

New concepts in Alternative Therapies

Treatment of TMJ disorders leads to Trauma Release Therapy (TRT)

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In the 1960s, not much was known about temporomandibular joint (TMJ) disorders. Many of my colleagues could not relate to TMJ—they thought I was seeing things that did not exist in orthodontic/dental practices.

However, over the past 30 years, we've not only recognized this disorder but learned a great deal about it, developing a wide range of therapies and approaches to relieve the symptoms. Having a front row seat to the way treatment of TMJ dysfunction has evolved, I've come to the conclusion that to effectively treat TMJ disorders, we must discover the cause. Often, the cause relates to previously experienced trauma. I've also learned that TMJ disorder cannot be treated separately from the rest of the body and the mind.

To understand my conclusions, it's important to consider the history of TMJ dysfunction treatment. James Bray Costen, MD, an ear, nose and throat (ENT) specialist in St. Louis in the 1940s and '50s, is credited with noting a set of symptoms that involved the head, neck, ear, face and jaws. In research with cadavers, he noticed a branch of the recurrent auriculo-temporal nerve that ran posterior to the temporomandibular joints. He felt that compression of that nerve was greatly responsible for the vast symptomology experienced by these patients. However, his theories were challenged and debunked by anatomists and physiologists of the day. Costen's syndrome was purged from texts and journals. Essentially, by the 1970s, it was seemingly forbidden to talk about Costen's work.

Therapeutic approaches for TMJ dysfunction then were in a no-man's land, treated neither by physicians nor dentists. In fact, there were no treatment codes for the temporomandibular joint, the only one in the body that was omitted. Orthopedic surgeons, neurosurgeons, oral surgeons, and ENT surgeons treated acutely impaired joints but virtually ignored patients with chronic problems, labeling them as crazies. Acute sufferers had various substances injected into the joints to attain relief: sclerosing solutions, alcohol, anesthetics, cortisone, and anti-inflammatories. The severely affected joints sometimes were removed. One method was to use the wire, or Gigli saw, to amputate the mandibular condyles.

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Various surgical joint replacements were developed and, later, arthroscopic techniques were used to repair and restore the functional movements of the jaws. None, though, were completely successful. In the late 1970s and into the '80s, the resilient disc itself was construed to be the basic hindrance to full range of motion. New diagnostic methods were developed, such as Jankelson's Mandibular Kinesiograph (MKG). Great effort was made using splints and removable orthotics of various types to recapture the discs on the mandibular condyles. Some success was obtained in conjunction with surgical placcation, but full restoration of function and reduction of pain was still elusive in a smaller but more difficult group of TMJ disorder patients.

More recently, we've reached a plateau in the success rates of recapturing discs, arthroscopic surgeries, injecting muscles and palliative physical therapy treatment modalities. TMJ disorder experts are quick to note that between 5 and 15 percent of their cases are nonresponsive to current treatment protocols. It is now necessary to shift our thinking about TMJ disorder to a new paradigm. In order to accommodate long-lasting change for patients, one of two methods must be developed: posterior temporal exercise to restore functional muscular balances, or therapy to remove the traumatic environmental experiences.

This is the atmosphere in which Trauma Release Therapy was developed. By searching for answers to problem cases in both TMJ disorder and orthodontics, I developed Trauma Release Therapy (TRT) to deal with various functional disorders as well as malocclusions. At one time, these were thought to be closely related or even synonymous. However, there are numerous examples of severe malocclusions without TMJ disorder symptoms.

There appeared to be a common clinical thread running through both problems. In the mid-1970s, dentists in the eastern United States were introduced to a new paradigm of knowledge relating, seemingly indirectly at first, to TMJ disorder. This was an offshoot of chiropractic called applied kinesiology, developed and refined by George Goodheart, DC. The technique was brought to my attention by psychologist George Eversaul, PhD, who was also an expert in bio-feedback therapies. I then began studying the principles of applied kinesiology with Drs. Eversaul and Goodheart, and

John Diamond, a physician. I also worked with Willie May, DDS, Aelred Fonder, DDS, Major DeJarette, SOT and Dave Bundy, DC. I invited chiropractors to my office to help primarily with TMJ disorder patients.

I took a tutorial course on cranial osteopathy with osteopathic physician Viola Frymann of LaJolla, Calif. She was imbued with the fundamental knowledge of the cranial mechanism first postulated by Dr. William Sutherland, an osteopathic student of Dr. Andrew Still, founder of osteopathy in the United States. Dr. Sutherland visualized the vast interrelations of the cranial structure, the internal membranes, dural tube, spinal column to the sacrum and cerebrospinal fluid as one pulsating unit, functioning like the cardiovascular system. Since these structures are intimately related to the brain and the rest of the central nervous system, Dr. Sutherland called it the primary respiratory system. Dr. Sutherland's work was expanded on by another osteopath, John E. Upledger, who developed CranioSacral Therapy. The Upledger Institute's CranioSacral Therapy courses can give the practitioner insight into the craniosacral system as well as precise techniques for accessing it.

