

## Subscapular Work, Getting It Right

Many of us use subscapular techniques as part of our treatment for the upper back. By accessing the medial border of the scapula it is possible to focus a treatment through the middle fibres of trapezius into rhomboid muscles and to go beneath these to the subscapularis muscle. Outlined here are some of the common errors therapists make when using subscapular work, along with some suggestions for getting the most from this technique.

### Common errors when performing subscapular work

1) *Assuming that the client has tight rhomboids.* This is perhaps the most common error made by therapists. Consider the client who has a kyphotic posture and sits with the classic “round-shouldered” pose. (We have all massaged clients like these!) In such cases the scapulae tend to be protracted around the ribcage, which means that the rhomboid muscles are lengthened and weak, not shortened and tight. Whilst rhomboids may certainly become overworked due to the maintenance of static postures, in general, people with kyphotic/round-shouldered postures do not have tight rhomboids.

Think about this, the function of the rhomboid major and minor are to retract the scapula. Rowers do this naturally. But how often in daily life do you retract your scapula compared to how often you protract them? Sit with a round-shouldered posture. What has happened to your rhomboid muscles? Now retract them. How does that change your posture?

One of the reasons rhomboids sometimes appear tight is because of the second common error:

2) *Not supporting the upper limb whilst performing subscapular work.* If you position the client in prone, for example, and take their upper limb behind them, they will naturally contract rhomboids in order to keep the limb in position. Therapists therefore often identify that the rhomboids are tight, but assume this is a defect rather than because the client is being forced to produce an isometric contraction of these muscles.

3) *Not addressing the “tight” spots accurately.* Often, levator scapulae is very tight, the muscle inserting at the superior angle of the scapula, a point some therapists confuse with rhomboid minor. We know this is the case because (i) when you massage such clients the tightness appears to increase as you slide your hand superiorly (ie. as you access levator scapulae) and (ii) because with kyphotic postures levator scapula tend to contract to elevate the scapula as when maintaining a static position for prolonged periods.

4) *Frictioning trigger spots.* The tight “knots” discovered by some therapists in the rhomboid area may be trigger spots<areas that refer pain elsewhere if “live”. Holding static pressures to these areas, perhaps with a stretch (as in Soft Tissue Release) is considered to be a good method of dealing with trigger spots rather than frictioning them. Ask yourself these questions: “when I friction the tight spots in rhomboid muscles do these spots really go away, or are they still there when the client returns for their next treatment? Is my frictioning being effective?”

5) *Causing discomfort.* If when massaging you press too sharply on the medial border of the scapula this causes discomfort and raises muscle tone. The muscles contract and as a result you assume they are tight and end up having to work harder to try and relax them! Clients with tight anterior deltoid and pectoral muscles (common in kyphotic postures) may find the half-Nelson position used in subscapular work is most uncomfortable and again may increase muscle tone when in this position, including the tone of rhomboids.

6) *Not including stretches to the medial rotators of the humerus.* If your client has a kyphotic posture medial rotators of the humerus will be tight. Subscapularis is a medial rotator of the humerus. There are easier ways to stretch this muscle (such as Proprioceptive Neuromuscular Facilitation) than trying to access it through rhomboid muscles.



7) *Using techniques that potentially damage the therapists thumb and fingers.* Many of us have fallen into the trap of continuing with subscapular treatments using thumbs because we know it is effective for the client. There are many alternatives.

### **Getting it right**

- 1) Don't assume rhomboids are tight.
- 2) If rhomboids feel tight, check your technique and ask yourself whether the client appears to be "holding" their arm.
- 3) Ensure that you support the shoulder. Use rolled up towels or a bolster if necessary.
- 4) Ensure that you support the elbow.
- 5) Reposition the client into whichever position gives you the best access. Try prone as well as side-lying. Try subscapular work in more than one position within the same treatment session if necessary.
- 6) Find ways to avoid damaging your hands, thumb and fingers. I know this sounds obvious. If you can't manage to access subscapular muscles despite varying the position of your client, then don't do it.
- 7) Experiment with using Soft Tissue Release and other stretching methods if rhomboids really are tight. Try doing a shoulder distraction in supine as this stretches both rhomboids and the posterior capsule.
- 8) If you feel tight "knots" and are confident of your technique, ask yourself which muscle you are actually on. If levator scapulae is tight, focus on that muscle. This is not necessarily best achieved by doing subscapular work.
- 9) Avoid frictioning trigger spots. Try applying static pressures and/ or combining this with a passive stretch instead.
- 10) Try active or passive stretches to anterior deltoid and pectoralis major *before* the subscapular work as a way of increasing range of movement in the shoulder joint and helping the client into the "half-Nelson" position.
- 11) Try passive shoulder mobilisations before subscapular work to relax all of the rotator cuff muscles.
- 12) Include stretches to the medial rotators of the humerus. These could be active, passive or PNF stretches.
- 13) Try a side-lying rhomboid stretch as part of your treatment, hooking your fingers under the medial border to give a gentle passive stretch.

Finally, (14) swop ideas! Listed here are just some of the observations and improvements I've made to my technique over the years with regards subscapular work, some of which I identified as a result of receiving this treatment myself. Talk to your colleagues, ex-students, teachers, anyone you know who might have ideas for how best to perform subscapular work. Practice on colleagues, attend workshops, receive treatment yourself. But most of all, swop ideas and share your knowledge. By helping each other we can ensure that more of us are doing great subscapular work and that more of us are getting it right!

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