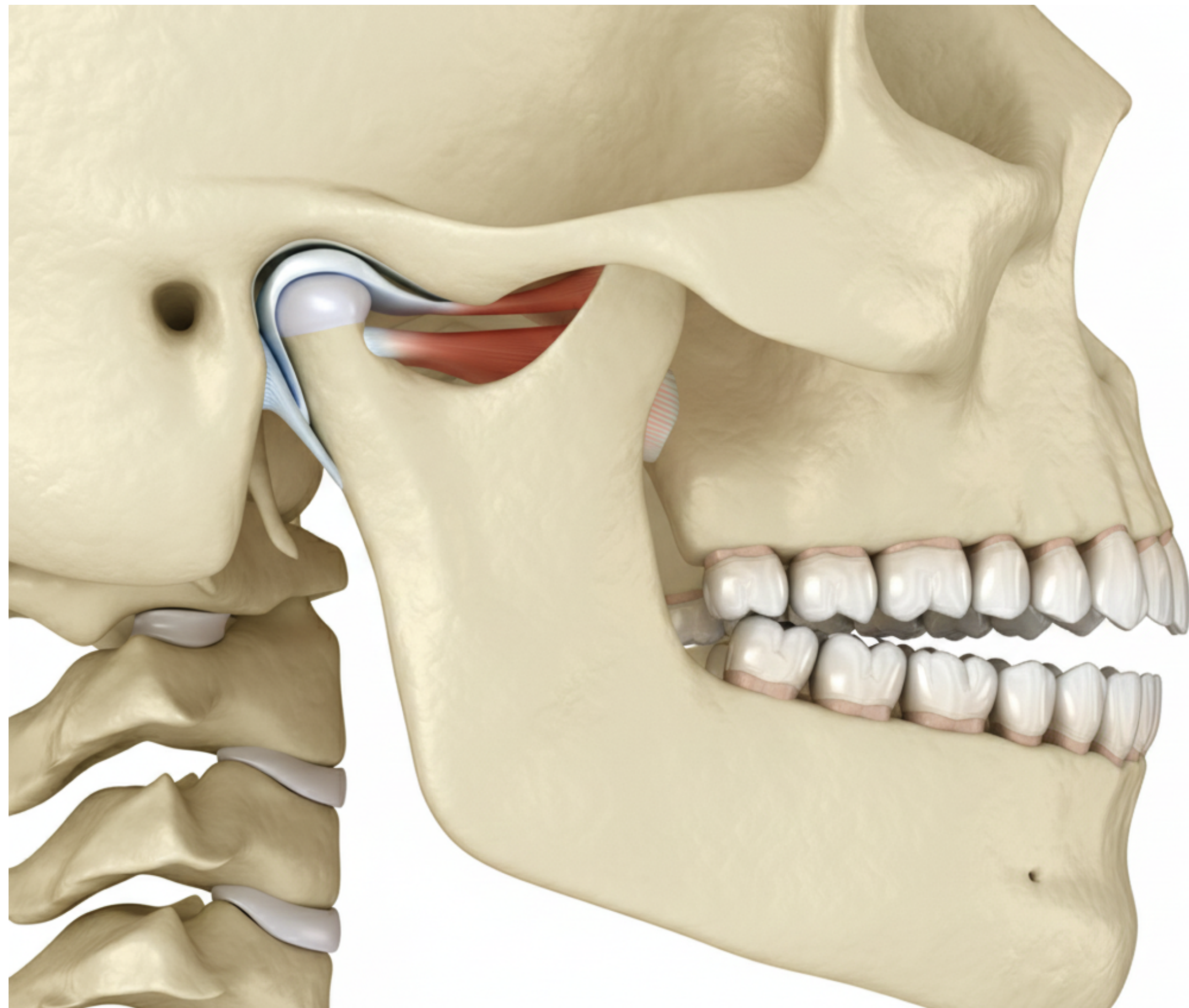


Unlocking the Jaw:

How Physical Therapy Fits into Your TMD Toolkit



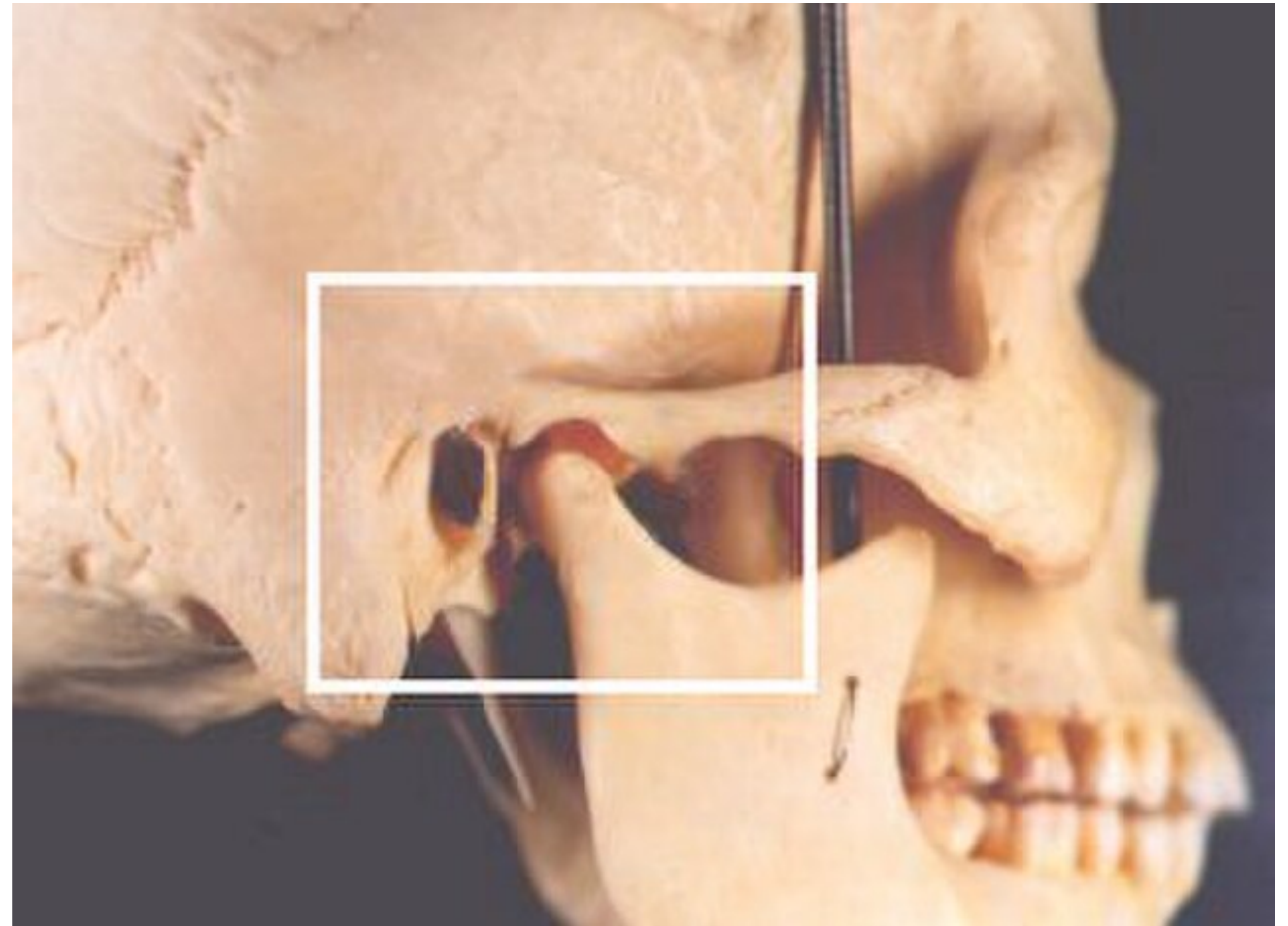
Alex Pagotelis, MS, PT, JSCC

Course Objectives:

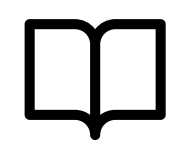
- Basic Anatomy and Function
- Diagnosis of TMD
- Causes of TMD
- Treatment Options

Basic Anatomy and Function of the TMJ

A guide to the structure,
Biomechanics, and clinical
significance of the
tempromandibular joint



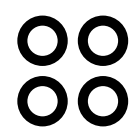
What is the TMJ?



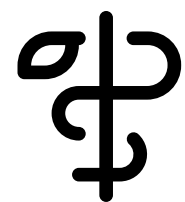
Definition: A paired synovial joint connecting the mandible to the temporal bone of the skull.



Location: Situated bilaterally just anterior to the tragus of the ear (preauricular region).



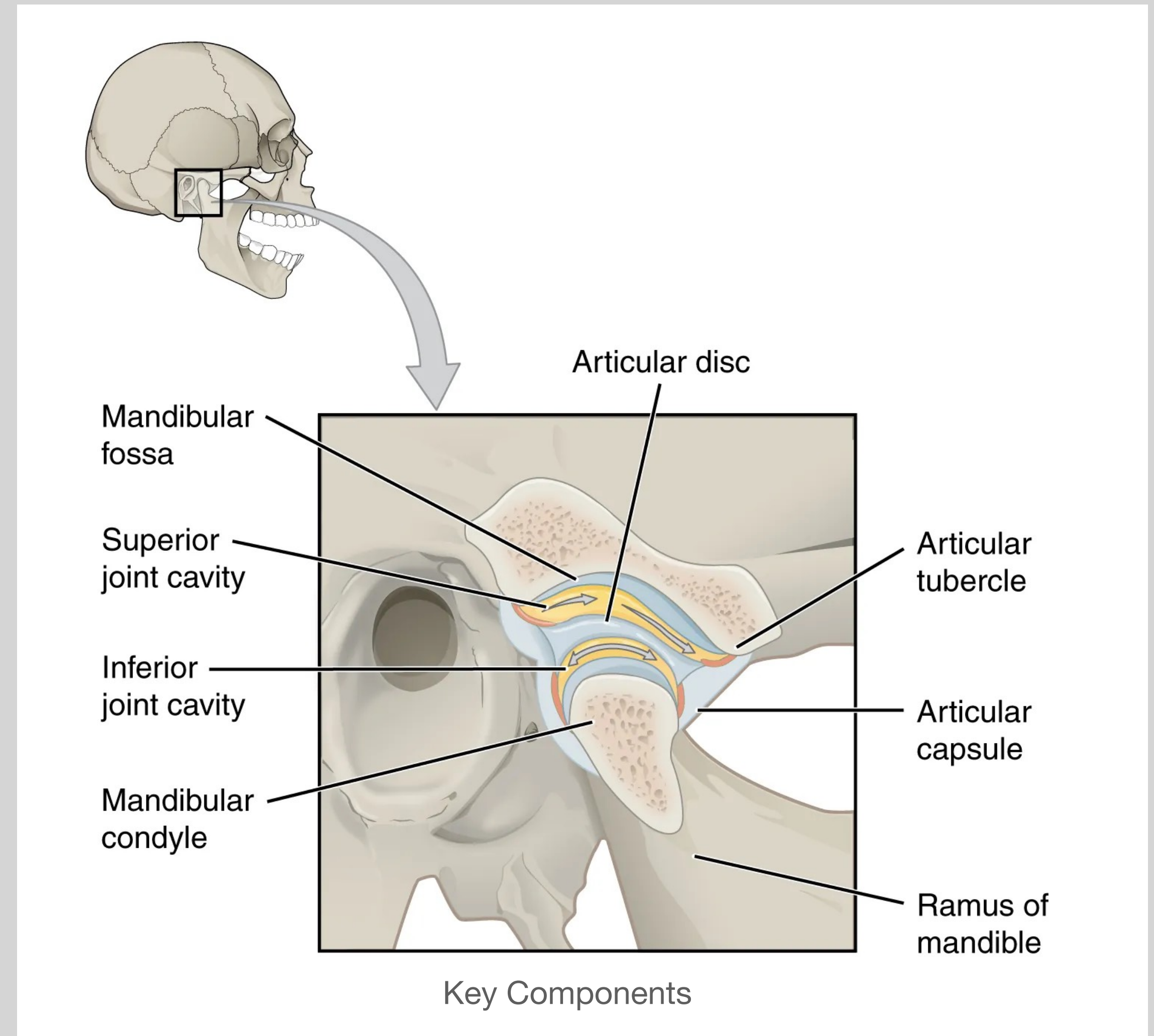
Classification: Ginglymoarthrodial joint allowing both hinge (ginglymus) and gliding (arthrodial) movements.



