Shoulder Taping

Gray Cook speaks to the clinician about how to use taping, specifically shoulder taping, in practice not just theory. This is an expansion of taping information originally introduced in the Functional Taping and Assessment DVD.

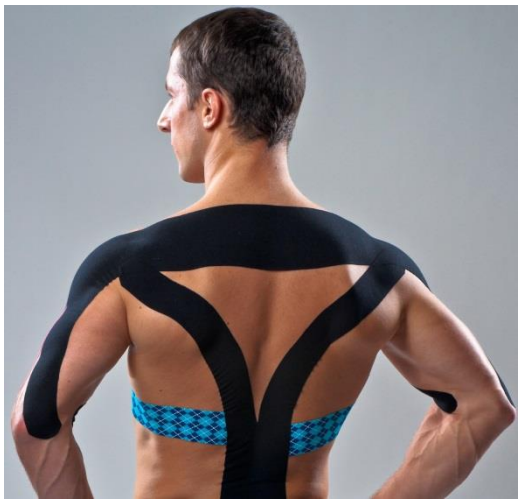
This is Gray Cook and I have another question. "You do not go into much detail in your taping video". I believe this question is probably from a physical therapist or an athletic trainer because they are making reference to a video DVD that we did on "Functional Taping".

Now you probably need a clinical background if you are going to be throwing tape on someone because there are a lot of contraindications for tape – skin problems, diabetes and lots of different issues that can arise when you throw tape on someone. But if you have a background in chiropractic medicine, the regular medical field, physical therapy or are a certified athletic trainer, it is probably appropriate to be talking tape.

Tape, to me, is way under used in rehabilitation. We did the taping DVD based on a lot of the mobilization techniques taught by Brian Mulligan. If you have not had a chance to get to one of the Brian Mulligan mobilization workshops, look at his books or even his videos, you are missing out on something because Brian has been in the physical therapy field forever. At the end of his career which was heavy into manipulation - what a chiropractor would call an adjustment and what a physical therapist would call manipulation – he realized that these little mobilizations with movement are almost more powerful than snapping, cracking and popping someone's joints. I concur. What he actually does is position the body, position you in a point of stability and then asks you to move so he is not really doing a mobilization at all. He is doing stabilization and you are performing the active movement. Now for patient comfort and safety, that is way better than passively just jerking someone around because they control the movement. But

secondly, you get to do an immediate appraisal of, “Did I make a difference or not?”

So let’s use the question about the shoulder. In the taping video, I do not really go into depth with positioning. Actually I thought I did but maybe I just did it quick or maybe I did not say enough. Either way when you are getting ready to tape someone into a more stable position, the first thing you need to do is to make sure that they are mobile. Some people are so tight in certain positions that they require some manual therapy, muscle work, soft tissue mobilization, stretching, trigger point work, foam rolls and stick work. They require something just to get moving to get into the right position. The scapula, we think, is a very mobile segment. We see people with a winging scapula. We see people stuck in a forward position but that does not necessarily mean that we can get them in that position of stability.



So one of the things I like to do if I am working on the right shoulder I will lay someone on their left shoulder, facing me with their head on a pillow, and I reach up under the arm with one hand and place my hand that went under their arm on the back of the scapula and place the other hand on top of the shoulder. I do a big circle of the available mobility of scapular range of motion which will get you a protracted elevated shoulder, a retracted elevated shoulder, a protracted depressed shoulder and a retracted elevated shoulder. Basically just think of all four directions. If we did a full arm shrug back, it would be upper trapezius. If we did a full arm shrug forward, we would be stretching the lower trapezius and probably using more of the pectoralis for that, maybe pec minor. Depression is going to take you down and back which is going to be more lower trapezius and rhomboid. The point is that you have to almost create a box or a circle, taking that thing up and back, down and forward, down and back, up and forward. A lot of people call that scapular PNF.

