Evaluating the effectiveness of the Jing Method™ on TMD symptom frequency in women aged 35-67

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"I certify that this work has not been accepted in substance for any degree and is not concurrently being submitted for any degree other than that of the Diploma in Advanced Clinical Massage and Sports Massage being studied at Jing Advanced Massage Training. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others".

Ms Charlotte Couse: Charlotte Couse

Date: 15.3.26

the sun & hanuman

let me tell you about the sun
& the wind-born monkey boy who
moved fast — the air smoothing his fur
curving round him like a silk scarf

he had the hunger of the young
the burning in his belly that
nothing could satiate except
the scarlet sky-hanging sun fruit

he leapt high through the thinning air
& opened his mouth wide & cried
when indra's thunderbolt cracked his
jaw as if it were a dropped clay pot

so the wind inhaled & stoppered
its breath & all was still as if
under glass not moving until
the devas granted the boy boons

if he fell in fire his fur would
not singe & in water droplets
would scatter like mercury &
even death's staff couldn't touch him

& so he's called broken jaw &
fractured things can be strong like him
a swift warrior with an open
heart & a firm yet relaxed chin

ABSTRACT

This paper examines the effectiveness of the Jing Method™ on TMD (temporomandibular disorder) symptom frequency in women aged 35-67. TMD is the second most common MSK (musculoskeletal) pain issue after lower back and is particularly prevalent in women. Initial treatments are physical therapy and self-care, so the multi-modal Jing Method™, which includes both approaches, is suitable.

The literature review section of this paper describes the aetiology and diagnosis of TMD, plus current conventional and alternative treatments, including the Jing Method™.

The study was an in-house design involving three participants and lasted 12 weeks. The first six comprised a control period with no intervention; weeks 7, 9, 11 combined a hands-on treatment plus self-care in the form of an exercise to improve jaw function. For weeks 8, 10, 12, participants were given a trigger point (TrP) self-massage exercise online. Results were recorded each week using the TMD-7 questionnaire, a general instrument evaluating TMD symptom frequency.

The Jing Method™ was found to decrease overall TMD symptom frequency by 41%. However, it treated some more effectively than others. Pain in the jaw/ears fell by 100%, forehead/temple pain by 50%, neck/shoulder pain by 43%. Noise when opening/closing mouth and headaches both dropped by 33%. On the other hand, difficulty opening mouth and difficulty eating/chewing food showed no improvement.

When the results of the study were compared with the 12 TMD diagnoses according to the international standard DC (Diagnostic Criteria) /TMD Axis I, it was hypothesised that the Jing Method was more effective at treating symptoms corresponding to myalgia, arthralgia and headache and less successful with those relating to intra-articular disorders.

During the six-week intervention period, symptom frequency decreased during the hands-on and the on-line interventions, showing both modalities to be effective. However, due to the small number of participants and general nature of the TMD-7 instrument, more research is needed. In terms of further research, combining the Jing™ TMJ protocol with the Jing™ hip and pelvis or lower back sequences was recommended.

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ABBREVIATIONS

AIS	Active Isolated Stretching
BPS	Biopsychosocial
BTEC	Business and Technology Education Council
CG	Control Group
DC	Diagnostic Criteria
EG	Experimental Group
G1	Group 1
G2	Group 2
GCPS	Graded Chronic Pain Scale
HFMAST	Heat, Fascia, Muscles, Acupressure, Stretching, Teaching
MFR	Myofascial Release
MSK	Musculo-skeletal
MTM	Manual Therapy Massage
MTPIR	Manual Therapy Post-Isometric Muscle Relaxation
NPRS/NRS	Numeric (Pain) Rating Scale
NSAID	Non-Steroidal Anti-Inflammatory Drugs
P	Parameter
PIR	Post-Isometric Muscle Relaxation
PNF	Proprioceptive Neuromuscular Facilitation
RCT	Randomised Controlled Trial
ROM	Range Of Motion
SCM	Sternocleidomastoid
sEMG	Surface electromyography
SSRI	Selective Serotonin Reuptake Inhibitors
TCM	Traditional Chinese Medicine
TE	Therapeutic Exercise
TENS	Transcutaneous Electrical Nerve Stimulation
TMD	Temporomandibular Disorder
TMJ	Temporomandibular Joint
TrP	Trigger Point
VAS	Visual Analogue Scale

LITERATURE REVIEW

Rationale

Temporomandibular dysfunction (TMD) is the most common musculoskeletal (MSK) chronic pain disorder after low back pain, probably because the temporomandibular joint (TMJ) is used more than any other (Busse et al., 2023). Most sufferers are between 30 and 50 years, with women four times more susceptible (Werner, 2013). It has been hypothesized this could be due to oestrogen levels, but evidence is currently lacking (Zieliński and Pająk-Zielińska, 2024).

The conventional medical approach is to avoid surgery, as this permanently changes the joint. Instead, the first line of treatment is physical therapy, pharmacology, occlusal splints, behaviour therapy and self-care (Wadhokar and Patil, 2022). Given how common TMD is, and how widely physical therapy and self-care are accepted as treatments, the effectiveness of the Jing Method™ (which combines both approaches) for TMJ pain in women is a suitable subject for research.