Primary Functions: Essential for mastication (chewing), speech, swallowing, and yawning.



Key Components: Mandibular condyle, mandibular fossa, articular tubercle, and the articular disc.



Muscles of Mastication

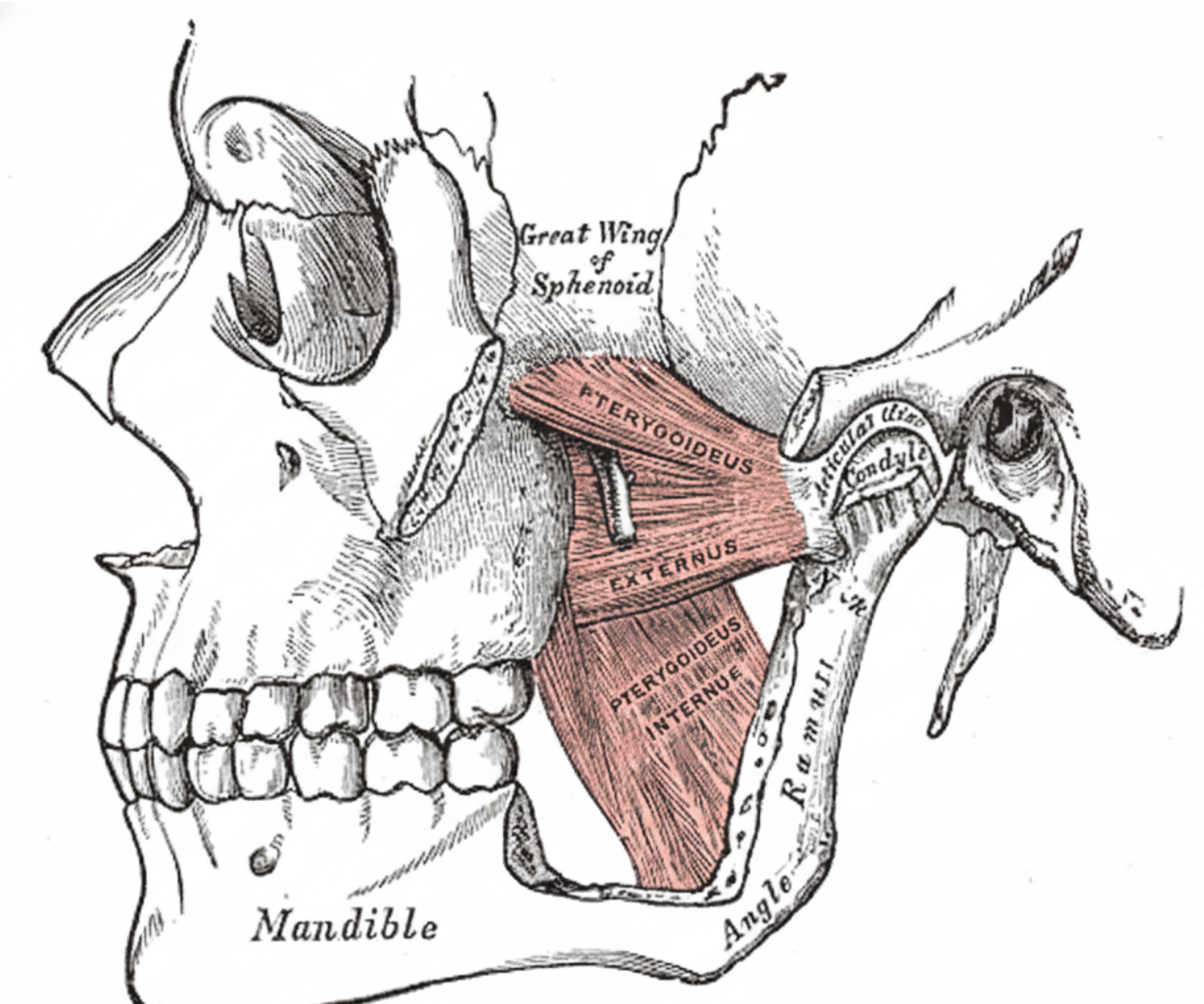
Masseter: The primary elevator (closing); superficial fibers also assist in protrusion of the mandible.

Temporalis: Fan-shaped muscle for elevation; posterior fibers retract the mandible (retrusion).

Medial Pterygoid: Elevates the mandible and assists in protrusion; forms a "sling" with the masseter.

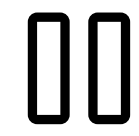
Lateral Pterygoid: Two heads (superior/inferior). The primary muscle for protrusion and opening (depression).

Assistive Muscles: Suprahyoids (e.g., digastric) and infrahyoids assist gravity in depressing the mandible.



TMJ Movement and Biomechanics

↻ The Mandibular Opening Cycle



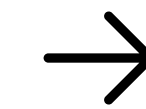
Closed/Rest

Condyle is seated in the mandibular fossa. Teeth are slightly separated (freeway space).



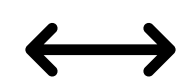
1. Rotation

Occurs in the first **20-25mm** of opening. The condyle rotates on the disc's inferior surface.



2. Translation

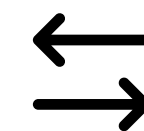
Beyond 25mm. The condyle and disc complex glide forward and down the articular eminence.



Protrusion & Retrusion

Protrusion: Bilateral anterior translation of condyles (guided by lateral pterygoids).

Retrusion: Posterior movement returning to centric relation (guided by posterior temporalis).



Lateral Deviation

Working Side: Condyle rotates (pivots) in fossa.

Balancing Side: Condyle translates downward, forward, and medially (orbiting condyle).



Key Takeaways

Summary of essential anatomical concepts, functional mechanics, and clinical implications of the TMJ.

1 Complex Structural Classification

The TMJ is a paired **ginglymoarthrodial** synovial joint, enabling both rotational (hinge) and translational (gliding) movements essential for jaw function.

2 Unique Tissue Composition

Unlike most synovial joints, the articular surfaces are lined with **fibrocartilage**, providing superior durability and repair potential under occlusal loads.

3 Sequential Biomechanics

Normal opening involves initial rotation in the **inferior compartment** followed by anterior translation in the **superior compartment**.

4 Functional Coordination

Smooth movement relies on precise coordination between the articular disc, collateral ligaments, and the **lateral pterygoid muscle**.

5 Clinical Significance

TMDs often involve internal derangement (disc displacement). Initial management typically focuses on conservative, non-invasive therapies.

Diagnosis of Temporomandibular Disorders (TMD)

A comprehensive guide to identifying and evaluating disorders of the jaw joint and surrounding structures



What is TMD?

Temporomandibular disorders represent a group of conditions affecting the temporomandibular joint (TMJ) and the muscles responsible for jaw movement. These disorders can significantly impact daily activities like eating, speaking, and facial expressions.

Common Symptoms Include:

- Pain in or around the jaw joint
- Joint noises during movement
- Muscle tenderness and stiffness
- Limited or restricted jaw motion

10-15%

Adults Affected

Prevalence in general population

2x

Female Ratio

Women affected twice as often

20-40

Peak Age Range

Most common age group



Key Clinical Features of TMD

Temporomandibular Joint Pain

Localized discomfort often felt near or around the ear region, typically worsening with jaw movement or function. Pain may radiate to surrounding facial structures.

Joint Noises (Crepitus)

Audible sounds during jaw movement including clicking, popping, or grinding (crepitus). These noises may occur with or without pain and can indicate internal joint derangement.

Muscle Tenderness

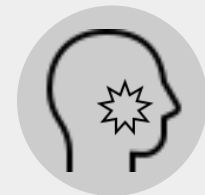
Palpable tenderness and tightness in the masticatory muscles, particularly the masseter and temporalis muscles. Patients often report soreness with chewing or clenching.

Movement Limitations

Restricted or abnormal mandibular movement patterns, including difficulty opening the mouth fully, jaw deviation during opening, or intermittent locking episodes that impair function.

Patient History: The Diagnostic Cornerstone

A thorough patient history is essential for accurate TMD diagnosis. Understanding the patient's symptoms, their onset, and contributing factors provides critical diagnostic insights before any physical examination.



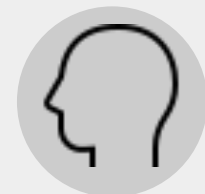
Pain Characteristics

Detailed inquiry about jaw pain location, quality, duration, intensity, and specific triggers. Document when symptoms began and any pattern of progression or fluctuation.



Trauma & Dental History

History of jaw trauma, recent dental procedures, orthodontic treatment, or prolonged dental work. Note posture-related factors like heavy computer use or phone cradling habits.



Associated Symptoms

Presence of headaches (frequency and location), ear-related symptoms such as otalgia or tinnitus, and neck or shoulder pain that may indicate myofascial involvement.



Psychosocial Factors

Assessment of psychological contributors including anxiety, depression, chronic stress, and sleep disorders. These factors often coexist with TMD and influence treatment outcomes.