Like I said, I am sort of not talking to non-clinicians here. I am talking to people who have a background in manual therapy and know what I am talking about. What you are going to want to do is after creating mobility in the scapula, stand them back up and have them reach overhead. Obviously you have someone with a shoulder issue. They have limited range of motion, a positive impingement sign, discomfort with elevation or something. Do not put your hand on the scapula. Put your hand right at the inferior medial angle of the scapula and help the lower trapezius create a contraction. You can do that manually. You basically shorten the distance between the inferior angle of the scapula and L-5. Shorten that position. What you are doing is creating sort of a pseudo-contraction of the lower trapezius.

There is another way to do this and it is actually neater. Have someone stand flatfooted with their feet planted and rotate as far as they possibly can with a full complementary head turn to the side of the bad shoulder. You really do help them return and retract those shoulders. Really keep a tall spine while you are turning. Most people get shorter when they turn which is the reason they have a problem with rotation. Really encourage a tall spine, turn the chin, turn the head, retract and depress, guide them into that position and see their forward flexion. See if the elevation of their shoulder is not better when they are rotated to that side. If it is, I think we must all admit that a natural retraction depression of that shoulder is complementary to the forward flexion that you need.

Now sometimes people need a little more upper trapezius. It is not that the upper trapezius is a primary stabilizer in overhead movements because actually it is not. Too much of that can actually hurt you. That lower trapezius comes in when you reach behind the back. But what we want to do with that upper trapezius is that if someone has sort of a lazy upper trapezius - just a depressed shoulder from carrying a shoulder bag, carrying a child or thinking that the weight training technique they were doing was doing a good job but was pulling them down and forward - then poor dead lifting technique is one of those. You do not shrug on a dead lift but you retract those shoulders

and set them in a neutral retracted position. Neutral means not too elevated, not too depressed – just straight on backward and retracted, holding the deck of cards between your shoulder blades.

In locking that position in and pulling it off the ground, the shoulders do not move. You do not have to move a stabilizer to strengthen it. Holding a stabilizer in its position under load is what it needs to do. So doing a bunch of shrugs and doing a bunch of retractions are not going to tell your stabilizers anything except that they are movers and they are not. So lock that shoulder into position with a straight bar, a kettlebell or a dumbbell dead lift and do not let the shoulder yield. Do not shrug. Do not curl. Do not do anything. Let the hips drive and let the shoulder hang from its socket.

What you are doing in this taping assessment is that you are reaching overhead and you are basically shortening the upper trapezius with your hands. Do not touch bones. Touch muscles. Go from origin to insertion and just do a little squeeze. Do it low. Do retraction. Do upper trapezius. Do lower trapezius. Which one helps? Whichever one helps, throw a strip of tape down there. We went over the taping technique in that DVD.

If you are a physical therapist, chiropractor, athletic trainer or sports medicine physician and you appreciate the Functional Movement Screen, a lot of our exercises and are not using your medical credential, start using some tape. Get you a roll of tape. Get you a roll of cover roll. Put in the DVD. Get someone who is willing to have tape put on and pulled off of them a few times. You will be light years ahead of where you were the day before. Many of us have great soft tissue and mobilization techniques. We know how to release things and get things moving but let me tell you something. They stand up, walk out of the clinic and by the time they get to the car and slam the door, they are right back on their preferred neuromuscular situation. Even if it is wrong, it feels familiar. What is the default? Default is, "I am going back to what is familiar". Wrong things are very often familiar.

What is a great way to reinforce what you did today? - a little strip of tape and a little biofeedback. Tell them to leave the tape on 2-3 days if they can. They can shower around it. We just prep the skin real good and make sure there are no skin problems. We have even taped a fresh knee surgery before. We just put Band-Aids over the portals or over the scar. If it is holding them in a position and if they can move better, freer and more comfortable with the tape, obviously it is providing a supportive role that the neuromuscular system has left on the table. We have to do that. So I would really, really encourage you not to do the taping stuff I am talking about unless you have that DVD in your hand. You will see how powerful it is. I would stake my career and reputation behind it because my hands are tied without the tape. All of my manual therapy skills go away with a sneeze if I cannot stick them there and tape them there.

Hope this helps. Hope that answered the question.

This is Gray Cook. For more information,
www.functionalmovement.com