Trauma Release Therapy: How it came about

Studying with Dr. Frymann was instrumental in the development of TRT. I learned that the cranial structures are resilient, a concept quite contrary to what I had believed. Additionally, I learned that the cranium has very subtle movements and a rhythmic impulse that is quite different from cardiovascular pulses and pulmonary movements. The entire cranium, as well as the body, has this pulsation that occurs anywhere from eight to 14 times per minute depending on the individual.

Cranial osteopathic treatment consists of gently holding the patient's head or sacrum and subtly allowing the restricted, tense tissues to release and become resilient once again. In this normalized state, the cranial rhythmic response is re-established throughout the body. After a treatment, the body feels completely relaxed and at ease. One of the interesting observations I had at the time was a fellow dentist who sought treatment from Dr. Frymann for unrelenting head, neck, and back pains. None of the other therapies or medications he had tried would ease the pain. As I watched, Dr. Frymann placed her hands on his head and was still for a moment. The man's body began to gently sway, first forward then sideways to the right. At that moment, Dr. Frymann asked if the dentist had been in an automobile accident. He replied that he couldn't recall any. Then, suddenly, he did remember an accident that occurred when he was driving trucks in college. His vehicle was hit broadside by another truck from the left, but he didn't think he was seriously injured. The position of his movements, however, indicated that he had strained his hip and back, and had a mild whiplash injury. The release of pain and tension was immediately evident.

On other occasions, the dentist recalled a diving accident where he sustained injuries to his jaw and face. Also, his college boxing career was recalled with a series of head snaps. Dr. Frymann's demonstrations were astounding and made me realize that there was some connection between the individual's chronic symptoms and the body's storage of all of these prior traumatic incidents. I could not help but reflect on how this could occur. After these treatments, the dentist was relieved of the headaches and tensions in his head, neck, face, and back. He said that he felt like a new man.

I wondered how what I had observed could relate to TMJ disorder, jaws, teeth, and malocclusions. Could this type of therapy resolve TMJ and improve our treatment? In another context, I began to see that the jaws were intimately related to the rest of the body. Yet, we were treating the TMJs, malocclusions, and dental problems as if they were separated from the body and mind. This was a quite a leap and I found myself groping for knowledge. The text book, *Osteopathy in the Cranial Field* by Harold Magoun, DO, explained and substantiated the work of Dr. Sutherland that was illustrated by Dr. Frymann's work. I saw that these concepts had far-reaching effects and, if mastered, could lead to another level of therapies with TMJ disorders and malocclusion.

In treating malocclusions, I had a sense that changes in the cranial structure, particularly the cranial base, could be a major factor in the development of the various classes of malocclusions. However, the osteopathic profession and the literature had not sufficiently related the cranial structure or aberrations with various facial features, particularly the malocclusions. I spent many hours looking at x-rays trying to understand how the relationships might take place. The major stumbling block I discovered was the portrayal of the cranial flexion and extension movements that were centered at the sphenoccipital synchondrosis (SOS). Drs. Magoun and Sutherland portrayed the basic flexion and extension movement of the SOS in an upward and downward movement, which was very difficult to substantiate in cranial x-rays. Also, with their traditional gear sprocket, cogwheel type of movement, the facial and jaw configurations would not coincide with the cranial patterns that I saw in the radiographs. It suddenly became obvious to me that changes in live patients were taking place in three dimensions unlike the calcified, dried bones I studied. Once I resolved and accepted the SOS as being patent, I could then visualize other structures surrounding that area moving and changing three dimensionally. Then, a face could be projected onto the cranial distortions and the relationship of the jaws and malocclusions suddenly became apparent, at least to my mind's eye.

The first application of the principles was in the TMJ area. Initially, after taking the tutorial course with Dr. Frymann, I did very little with the techniques that I learned. However, I now understood that prior traumatic experiences might have been involved and osteopathic correction of these factors may resolve the TMJ problem. I referred several TMJ patients to

various osteopaths in the area, even as far away as the osteopathic college in Pomona. There also was a chiropractor in our area who practiced the sacral occipital technique (SOT), which is based on the works of Dr. DeFarnette. However, results from the chiropractor were not as promising.