Physical Examination Essentials

Range of Motion Assessment

Systematic evaluation of jaw function is fundamental to TMD diagnosis:

- **Maximum mouth opening:** Measure interincisal distance (normal ~40-50mm or 5 cm)
- **Lateral excursions:** Assess side-to-side movements (~10mm or 1 cm each direction)
- **Protrusive movement:** Forward jaw displacement capacity
- Note any deviation, deflection, or asymmetry during these movements

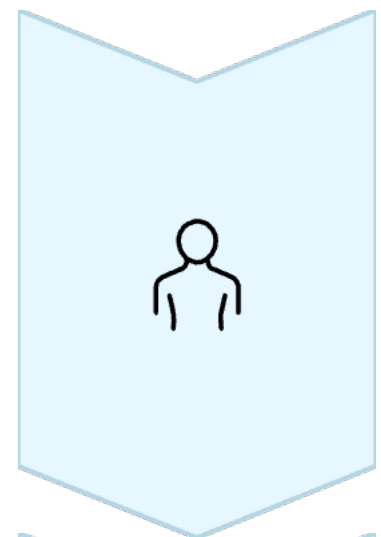
Palpation Techniques

Careful palpation reveals critical diagnostic information:

- **TMJ palpation:** Lateral and posterior (via external auditory canal) assessment for tenderness and joint sounds
- **Muscle examination:** Palpate masseter, temporalis, and pterygoid muscles for spasm, trigger points, or pain
- **Additional findings:** Check for jaw locking, malocclusion signs, or dental wear patterns

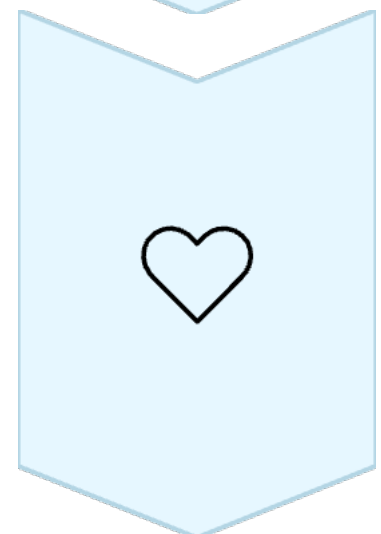
Diagnostic Criteria: DC/TMD Framework

The Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) provides a standardized, evidence-based approach for clinical and research diagnosis. This dual-axis system ensures comprehensive patient evaluation.



Axis I: Physical Assessment

Comprehensive evaluation of physical disorders affecting the temporomandibular joint and masticatory muscles. Includes standardized examination protocols, measurement techniques, and classification of joint and muscle pathology.



Axis II: Psychosocial Assessment

Evaluation of psychological status, behavioral factors, and psychosocial impact of pain. Assesses depression, anxiety, pain-related disability, and overall quality of life to guide holistic treatment planning.



Integrated Diagnosis

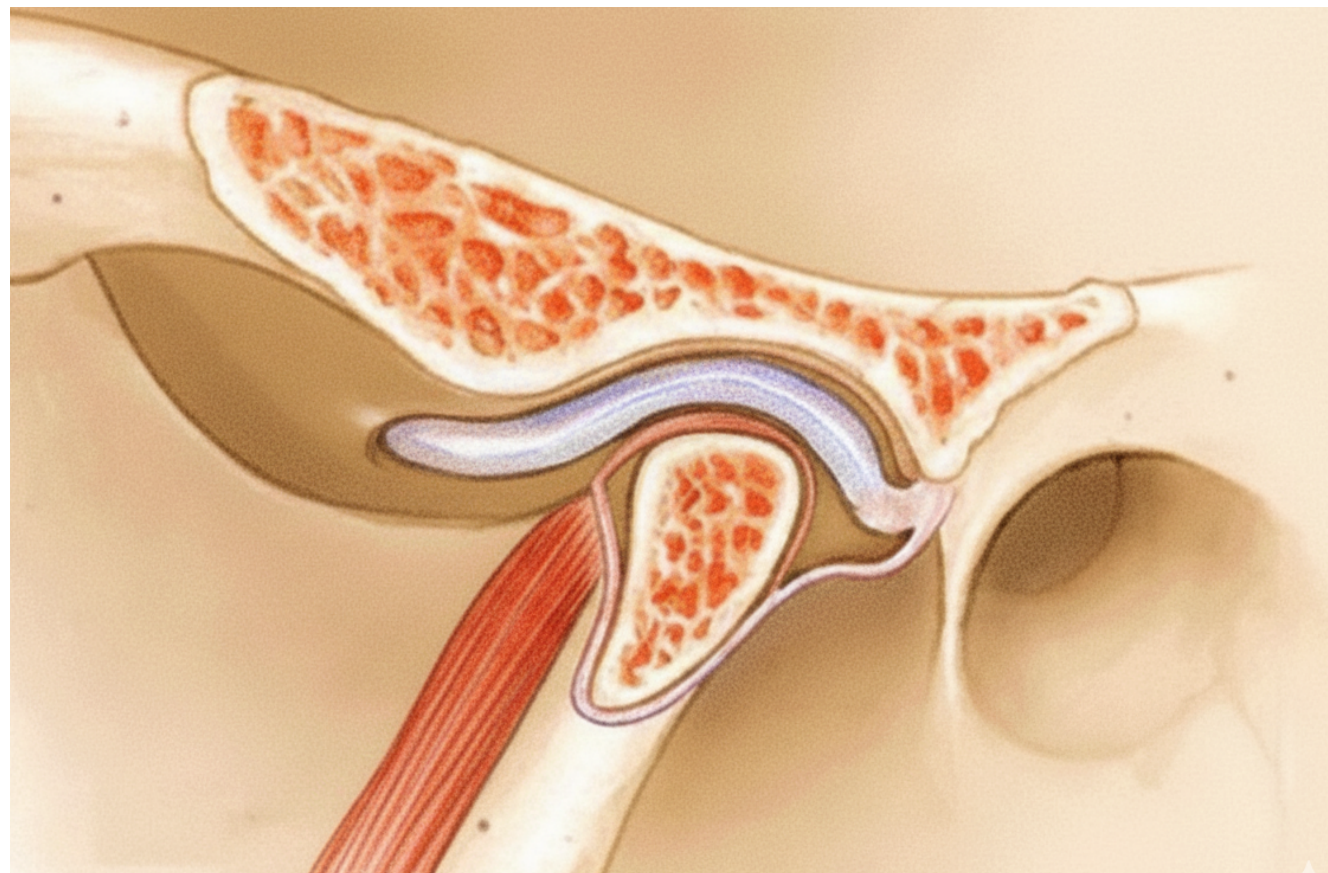
Provides validated criteria for consistent diagnosis across clinical and research settings. Enables evidence-based treatment decisions and facilitates communication among healthcare providers for optimal patient outcomes.

Classification of TMD Types

Intra-articular Disorders

Conditions affecting structures within the TMJ capsule:

- **Disk displacement:** With or without reduction, affecting joint mechanics
- **Osteoarthritis:** Degenerative changes to joint cartilage and bone
- **Inflammatory conditions:** Including synovitis and capsulitis



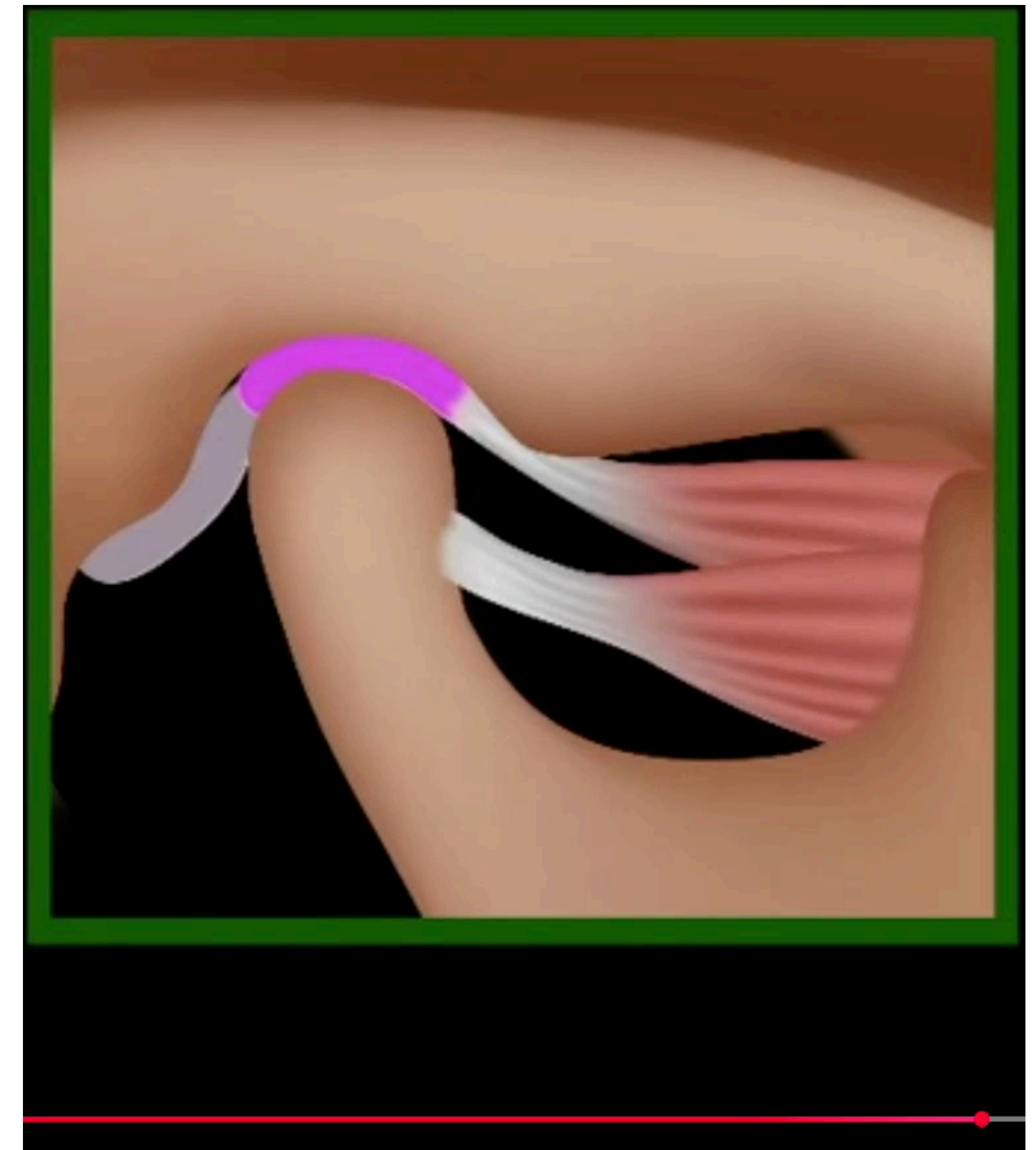
Intra-Articular Disorders

Disc Displacement with Reduction

Patient History: Report of any joint noise (click or pop) present in the last 30 days.

Examination: Clicking, popping, or snapping detected on opening, closing, and/or excursions.

Key Feature: Disc returns to normal position on opening ("reduction").



