs do not move against each other haphazardly but are subject to certain laws: they are fastened to each other and to the locomotor system by the mesenteries, omenta, or ligaments. This limits their range of motion. We also find this feature in the joints of the locomotor system. Ligaments permit and limit the extent and direction of movement.

Barral hence constructs his theory parallel to the parietal joints. His treatment techniques are also, to a large extent, informed by them. Similar to the parts of a joint, the organs are tested for their ability to move and directly treated to increase mobility, until a normal range of motion is restored. It is only his concept of visceral motility that follows a more energetic approach, which I will treat in more detail below.

Georges Finet, DO, and **Christian Williame, DO**, two Belgian osteopaths, carried out extensive radiograph- and ultrasound-supported studies in the 1980s, to examine the movements of the abdominal organs in relation to diaphragmatic breathing. In the course of their research, they discovered organ movements that follow certain rules. For the organs that they studied, they defined

movement directions and extents, which largely concur with Barral's results. In addition, they developed a treatment method to influence disturbed organ movements and were also able to control their method using X-rays or ultrasound waves. In contrast to Barral, who palpates the organs and moves them directly in his mobilizing techniques, Finet and Williame utilize the anterior parietal peritoneum in their therapy. By moving the peritoneum, they achieve a mobilizing effect without palpating the organ itself. They call their method fascial because the peritoneum is seen as fascia and connects all abdominal organs with each other. If you pull on one part of the anterior peritoneum, this also has an effect on a distant region, e.g., the peritoneum of the pancreas. You could compare the peritoneal cover to a balloon: if you push or pull on one part of the balloon, this pull spreads throughout the entire balloon and deforms it.

Ultimately, both treatment concepts succeed in restoring the physiologic mobility of an organ, with the only difference being that Finet and Williame do so a little less invasively. The indication for this method thus also extends to organs that, because of a disorder, should not be palpated and mobilized directly. In this book, I introduce what I believe to be the most effective technique from the treatment concept according to Finet and Williame, namely expiratory dysfunction. I consider it particularly successful because the mobilizing effect is herein achieved by the diaphragm in the context of respiration, meaning that the patient's body is thus carrying out the real "work" itself.

In the circulatory movements according to **William A. Kuchera, DO**, and **Michael L. Kuchera, DO**, the osteopath does not aim at contact with the affected organ, but rather analyzes which arteries, veins, vegetative nerves, and lymphatic vessels supply an organ and dispose of its waste, using special techniques to influence the circulation of the organ. In this technique, the mobilization of the organ is not of primary importance. This concept is thus an excellent complement to the mobilizing concepts of Barral and Finet/Williame. These manipulations are less invasive and far too little known in some countries. For didactic reasons, I have recorded the appropriate techniques for each organ, knowing full well that an exact separation of its circulation and therefore an isolated treatment of an individual organ is not possible. The techniques themselves are described all together in the general section of the book.

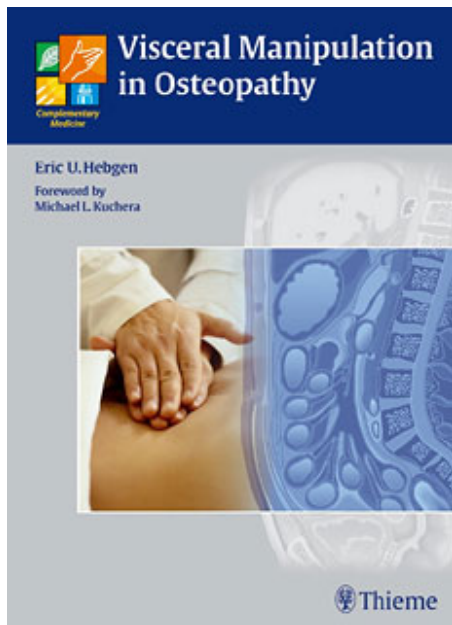
The fourth treatment concept is the reflex therapy according to **Frank Chapman, DO**. The Chapman points are a valuable diagnostic tool, can provide follow-up results after treatment with visceral manipulation, and

take advantage of the vegetative nervous system to influence the internal organs. Reflex therapy should be found in every therapeutic tool kit. The Chapman points have become highly valued tools for me.

These treatment techniques are supplemented by concise information about the physiology and clinical pathology of the individual organs. This information is not intended to be exhaustive but rather as a quick reference source in one's daily work.

While reading this book, you will encounter the term "central tendon" again and again. This is not to be confused with the "core link." That term is used in the English literature to refer to the connection between the base of the skull and the sacrum or coccyx via the dura mater. The central tendon, by contrast, refers to a fascial string that also runs through the body from the base of the skull to the pelvic floor, but is located anterior to the spinal column in the superficial and deeper-lying fascial layers of the body and does not include the dura mater. This fas-

cial continuum works together as a functional unit: if a dysfunction is present in the body that should be protected in a global chain of protection, the central tendon can collaborate in this effort. The ability to carry out a fascial contraction is therefore of great importance. The fascia contracts towards the location of the dysfunction, thereby contributing to the protection of this area. As the fascial organ coverings (peritoneum, pericardium, pleura) are integrated into this system, compensatory increases in tension are also found in this fascia. As circulation passes through the fascia, elevated fascial tension disturbs the circulation of the tissue behind it. In concrete terms, this means that pathologic tension in the central tendon disturbs the circulation in the organs and can be the trigger point for impaired organ function or result in a reduced ability of the organ to compensate for biological, physical, or chemical noxa. Restoring normal tension in the central tendon is hence of vital importance for undisturbed organ function.



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