Definition

TMD is a broad term, referring to neuromuscular and MSK conditions of the masticatory muscles and TMJ. The muscles comprise: temporalis, masseter, medial and lateral pterygoid muscles; the ligaments: temporomandibular, stylomandibular, and sphenomandibular. The TMJ is formed by the glenoid fossa of the temporal bone and the mandibular condyle, which are divided by an articular disc creating two joints with different movements. The superior joint (between the disc and the glenoid fossa) glides; and the inferior joint (between the disc and the condyle) opens like a hinge (Maini and Dua, 2023). The third branch of the trigeminal nerve innervates the TMJ, as well as the auriculotemporal nerve, which is highly sensitive to pain (Lomas et al., 2018)

Aetiology

TMD aetiology can be divided into myofascial disorders (due to muscle tension, fatigue and spasm) and intra-articular (stemming from mechanical or inflammatory

joint issues). Myofascial complaints can be caused by teeth clenching and grinding, bad posture, stress and anxiety. Intra-articular causes include internal joint derangement, osteoarthritis, capsular inflammation, hyper mobility, traumatic injury, plus inflammatory conditions such as rheumatoid arthritis and ankylosing spondylitis (Lomas et al., 2018). However, sufferers can have a mix of patterns.

Diagnosis

TMD is mainly diagnosed by symptoms and physical examination. Symptoms include reduced jaw mobility, headache, neck pain or stiffness, teeth grinding, and pain with mouth opening (Wadhokar and Patil, 2022). The mandibular range of motion (ROM) tests will often measure opening (minimum normal 40 mm) and right/left movements (minimum 7 mm) (Wright and North, 2009).

Physical examination includes palpation of masseter, temporalis, and sternocleidomastoid (SCM) for trigger points (TrP) and spasms. The joint is assessed by the practitioner placing fingers over the TMJ and asking the patient to open their mouth while they palpate for clicking/popping (indicating disc displacement). In severe cases, radiologic imaging can be used (Wadhokar and Patil, 2022).

TMD diagnostic criteria can be broadly divided into four groups according to international standards developed by the International Network for Orofacial Pain and Related Disorders Methodology (INfORM) (Malmberg et al., 2024). These are: myalgia, arthralgia, intra-articular disorders and headaches (Table 1), which can be subdivided further into 12 diagnoses for TMD (Palmer and Durham, 2021). These are not mutually exclusive, and patients can present with several diagnoses.

Table 1: DC (Diagnostic Criteria) /TMD Axis I: 12 most common TMD Diagnoses (Palmer and Durham, 2021)

Diagnosis	Subcategory	Summary history & examination findings
1. MYALGIA History is positive for pain in the jaw, temple, in ear, in front of the ear; pain modified with jaw movement, function or parafunction.	2. Local myalgia 3. Myofascial pain 4. Myofascial pain with referral	Pain local to palpation Pain within body of muscle Pain spreading outside the body of muscle Examination: pain in masseter/temporalis produced by palpation or max assisted/unassisted opening.
5. ARTHRALGIA History as for myalgia		Pain in temporomandibular joint region produced by palpation or assisted/unassisted jaw movements
INTERARTICULAR DISORDERS	Disc displacements 6. with reduction 7. with reduction with intermittent locking 8. without reduction, with limited opening 9. without reduction without limited opening	Click, pop, snap: on open and close (1 out of 3 movements), or one of opening and closing plus a lateral movement History of lock (does not matter how long) History: decreased mouth opening and inability to eat or interference with eating examination: max assisted opening <40 mm History as above but max assisted opening >40 mm
	10. Degenerative joint disease	Crepitus in any movement with little pain
	11. Subluxation	history: lock open & self-manipulation to achieve closure
12. HEADACHE Attributable to TMD		History: headache in temple and modified with jaw movement, function, or parafunction. Examination: familiar headache with palpation temporalis or with jaw movements

Conventional Medical Treatment

Physical therapy can include exercises such as Rocabado, goldfish (similar to the Oxford University Hospital TMJ Exercises) and Mulligan. The six Rocabado movements encourage jaw, neck and body postural awareness and correction (Pundkar, Patil and Naqvi, 2021); goldfish stretches the TMJ's fibrous bands, thus reducing stiffness (Lawson, 2024); Mulligan TMD exercises are mobilisations to improve joint function (Faizan Waheed et al., 2025).

These interventions have been shown to be successful, and their results are summed up in Table 2.