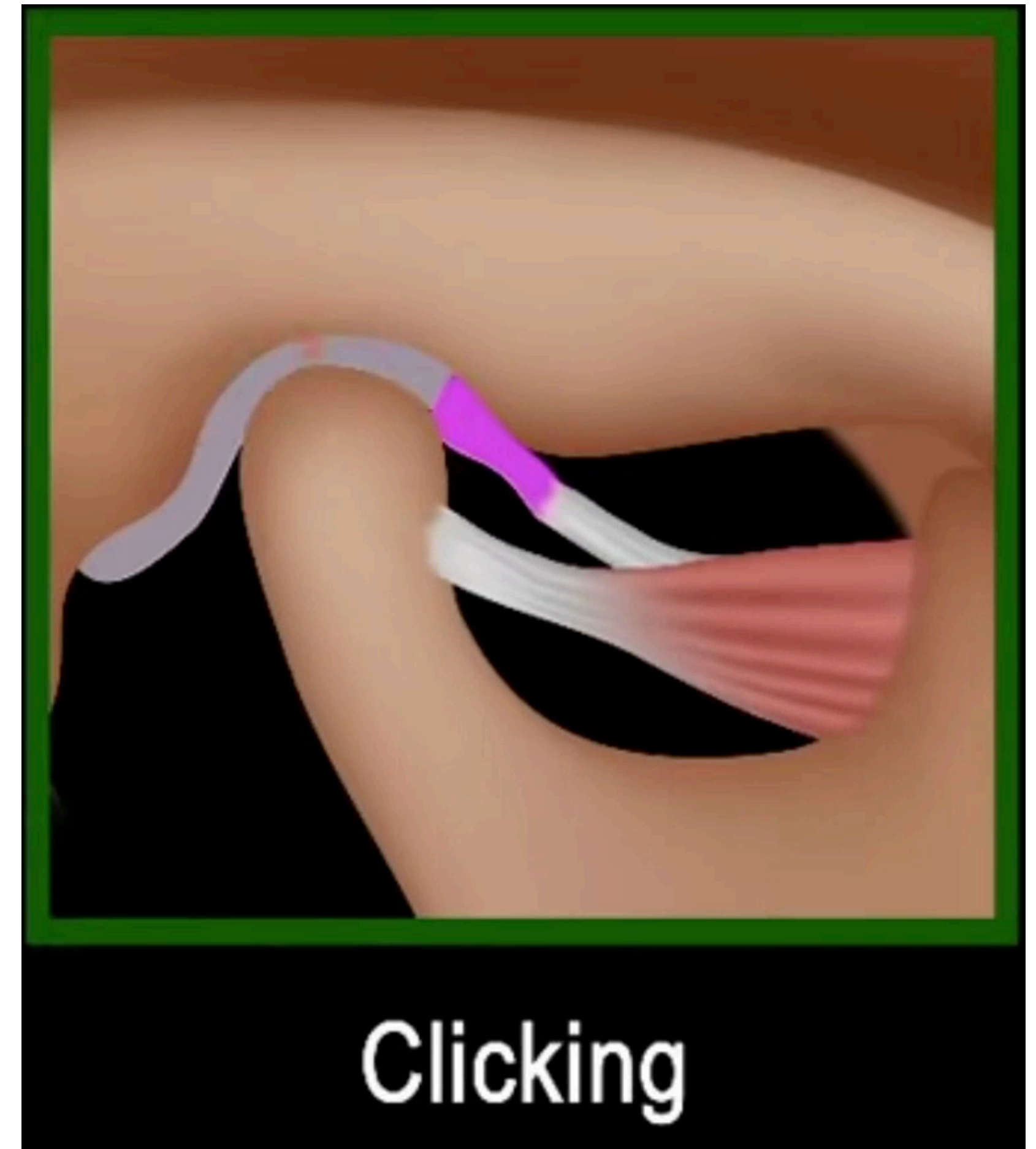
Intra-Articular Disorders

DD Without Reduction (Limited Opening)

Range of Motion: Assisted opening < 40 mm

History: Prior locking or catching; current "closed lock" sensation.

Pain: Often painful on attempted maximum opening.



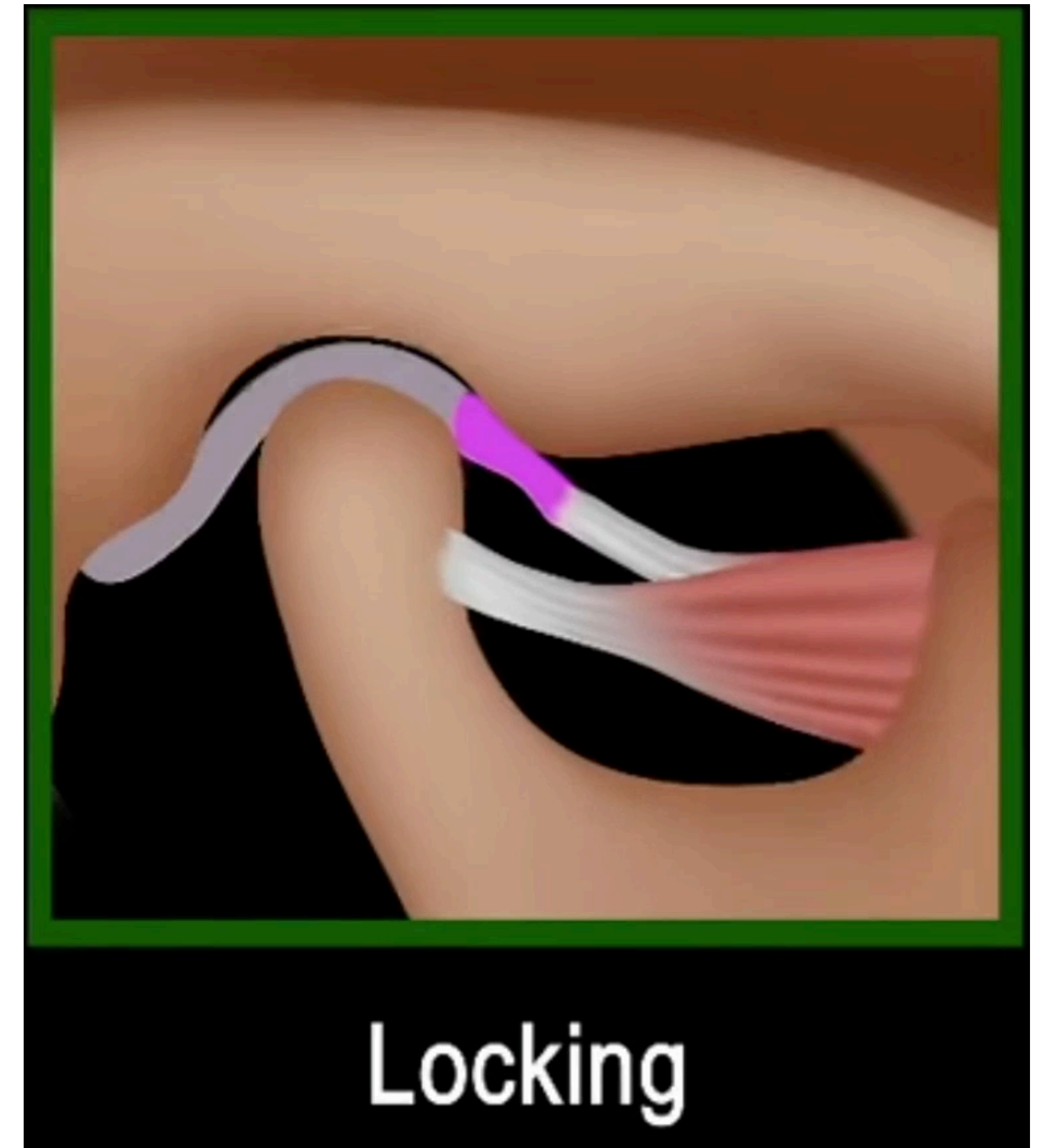
Intra-Articular Disorders

DD Without Reduction (No Limitation)

Range of Motion: Assisted opening ≥ 40 mm.

History: Supports prior displacement; current mechanics suggest chronic non-reduction.

Crepitus: May be present if degenerative changes have begun.



Intra-Articular Disorders

DD with Reduction + Intermittent Locking

Intermittent Locking: History of locking with limited opening that self-resolves.

Maneuver: Patient often maneuvers jaw to unlock and restore movement.

Classification of TMD Types

Intra-articular Disorders

Conditions affecting structures within the TMJ capsule:

- **Disk displacement:** With or without reduction, affecting joint mechanics
- **Osteoarthritis:** Degenerative changes to joint cartilage and bone
- **Inflammatory conditions:** Including synovitis and capsulitis

Extra-articular Disorders

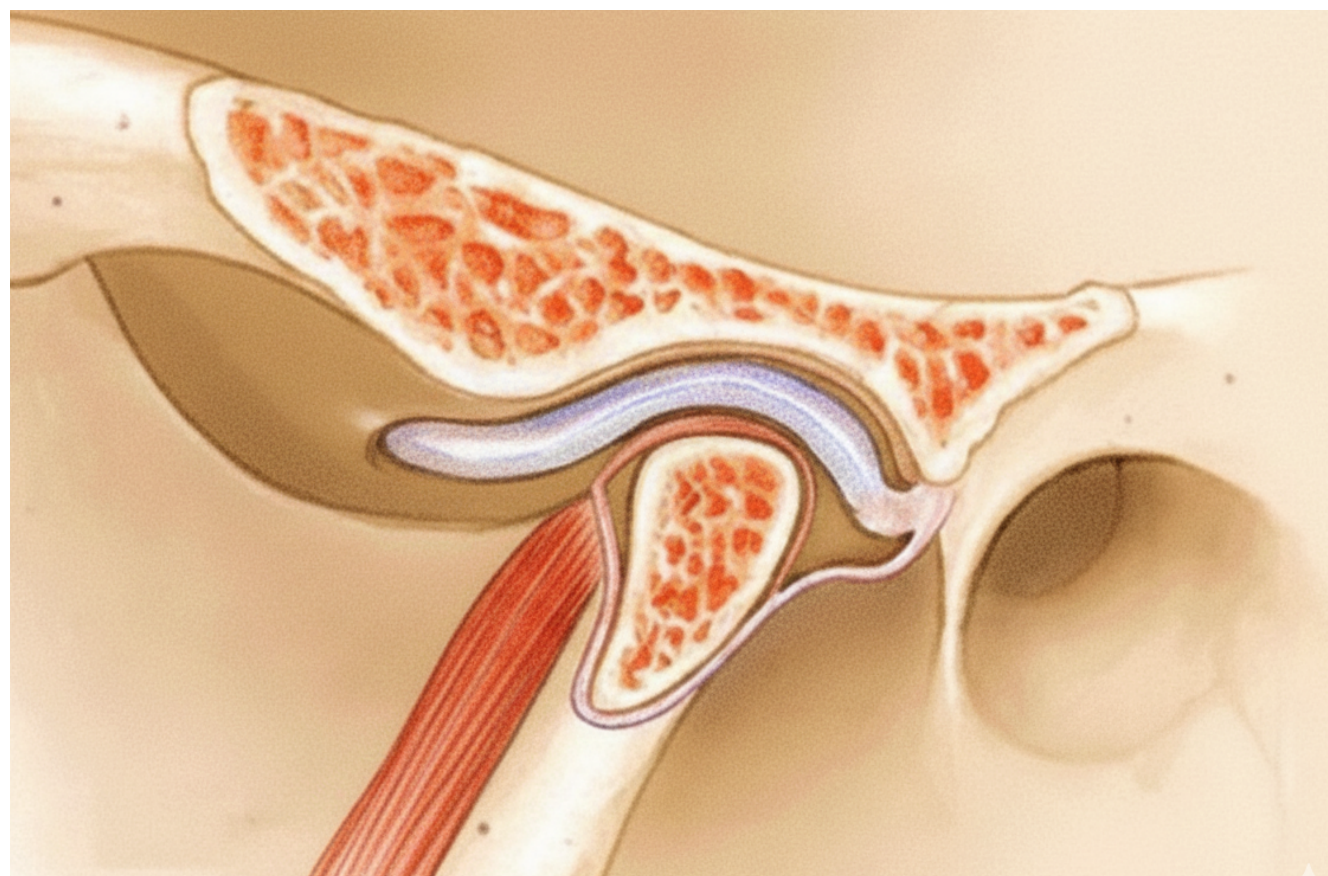
Conditions primarily affecting muscles and surrounding tissues:

