

Abdominal Exercise Stabilization

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We had extensive coverage with intrinsic stabilization. More specifically, the training goal is coactivation of the multifidi with the transverse abdominis which provides intrinsic stabilization during a posterior pelvic tilt. So, even before we fire the lower rectus abdominis, intrinsic stabilization (closed chain) must occur. So, intrinsic stabilization (abdominal hollowing) is first followed by a posterior pelvic tilt (lower rectus abdominis) and then finally, the upper rectus abdominis fires to complete a curl up. They used the following metaphor: "You can't shoot a canon from a canoe".

This is a very good article because I was not aware of the gadget that Janda invented so I will buy one for me to use and my patients. Trunk flexion is one of the 7 movement patterns (Janda), referred to as functional testing. There are 4 stages of motor control:

1. Kinesthetic awareness (the patient finally recognizes a proper contraction sequence)
2. Volition (the patient can now routinely fire the muscles in the correct pattern)
3. Coordination (the patient can now coordinate 2 movement patterns simultaneously)
4. Automization (the movement pattern is now subcortical. Neuromuscular reeducation has occurred-now through the cord rather than thinking about it. It is a reflex or referred to as engram formation)

Since core stabilization and proximal stability are prerequisites for peripheral mobility/function, I usually start all by rehab programs with this movement pattern... even neck or upper extremity problems. I then focused on 1-leg standing, neck flexion, hip extension, hip abduction, trunk lowering from the push-up position, and finally shoulder abduction-in that order.

Simply put, build from the bottom up, and proximal to distal. 1-leg standing for proprioception and reaction time of the gluteals. Move to the neck. This completes the axial skeleton or core. Now move to appendicular skeleton; the hip extensors and abductors because we are billing from bottom-up. Next, scapular stabilization because it is proximal to the glenohumeral joint. Lastly, shoulder abduction pattern.

In theory, by correcting posture and movement patterns obviously brings us to anatomical position; palms forward. This should help eliminate many of the peripheral problems such as shoulder impingement tendinitis, lateral epicondylitis, carpal tunnel syndrome, etc. It is actually a pretty simple concept. I love the Europeans. This exercise unit will speed up the process. Thanks a million-

On Tue, Nov 17, 2009 at 11:25 AM, Allan F. Perfilio , D.C. <alpcc329@comcast.net> wrote:
but it is still interesting .

<http://www.cbass.com/HardestSitup.htm>