Anterior Chest Wall Release

The Anterior Chest Wall Release (Figures 344–348) was originally called the Thoracic Inlet Release, which is semantically misleading and anatomically incorrect. The fascia throughout the anterior and posterior chest wall is the only known physical structure that can be affected during this release.

The Anterior Chest Wall Release is an advanced technique since the therapist must be able to rely entirely upon feedback to initiate and to complete the release. The subjective sensation for both the therapist and the patient during the Anterior Chest Wall Release is that “something” is being released that feels very different from the sensation associated with the release of specific muscles. The end-feel of the Anterior Chest Wall Release is a profound release of tension throughout the entire anterior and, usually to a lesser extent, the posterior chest wall. Often the patient will take a very deep breath as the end-feel is reached triggering multiple releases throughout the upper trunk and, to a lesser extent, throughout the entire body. Therefore, the Anterior Chest Wall Release is also a Gross Release of the Fascia of the Upper Trunk.

The Anterior Chest Wall Release is initiated by compressing the patient’s chest between the therapist’s hands. When the right amount of compression is released, the inherent tissue motion begins to guide the therapist’s hands. When first learning this technique, the therapist must have one hand on the patient’s anterior chest wall and the other hand over the upper thoracic spine to amplify the feedback from the patient’s body. Once the therapist is able to follow this subtle feedback with relative ease, the release can also be performed with one hand on the patient’s anterior chest wall.

Feedback will direct the therapist’s top hand in a back-and-forth motion or a circular or elliptical pattern around the anterior chest wall. The amplitude of the motion cannot be predicted, and touching a woman’s breast tissue may be unavoidable. This should be explained before beginning this release. Both the therapist and the patient must have a clear understanding there is nothing sexual in this contact. Having a chaperone in the room during this release may be prudent. *If the patient expresses any reluctance or uneasiness, do not proceed with this release. When in doubt, don’t!* The therapist’s bottom hand may not move at all, may move in an opposite direction of the top hand, or may mirror the movement of the top hand. When tightness or a restriction is felt, the therapist should apply a gentle stretch in the same direction which the therapist’s hand was being led. The stretch may stop the inherent tissue motion until the release is achieved, the therapist’s hand may be led further into the direction of the stretch, or it may be led into a different pattern of movement. Maintain the stretch until a release is felt and the inherent tissue motion resumes.

The length of time the stretch is maintained varies and is often merely a slight hesitation in the movement pattern. When a large area of restriction is encountered, the inherent tissue motion may stop and the patient may become still. Maintain the same amount of stretch and compression, and wait for the release. Both the therapist and the patient may feel that the patient has stopped breathing. There may be a feel of “watchful waiting.” Some patients will begin to breathe rapidly or pant before taking a deep breath followed by the release. Following the release, the therapist’s hand may be guided into the same movements as before but with much greater ease, or the release may lead directly into the next area of restriction, stopping all movement again. The therapist must be patient and continue to repeat this sequence until an end-feel is reached.

The therapist may be directed more often and for a much longer period of time to the patient’s non-dominant side. When the tension on both sides is close to being equal or is equal, the therapist’s hand will be led into larger movements that cover both sides of the anterior chest wall. When the same path is followed without change multiple times, increase the stretch at the outer borders of the pattern. If tightness or restrictions are still present, the movement pattern will expand or will change direction, with or without facilitating a three-dimensional release. Repeat the release sequence until an end-feel is reached.

When all the tightness and restrictions of the anterior chest wall are released, the same interlocking pat-