- **Myofascial pain:** Most common TMD subtype with muscle trigger points
- **Muscle dysfunction:** Including spasm, contracture, and hypertrophy
- **Tendinitis:** Inflammation of masticatory muscle tendons

Secondary Headache

Headache disorders related to TMD pathology:

- Headache attributed to TMD as a secondary diagnosis
- Often presents as temporal or frontal headaches
- May be confused with primary headache disorders



Differential Diagnosis to Consider

TMD symptoms can overlap with various other conditions. A systematic approach to differential diagnosis ensures accurate identification and appropriate treatment referral when necessary.

Dental Pathology

Dental caries, periapical abscess, periodontal disease, cracked tooth syndrome, and malocclusion can mimic TMD pain patterns. Thorough dental examination is essential.

Neurological Conditions

Trigeminal neuralgia, occipital neuralgia, and other neuropathic pain syndromes may present with facial pain. Consider also migraine and tension-type headaches in the differential.

Otologic Disorders

Ear pathology including otitis media, external otitis, and Eustachian tube dysfunction can cause symptoms near the TMJ. Referred otalgia is common with TMD.

Systemic Conditions

EDS, Fibromyalgia, rheumatoid arthritis, cervical spine disorders, and other musculoskeletal or systemic pain disorders may coexist with or mimic TMD symptoms.



Summary & Clinical Takeaway

1 Clinical Foundation

Accurate TMD diagnosis relies primarily on thorough patient history and focused physical examination. These remain the cornerstone of evaluation before considering advanced diagnostic measures.

2 Standardized Approach

Utilize the DC/TMD criteria framework for consistent, evidence-based diagnosis and treatment planning. This dual-axis system addresses both physical and psychosocial dimensions of the disorder.

3 Imaging as Adjunct

Advanced imaging supports clinical evaluation but does not replace it. Reserve MRI and CT for unclear cases, refractory symptoms, or when surgical intervention is being considered.

4 Early Intervention Matters

Early and accurate diagnosis significantly improves patient quality of life and guides effective conservative management strategies. Timely recognition prevents chronic issues and optimizes the outcomes for treatment.

Understanding the Causes of Temporomandibular Disorder (TMD)



Primary Causes of TMD: Multifactorial and Often Overlapping

Temporomandibular disorder rarely stems from a single cause. Understanding the complex interplay of mechanical, structural, and inflammatory factors is essential for accurate diagnosis.



Mechanical Strain

Excessive load on jaw muscles and joints from overuse, repetitive movements, or sustained positioning creates chronic stress on the TMJ complex.



Bruxism

Habitual teeth grinding or clenching, often unconscious during sleep or stress, generates tremendous force that damages joint structures and exhausts muscles.



Trauma & Injury

Direct trauma to the jaw, head, or neck—including fractures, dislocations, or whiplash—can permanently alter joint mechanics and trigger chronic dysfunction.



Arthritis

Degenerative conditions including osteoarthritis and rheumatoid arthritis cause inflammation, cartilage breakdown, and progressive joint deterioration.



Structural Displacement

Displacement or damage to the articular disk or mandibular condyle disrupts normal biomechanics, leading to clicking, popping, and restricted movement.

Behavioral and Psychological Contributors

Beyond physical causes, psychological and behavioral patterns play a significant role in TMD development and perpetuation. Recognizing these factors enables comprehensive treatment planning.

Stress & Anxiety

Emotional stress triggers increased muscle tension throughout the body, particularly in the jaw. Chronic anxiety leads to sustained clenching and the muscles of mastication constantly being on alert.

Parafunctional Habits

Repetitive behaviors like excessive gum chewing, nail biting, pen chewing, and cheek biting create cumulative microtrauma and muscle fatigue over time.

Postural Dysfunction

Forward head posture and poor neck alignment alter the biomechanical relationship between the cervical spine and mandible, increasing strain on TMJ structures.

Systemic Conditions

Comorbid pain syndromes including fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome often correlate with increased TMD severity and how chronic the issue is.



Muscle-Related Causes: Myofascial Pain

Myofascial pain dysfunction represents the most prevalent form of TMD, affecting the muscles of mastication, the neck, and surrounding structures. This muscular component often coexists with joint pathology.

1

Muscle Overuse & Fatigue

The masticatory muscles—masseter, temporalis, medial and lateral pterygoids—become chronically fatigued from sustained contraction, overwork, or inadequate rest periods. This leads to trigger point formation and referred pain patterns.

2

Spasm & Hypertonicity

Protective muscle guarding evolves into sustained spasm, reducing blood flow and oxygen delivery. This ischemic environment creates a self-perpetuating cycle of pain, tension, and further dysfunction.

3

Inflammatory Cascade

Repeated microtrauma from grinding and clenching triggers inflammatory response within muscle tissue. This inflammation sensitizes nociceptors, amplifying pain signals and creating chronic discomfort.

Summary: Why Understanding Causes Matters

Accurate identification of TMD etiology is foundational to developing effective, personalized treatment strategies that address root causes rather than merely managing symptoms.

1 Multifactorial Nature

TMD rarely results from a single cause—mechanical stress, behavioral patterns, trauma, arthritis, and psychological factors typically combine to create and perpetuate the disorder.

2 Early Detection Impact

Identifying contributing factors like bruxism, postural dysfunction, or early arthritic changes enables timely intervention, potentially preventing progression to chronic, debilitating TMD.

3 Patient Education Value

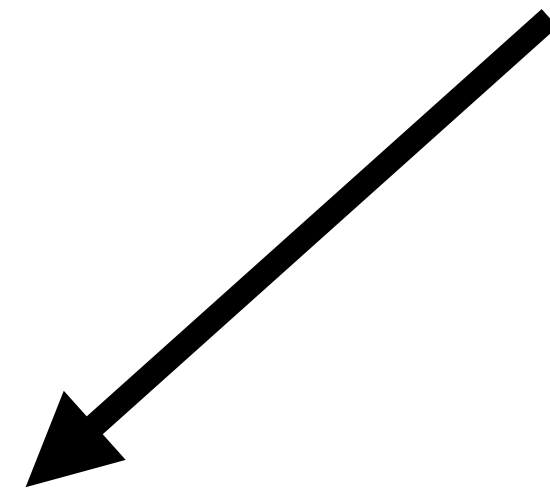
Teaching patients about modifiable risk factors—stress management, habit cessation, ergonomic improvements—empowers them as active participants in prevention and recovery.



Treatment Options for Temporomandibular Disorders (TMD)

A comprehensive guide to integrative TMD management combining musculoskeletal expertise with dental precision for optimal patient outcomes.

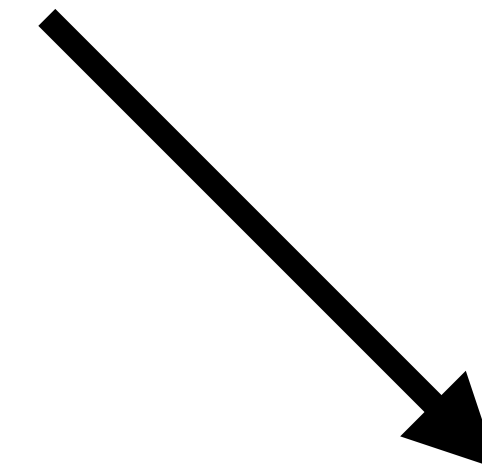
Treatment Options for Temporomandibular Disorders (TMD)