In searching for an osteopathic solution, we were pleased to have Dr. Gerald Slatterly open his practice in nearby Laguna Niguel. Previously, we had sent patients to see Dr. Frymann, although she preferred to work primarily with infants and children. We had 70 to 80 patients seeing Dr. Slatterly and, since we were referring many patients to his office, I scheduled an exam for myself just to be able to relay to patients what the procedure would be like. As I lay on the examining table, Dr. Slatterly placed his hand at my lower back area and indicated that he felt that I had some kind of traumatic experience very recently. I didn't recall any at that moment and as he proceeded with the examination, he had me bring my left leg up slightly off the table and told me to hold it in a certain posture. Then as he moved his hands up along my upper thoracic vertebrae, he noted that something had strained my shoulders and he had me bring my arms to various positions; the left one was slightly upward ahead of the right. He noted that my eyes were focused slightly to the right and forward. I turned my eyes in the direction that he felt my neck tension. As soon as he did this, I recalled an incident two months prior when I was skiing. As I prepared to make a last run down the hill, I had to choose between going right straight down the fall line or an easier route to the left and possibly miss the last chair lift. At the last instant, I decided to take the easy way down. As soon as I made the turn slightly to the left, passing the tree that I was focused on, my ski tips crossed and I took a fairly hard spill. It was my left leg that came out of the ski binding. That was the leg that was strained, along with my lower back. My arms, which had held the ski poles, returned to the same posture they were at the moment the skis crossed and pitched my body forward.

That, indeed, was a valuable experience for me to see that prior traumas reside in the tissues of the body, and with a sensitive touch, one can locate and release these tensions much as I had observed with my dentist colleague. Not long after my visit, Dr. Slatterly closed his practice. There were about 70 patients who were in various stages of treatment with nowhere to turn. I referred them to various practitioners in the area, as far away as Pomona and LaJolla. However, many came back disappointed that the problems were unresolved. I found myself in the position of learning how to treat these individuals. Over a period of time, I became quite adept, and could feel what went on in the body system. At the same time, I availed myself of several different physical therapies as they were starting to be noticed for treatment of different joint disorders in the TMJ area. I also learned about and experienced Rolfing, CranioSacral Therapy, Feldenkrais, Shiatsu, acupuncture, acupressure and electro-acupuncture

developed by Dr. Voll in Germany. I started to see that the body is a whole unit with compensating mechanisms unlike anything I had ever known before.

Now, we had another glimpse of how the body manages prior traumas, suppresses them, and compensates for some of their effects. Problems come about when traumas accumulate in certain areas, particularly certain joints or body areas. From my work in Rolfing, Feldenkrais, and SomatoEmotional Release, I came to understand that these therapies also elicit emotional experiences and memories of prior traumas. This phenomena is expressed in severe TMJ disorders, in those patients who had many therapies with no significant results, and where surgery was recommended or performed. In working through the physical and emotional suppressions, we found that the tissues became more resilient, normalized and, eventually, we were able to re-establish the full range of function of the jaw joints.

As the emotional component began to evolve in our treatment, I took The Upledger Institute's CranioSacral Therapy and SomatoEmotional Release courses, through the advanced level. This training helped me to confirm, develop, and enhance my awareness and appreciation of the patient's inner wisdom. I also learned to work with a team of therapists to muster and mobilize the patient's energies.

In learning to work with the entire body-mind complex, I developed the Trauma Release Therapy Issues List. My insight into these mental/emotional issues developed from patient accounts of what they were experiencing during or after the therapy sessions. I began to focus on the main body systems, calling those out and seeing what responses we had in the various body zones. It appeared to be effective in relieving major body systems of the traumas. I soon came to see that certain sensations and feelings were related to certain types of trauma. I started to ask a question, "Are there any other issues of significance?" From that question, we were able to compile a substantial list of major body system sensations, feelings, mental-emotional issues, and suppressed perceptions that we now use in Trauma Release Therapy.

Traumas that occur early in life are readily forgotten, but do not leave the body-mind complex. The body and mind have a remarkable suppressive capacity, perhaps to allow life to go on without hindrance. For the most part, we are able to live without having these traumas become major obstacles to the quality of our lives. However, we are finding that when certain basic feelings are affected (during infancy), such as lack of love, perceived lack of nurturing or of not being cherished, then any traumatic experience apparently becomes magnified and is perceived to be more powerful to that individual. To illustrate how traumatic and far-reaching this response might be for the physical and mental well-being of the individual, allow me to relate the case of a long-suffering adult patient who had made the rounds of quite a few medical and dental practitioners. She had intense unrelenting facial,

head and neck pains, popping and clicking jaws, and difficulties in chewing food and sleeping. Her life was totally consumed by chronic pain, so much so that her self-esteem was very low and manifested itself in her appearance, dress, and personal hygiene.