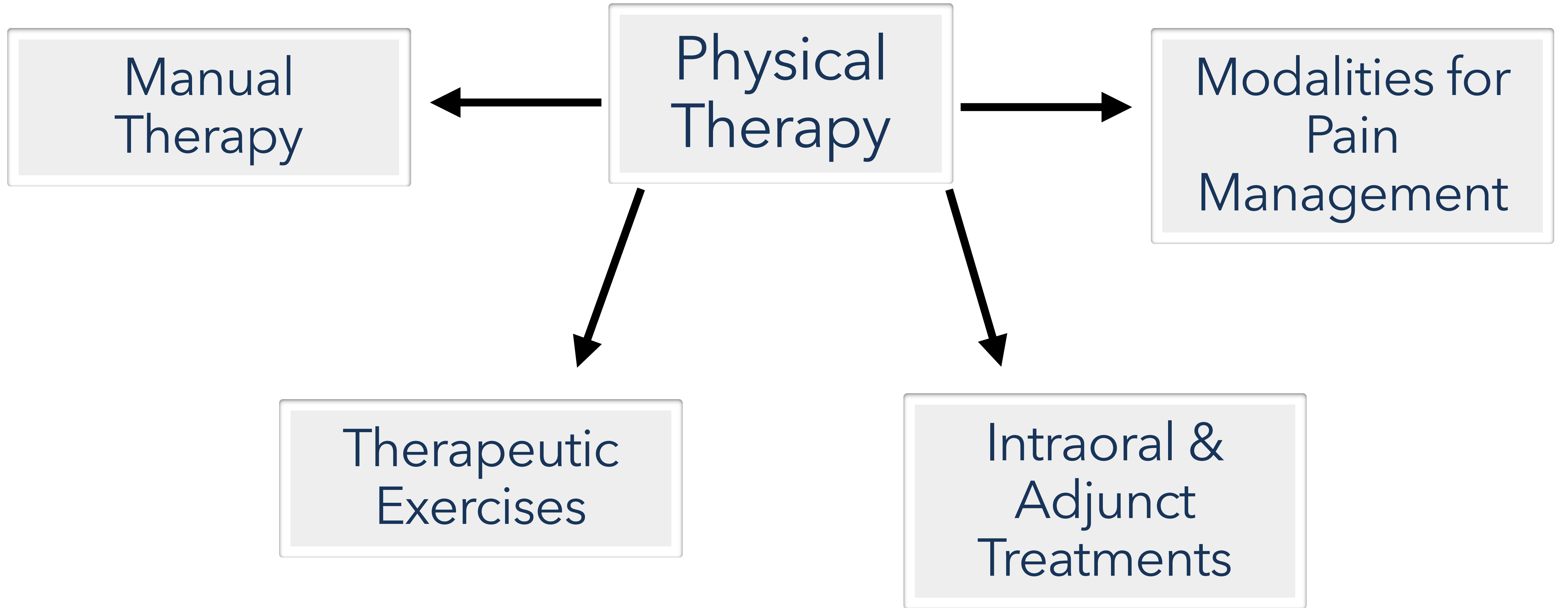
Physical
Therapy



Chiropractic



Dentistry



Manual
Therapy

Physical
Therapy

Modalities for
Pain
Management

Therapeutic
Exercises

Intraoral &
Adjunct
Treatments

Manual Therapy

Joint Mobilization

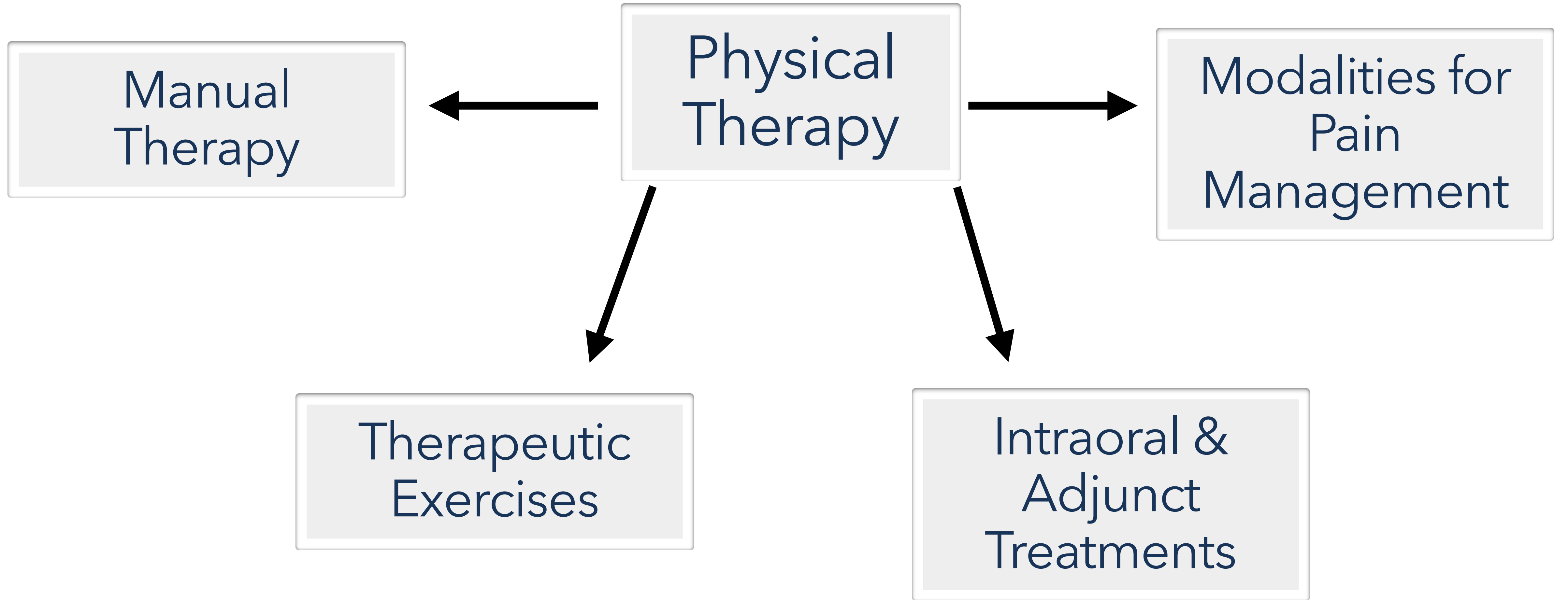
The therapist uses their hands (often wearing gloves to work inside the mouth) to gently glide or distract the jaw joint. This helps "unstick" the joint and improve the range of motion. (MWM)

Soft Tissue Mobilization

Targeting the masseter and temporalis muscles to release "knots" or trigger points.

Examples:

- Myofascial Release
- Massage



Manual
Therapy

Physical
Therapy

Modalities for
Pain
Management

Therapeutic
Exercises

Intraoral &
Adjunct
Treatments

Therapeutic Exercises

Rocabodo's 6x6 Program

One of the most famous PT protocols for TMD, involving six exercises performed six times a day, including tongue rest positions and neck stretches.

Controlled Opening

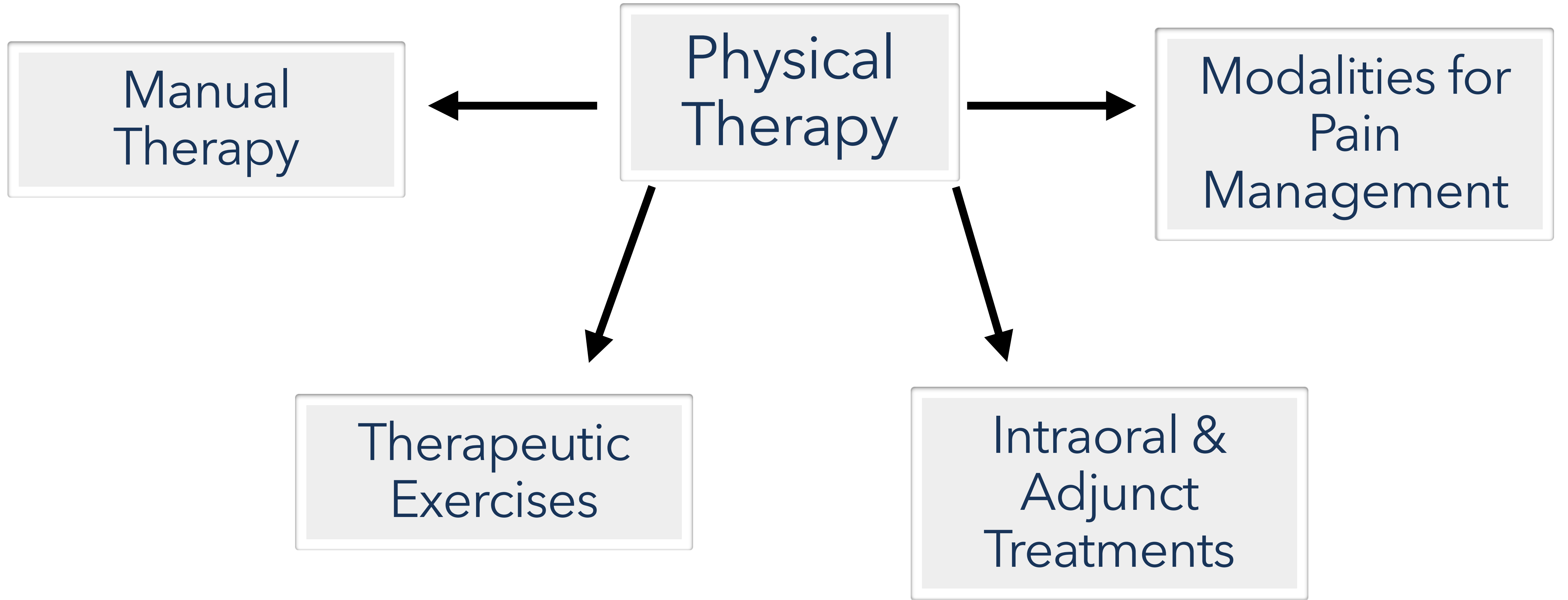
Opening the mouth while keeping the tongue on the roof of the mouth to ensure the jaw moves in a straight line without "deviating" or clicking

Isometric Strengthening

Gently pushing against your jaw with your hand while the jaw resists the movement, which strengthens the muscles without taxing the joint.

Chin Tucks

Since forward-head posture is a major contributor to TMD, these exercises help realign the cervical spine to take pressure off the jaw.



Manual
Therapy

Physical
Therapy

Modalities for
Pain
Management

Therapeutic
Exercises

Intraoral &
Adjunct
Treatments

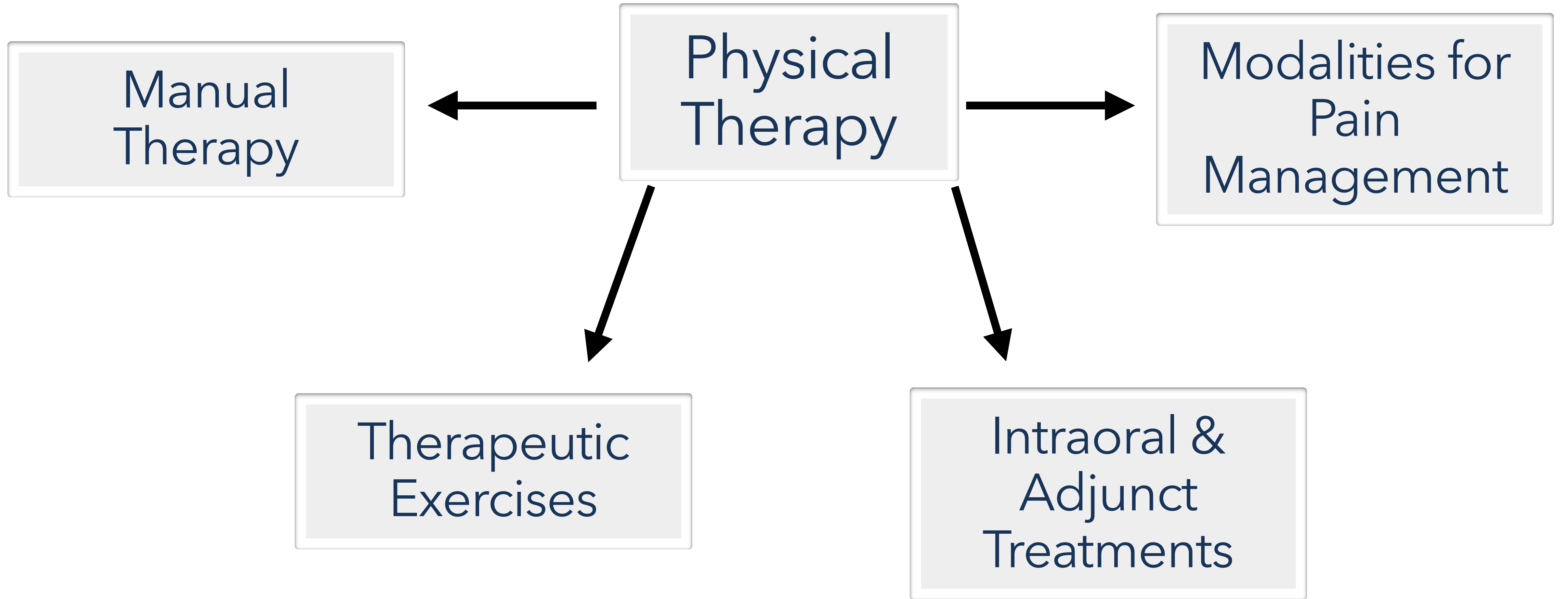
Intraoral & Adjunct Treatments

Intraoral Release:

Manual stretching of the muscles from *inside* the cheek, which is often more effective for the lateral pterygoid muscles.

Dry Needling

If allowed in your state, a PT may use thin needles to release deep trigger points in the jaw or neck muscles that are difficult to reach with hands alone



Manual
Therapy

Physical
Therapy

Modalities for
Pain
Management

Therapeutic
Exercises

Intraoral &
Adjunct
Treatments

Modalities for Pain Management

Cold Laser

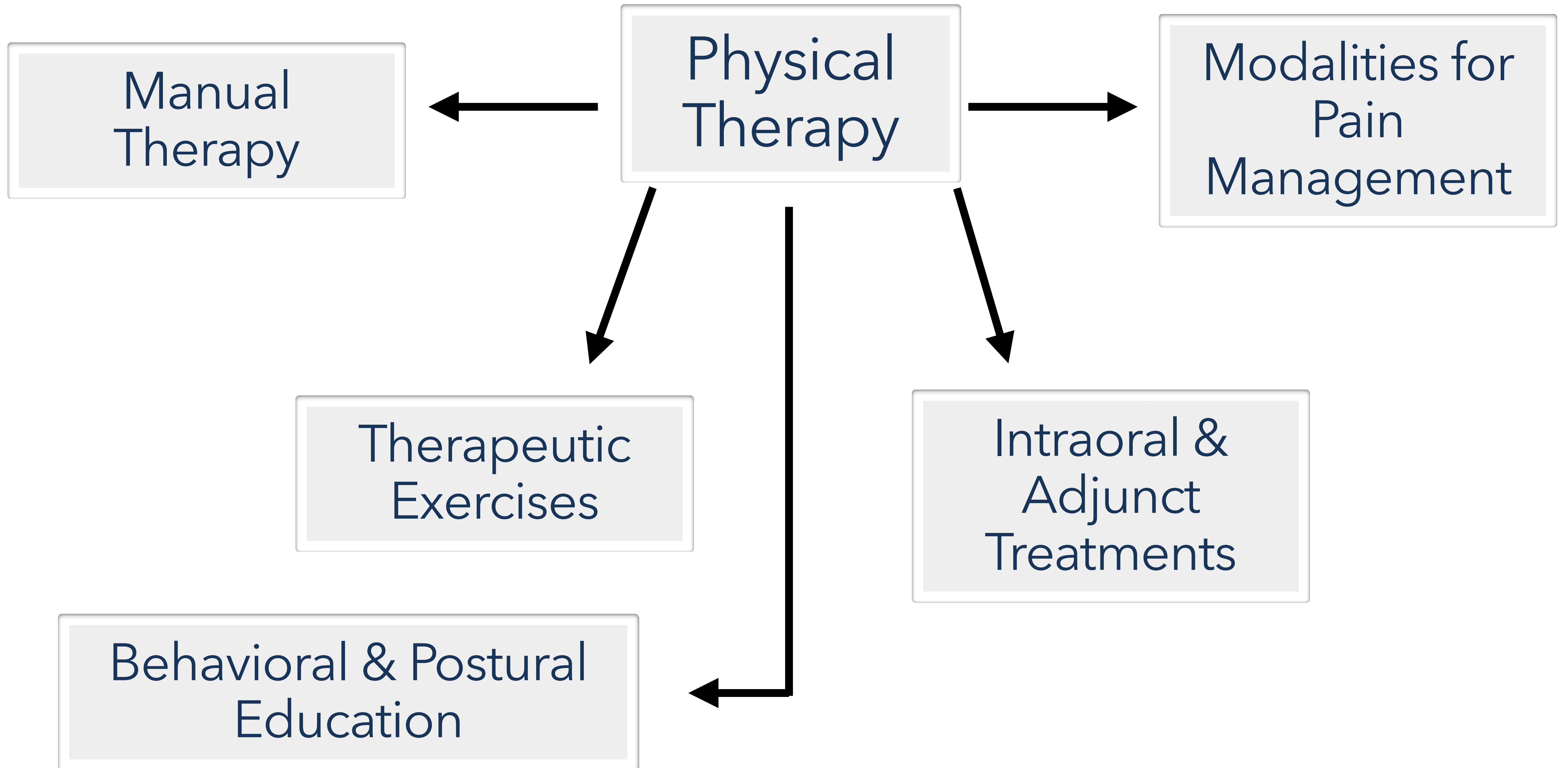
Used to reduce inflammation and promote tissue healing at the cellular level.

TENS (Electrical Stimulation)

Uses low-voltage electrical currents to scramble pain signals.

Ultrasound

Uses sound waves to create deep heat, increasing blood flow and relaxing tight muscles.



Manual
Therapy

Physical
Therapy

Modalities for
Pain
Management

Therapeutic
Exercises

Intraoral &
Adjunct
Treatments

Behavioral & Postural
Education

Behavioral & Postural
Education

Sitting & Standing Posture

Sleep Posture

Parafunctional Habit Awareness

Sitting & Standing Posture

The Forward Head Effect

Muscular Pull – To keep your head from falling forward, the muscles in your neck and throat must tighten. This creates a backward pull on the lower jaw

Joint Compression – The constant backward tension forces the mandibular condyle into the back of the socket, compressing the nerves and blood vessels behind the joint disc.

Malocclusion

Slumped Posture – When you slouch, your lower jaw naturally shifts slightly backward and upward.

Increased Stress – This can cause your teeth to hit unevenly or prematurely. Over time, it puts repetitive stress on the TMJ and leads to clenching or grinding because your muscles are struggling to find a stable resting position.

Referred Muscle Tension

Muscle Chains – If your shoulders are rounded or hunched while sitting at a desk or standing, the tension travels up the "muscular chain" into your face.

The Progressive Cycle – Tight neck muscles limit the jaw's range of motion, making it harder to open your mouth fully or chew comfortably, which in turn causes more facial muscle spasms.

Optimal TMJ Resting Position

The teeth are slightly apart.

The tongue is resting gently on the alveolar ridge.

The jaw muscles are at their lowest level of activity or activation.

Behavioral & Postural
Education

Sitting & Standing Posture

Sleep Posture

Sleep Posture

External Pressure and Displacement

When you sleep on your stomach or side, the weight of your head, which is about 10-11 lbs, presses against the pillow. This force can push the mandible laterally or backward. Over time, this constant pressure can cause the disc within the joint to shift or become compressed, leading to clicking, popping, or inflammation.

Muscle Tension and "The Arm Pillow"

Side sleepers tuck a hand or arm under their pillow for support creating a hard, uneven surface that forces the jaw into an unnatural angle. This posture puts the masseter and temporal muscles on tension rather than relaxation, leading to significant muscle fatigue and pain upon waking.

Airway and Breathing

Sleeping on your back may compromise the airway by causing the chin to tuck towards the chest. This can trigger the body to subconsciously grind or clench the teeth. The brain uses clenching as a way to "stiffen" the airway and keep it open, but can severely overwork the TMJ.

Connection Between the Spine & Jaw

The jaw is mechanically linked to the cervical spine. Any posture that strains the neck, *like stomach sleeping*, creates a "pull" on the muscles that connect to the jaw. If your neck is out of alignment, your jaw cannot rest in its neutral position.

Behavioral & Postural
Education

Sitting & Standing Posture

Sleep Posture

Parafunctional Habit Awareness

Parafunctional Habit Awareness

Daytime “Micro-Habits”

Teeth Contact – There should be a slight gap in the top and bottom teeth at rest.

Jaw Bracing – Teeth are not touching but there is tension in the jaw. (Isometric Contraction)

Tongue Thrusting – Forcibly pressing the tongue against the back of the teeth creating pressure on the dental arch and TMJ.

Postural Habits

“Chin-in-Hand” – Resting your jaw on your hand or knuckles.

“Telephone Bracing” – Holding a phone between the shoulder and ear.

Stomach Sleeping – Causes poor neck alignment and places an abnormal prolonged stretch on the TMJ

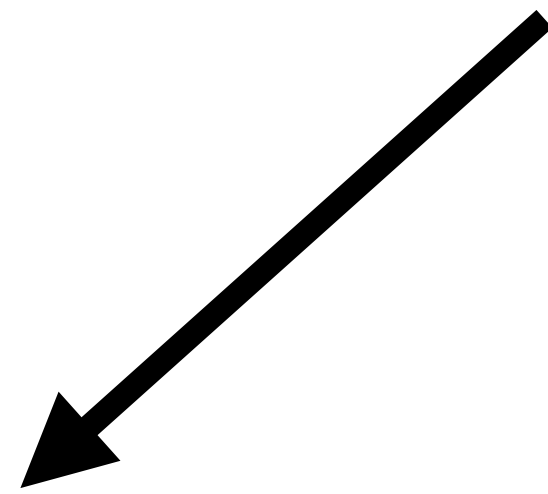
Oral Fixations & Biting

Object biting – Pens, pencils, fingernails, which cause the jaw to project forward, placing stress on the jaw ligaments.

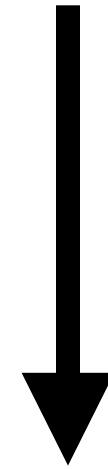
Cheek or Lip Biting – Highly associated with stress and thus upper trapezius and neck tension.

Excessive Gum Chewing – Will not cause problems in small doses but excessive “chain-chewing” keeps the jaw muscles in constant tension.

Treatment Options for Temporomandibular Disorders (TMD)



Physical
Therapy



Chiropractic

Chiropractic

Jaw Adjustments

Chiropractors use gentle, manual manipulation to realign the jaw joint (temporomandibular joint). This can help reduce clicking or popping sounds and improve the jaw's range of motion.

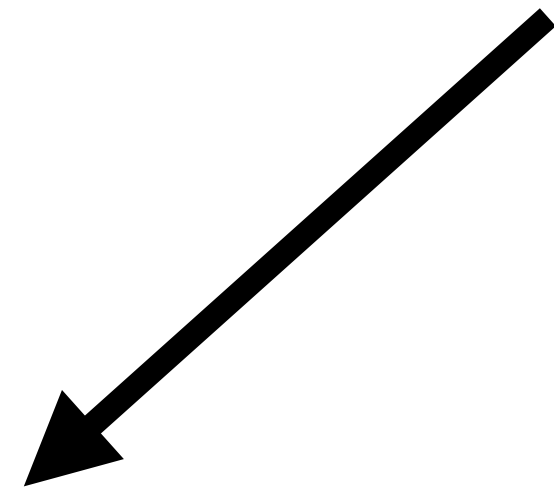
Spinal and Neck Realignment

Misalignments in the upper cervical spine (neck) can strain the nerves and muscles connected to the jaw. Adjusting the spine helps restore proper nerve communication and reduces secondary tension.

Graston Technique

The tools help identify and break up "knots" or **adhesions** in the masseter (the main chewing muscle) and surrounding tissues, which can otherwise restrict your range of motion.