Her personal life was a shambles—she became socially reclusive, unstable, depressed, had difficulty in relationships, and was accused of being a hypochondriac. These problems kept her from returning to her native Holland her entire adult life. The patient believed the cause of her problem to be a particular upper anterior tooth that was previously restored with a porcelain crown. She was at the point of having the tooth extracted when she came to see me.

We focused on the most painful zones in her mouth (pre-maxilla), face, head, and neck. After removing the numerous traumas to those areas from blows, falls, and other injuries, early childhood traumas surfaced. She was severely abused as a child during the war. Once those traumas were released from her body-mind complex, her outlook on life changed dramatically. She began to dress better and take more care with her appearance. She brought her family together and planned a trip to Holland. Her teeth no longer bothered her and needed no further intervention.

Another example of the use of TRT was with a 13-year-old youngster. He was markedly below the scale in height and was told that he would probably not attain the usual stature of the males in his age category. He had a slight build and fairly good coordination but walked with a wobble. In the examination, I saw he had excessive lower and upper back lordosis. He was very angry and belligerent toward his parents who adopted him at the age of two weeks. In peeling off the layers of the boy's traumatic experiences, including going back to the birthing process and before, there was a time in the third trimester that apparently, the mother decided to give him up for adoption. This would be an issue of abandonment and when we got to that question, the reaction in his curled up body was extremely intense. For this portion of the TRT process all that was done was to mention words on a list. He curled up in a fetal position and had tremendous tightening of his entire body. He made moaning and groaning sounds. Within six months of the TRT, he grew five inches. He was already good at math but went on to become the top student mathematician in Kansas. He played various sports, including baseball and basketball. His attitude turned 180 degrees.

There are numerous cases of patients who have had chronic headaches most of their adult lives, even migraine types, who don't have them today after the TRT program. Others, with all types of jaw disorders, vertigo problems, or dizziness don't have them today. Still others with gagging reflexes so great that certain types of dental work couldn't be done, are better today.

Some zones accumulate traumas repeatedly from a very early age, for example stubbing a big toe over and over or

injuries primarily to one side of the body or a particular limb. Apparently, a pattern is established and becomes a learned experience. One such individual suffered severe trigeminal neuralgia (*tic douloureux*) on the left side of her face. The pains were so intense that, after seeing numerous specialists, and taking a purseful of medications and anesthetic injections, she was ready to "cut [her] head off and throw it away."

After initially removing approximately 20 traumas—blows and falls from the left side of her face—the pains subsided. Her depression, chronic fatigue, and jaw disorders cleared up. She then recalled that she was a klutzy child, always falling on her face or being struck by balls and other objects.

One of the benefits of TRT is not only accessing and rooting out accumulations of prior traumatic experiences, but also in relieving a traumatic experience as soon as it occurs as a type of first aid. The results can be quite dramatic—the pain level is immediately reduced, there is no inflammation or bruising, and healing takes place at an accelerated rate. This procedure relates to any part of the body, from the top of the head to the bottom of the feet.

An incident that occurred on a ski trip illustrates this well. On the first day of a week-long trip, my companion, a fellow physician, felt a cramp in the left leg muscle. I relieved the cramp on the slopes and we continued skiing. The next day, it was obvious that the cramp was actually a sprain of the left ankle, which had swollen to twice the normal size. After I worked on the ankle for about 40 minutes, the man was able to slip into his boots, tighten them down, and move about as usual. I asked him to step into the ski bindings and he was able to do so and perform all of the maneuvers he might experience on the slopes.

This, however, did not convince him to continue skiing. Instead, he went down to the village dispensary and had the ankle examined. The exam indicated that the ankle be put into a cast; he should stop skiing for the rest of the season. The man didn't quite take that advice seriously since he was ambulatory and had no inflammation or pain. He went to the ski shop and tried on some boots before purchasing an advanced model, which fit very snugly. He was able to weather that process without any problems, and skied with us the rest of the week. He has had no problem with the ankle since.

TRT is easy to learn and perform on yourself—a self TRT method is taught in our courses. The TRT process does not depend on the therapist's palpatory skills, but in learning to direct the individual or self toward tension, tightness, or pain. We use pain as a favorable signal. We pay attention to it as a legitimate indication of the condition of body tissues.

Treatment of TMJ disorders have come a long way since the observations of James Bray Costen. We now have many new avenues to explore beyond the immediate area of the face to help TMJ disorder sufferers. Among these is Trauma Release Therapy, which relieves painful and dysfunctional conditions and may have other favorable implications for the individual.