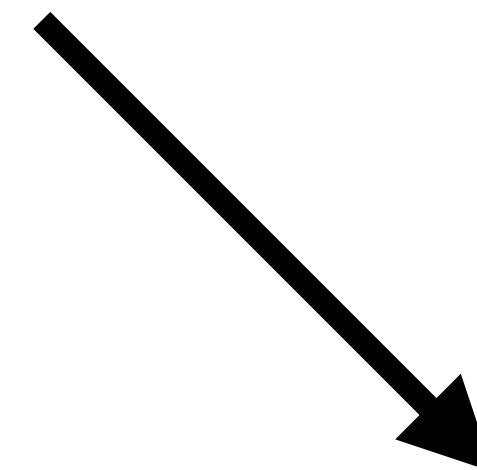
Treatment Options for Temporomandibular Disorders (TMD)



Physical
Therapy



Chiropractic



Dentistry

Dentistry

Oral Appliance Therapy

Stabilization Splints (Bite Guards)

Repositioning Splints

Pharmacological Treatments

Muscle Relaxants

NSAIDs

Low-dose Tricyclic Antidepressants
– For Nocturnal Bruxism

Therapeutic Injections

Botox

Trigger Point Injections with
either an Anesthetic or
Corticosteroid Injection

Bite and Structural Adjustments

Restorative Dentistry – Replacing
Crowns or Bridges

Orthodontics

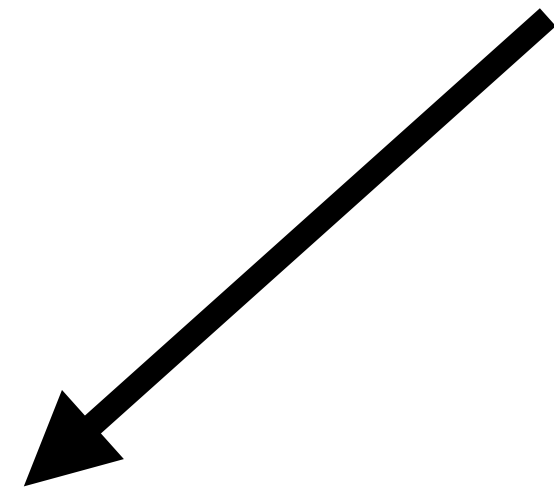
Specialist Referrals (Surgical & Advanced)

Arthrocentesis

Arthroscopy

Open-Joint Surgery or Jaw Reconstruction

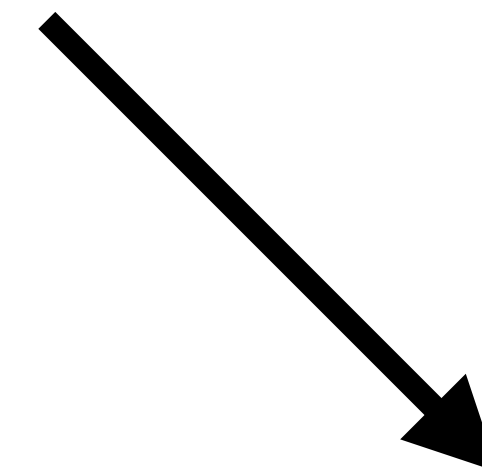
Treatment Options for Temporomandibular Disorders (TMD)



Physical
Therapy



Chiropractic



Dentistry



Neuromuscular Reeducation



Brain-Muscle Communication

A specialized therapeutic approach that retrains the vital communication pathways between your brain and muscles, rewiring neural connections for optimal function.



Enhanced Movement Quality

Dramatically improves balance, coordination, posture, and proprioception to achieve pain-free, efficient movement patterns in daily life.



Empowered Recovery

Leverages neuroplasticity and motor learning principles to help patients recover from injury, surgery, and neurological conditions with measurable results.



Functional Independence

Provides the foundation for regaining control, improving overall function, and confidently returning to daily activities or peak athletic performance.

Neuromuscular Reeducation

Definition

A therapeutic technique that restores the functional link between the mind and body by retraining the central nervous system to accurately control muscle timing, force, and coordination.

Fascial Counterstrain

Fascial Counterstrain

What is Fascial Counterstrain?

Fascial Counterstrain is based on the idea that every structure in your body – from nerves and arteries to ligaments and organs—is encased in fascia. When an injury or repetitive strain occurs, the fascia can go into a reflexive spasm to protect the area. If this spasm doesn't "reset" on its own, it leads to chronic pain and inflammation.

The Technique: A practitioner identifies a specific "tender point" (a diagnostic indicator of a fascial spasm). They then gently move the patient's body into a position of comfort that slackens or shortens the involved tissue.

The Goal: By holding this position (usually 45-60 seconds), the nervous system receives a signal that the "threat" is gone, allowing the protective reflex to reset and the tissue to relax and go back to its normal tension.

Fascial Counterstrain

How it Benefits Patients with TMD

Releasing Nerve & Vascular Spasms

FCS can specifically target the fascia surrounding the trigeminal nerve and the local arteries. By releasing these spasms, it reduces "burning" pain and improves the "clogged" feeling often felt in the jaw or ears.

Decompressing the Joint Cartilage

FCS includes techniques designed to treat the **articular disk** and cartilage of the TMJ itself. If the cartilage is held in a "guarded" state due to trauma (like dental work or whiplash), FCS can help restore its normal glide, which often reduces the **popping and clicking** sounds associated with TMD.

Reducing Inflammation and Edema

Chronic TMD often results in "trapped" inflammatory chemicals. By relaxing the smooth muscle in the lymphatic vessels and veins, FCS restores proper drainage, which helps clear out the swelling that makes the jaw feel stiff and heavy.

Addressing "Eye Myochains"

FCS looks at the body in "chains." For example, the **Ocular Myochain** links the eye muscles to the jaw. Strain from screen time or vision issues can reflexively tighten the jaw muscles. An FCS practitioner can release tension in these distant areas to provide relief for the TMJ.

Fascial Counterstrain

In Summary:

Pain-Free Treatment: No "cracking" or painful stretching; the therapist moves you into positions that feel good.

Improved Range of Motion: Helps you open your mouth wider and more comfortably.

Decreased Headaches: Effectively treats tension headaches and migraines that often accompany jaw issues.

Nervous System Reset: It calms the "fight or flight" response in the jaw muscles, which is common in chronic clenchers and grinders.

Clinical Outcomes & Evidence

73%

Patients report
immediate pain reduction

+8mm

Average increase
in mouth opening

1–3 Tx

Typically needed to
achieve lasting relief

0

Adverse events
reported in trials

Documented Patient Outcomes

- Significant reduction in jaw pain
- Decreased headache frequency & intensity
- Resolution of ear symptoms (tinnitus, fullness)
- Improved cervical range of motion
- Reduced bruxism frequency (patient-reported)
- Improved sleep quality and bite comfort
- Decreased reliance on NSAIDs

Supporting Evidence

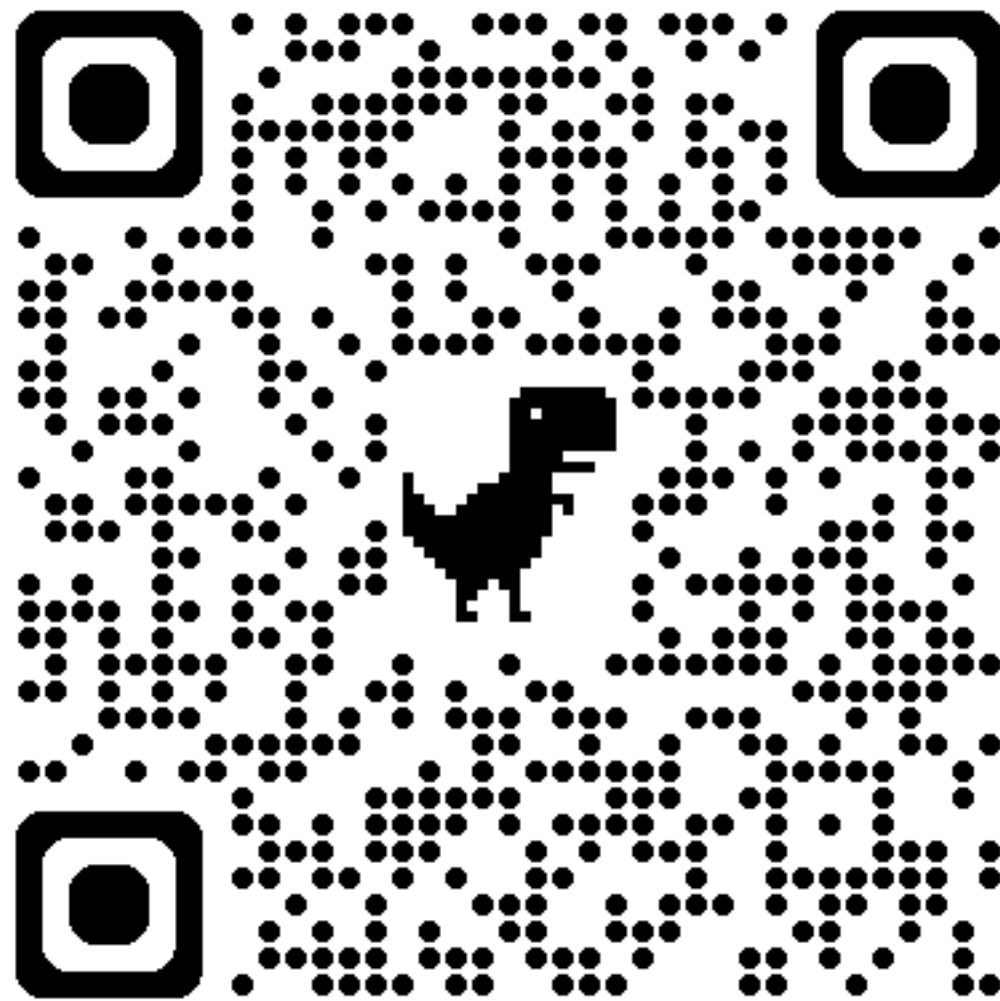
- Jones Counterstrain reduces fascial tender point sensitivity by up to 70% (Jones, 1995)
- Manual therapy including SCS significantly improves TMJ pain & function (La Touche et al., 2009 — J Oral Rehab)
- Counterstrain techniques reduce inflammatory markers in connective tissue (Wynne et al., 2006)
- Cervical manual therapy reduces TMD-related headache (Calixtre et al., 2016 — JOSPT)
- FCS addresses neurogenic pain pathways not reached by joint mobilization alone

Why Fascial Counterstrain vs Other Manual Techniques

	FCS	Other Manual Techniques
Pain during tx	None	Often moderate
Force used	Minimal	Moderate–high
Target tissue	Fascia + proprioceptors	Joint / muscle
Neurological reset	Yes (spindle)	Partial / Temporary
TMJ capsule access	Indirect via fascia	Direct joint Mob
Patient tolerance	Excellent	Variable

Fascial Counterstrain

Resources



Course Summary:

- Basic Anatomy and Function
- Diagnosis of TMD
- Causes of TMD
- Treatment Options

Q & A

Contact Information



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BIO

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