Table 2: Effectiveness of TMD exercises in trials

Exercise	Participants	Result	Reference
Rocabado	30	67% pain decrease (6.91 to 2.23)	Pundkar, Patil and Naqvi, 2021
Goldfish & cervical extensor strengthening:	20	48% decrease in TMD severity (36.05±9.94 to 18.42±10.81)	(Alagia Thiruvevenkadam et al., 2021)
Goldfish only	20	50% decrease in TMD severity (39.76±11.45 to 19.76±8.58)	(Alagia Thiruvevenkadam et al., 2021)
Mulligan & Clamshell	30	22% increase in joint mobility (70.3 ± 13.2° to 85.6 ± 8.9°)	(Faizan Waheed et al., 2025)
Mulligan only	30	9.5% increase in joint mobility (71.4 ± 12.5° to 78.2 ± 11.4°)	(Faizan Waheed et al., 2025)

Drugs prescribed for TMD include non-steroid anti-inflammatories (NSAIDs) and paracetamol for chronic and acute pain; muscle relaxants such as benzodiazepines; and tricyclic antidepressants. A systematic review of NSAIDS on TMD concluded that although they could improve pain levels and mouth opening, the anti-inflammatories were more effective with acute conditions and may not relieve the pain under central sensitisation theory (Kulkarni, Thambar and Arora, 2020).

In a clinical trial of 60 patients, muscle relaxants (5 mg diazepam) decreased pain from 7.70+2.4 to 4.01±3.06 using a Visual Analogue Scale (VAS) (Hassan et al., 2022). Benzodiazepines and tricyclic antidepressants are more commonly used to treat TMD than the most prescribed anti-depressants, selective serotonin reuptake inhibitors (SSRIs), as the later can cause bruxism (Rajan and Sun, 2017). However, drugs have side effects (NHS – NSAID, 2022), (NHS – Diazepam, 2022), (Side effects of amitriptyline for depression - NHS, 2025).

Intra-articular injections are performed if the pain is severe, with local anaesthetics or corticosteroids (Wadhokar and Patil, 2022). The injections can reduce pain for four to six weeks, according to Garstka et al's literature review (2023). Again, these medications can have side-effects and must be used with caution if patients have certain co-morbidities (e.g. hypertension). They also need to be carried out by a healthcare professional (NHS – Side effects of hydrocortisone injections, 2024).

There are two types of splints: occlusal to correct upper and lower teeth; and non-occlusal for increasing mouth opening, releasing muscle tension, and teeth grinding (Wadhokar and Patil, 2022). A 2020 systematic review by the British Dental Journal of 37 trials concluded that there was no evidence that splints reduced pain (Riley et al., 2020).

Cognitive behaviour therapy, which helps sufferers manage thoughts and emotions that can aggravate the condition, has proved to be effective for chronic TMD. A RCT (randomised controlled trial) of 79 participants showed a 35% improvement in activity interference compared to 13% in the control group (Turner, Mancl and Aaron, 2006).

Botox is another treatment for TMD. In a retrospective review of 71 participants, 55 reported significant improvements in terms of pain and/or function (Connelly et al., 2017). However, the study does not say how long the beneficial effects lasted, and there are potential side effects e.g. allergic reactions and facial weakness (Neurotoxin for treatment of temporomandibular joint dysfunction (TMJD) | Royal Free London, 2025).

Alternative Approaches

Acupuncture and dry needling are increasingly becoming accepted by conventional medicine. A systematic review of 11 randomised clinical trials of acupuncture on TMD pain using a VAS scale showed that it could have a positive effect. However, larger sample figures were needed as well as research into the long-term effects (Di Francesco et al., 2024)

Warm needle acupuncture, where moxa (dried artemisia) is burned on the head of a needle, is also used in Traditional Chinese Medicine (TCM). In TCM, facial pain is often diagnosed as invasion of cold and wind, so heat may help to dispel this. However, research into its effectiveness is limited (Liu et al., 2021).

TENS (Transcutaneous Electrical Nerve Stimulation) has potential for TMD relief, particularly as machines can be bought relatively cheaply, and patients can administer the treatment at home. A clinical study of 36 TMD sufferers found it alleviated pain according to a VAS score by 41%, (Abe et al., 2020).

There has been little research into the effect of manual therapy on craniomandibular structures in TMD. A literature review published in 2021 considered 2,720 papers, but only six satisfied its inclusion criteria. Even in these, the evidence was low because of high heterogeneity and low sample size (Asquini et al., 2021).

The lack of research prompted researchers in Poland in 2023 to carry out an RCT into the efficacy of manual soft tissue therapy and therapeutic exercises in patients with pain and limited mobility TMD. This trial comprised 82 female TMD sufferers in the intervention group (G1), and 104 women in the control group (G2). G1 was divided into three cohorts: therapeutic exercise (TE); manual therapy — massage and therapeutic exercises (MTM_TE); manual therapy — post-isometric muscle relaxation (MTPIR_TE). G1 was treated for 10 days and their pain levels recorded on a numerical rating scale (NRS) 0-8 (Gębska et al., 2023). The results are summarised in Table 3.

Table 3: Effectiveness of exercise, massage and PIR in Gebska et al's RCT

Intervention	Result
TE	17% decrease in pain (6 to 5)
MTM_TE	83% decrease in pain (6 to 1)
MTPIR_TE	67% (6 to 2)

As a result of these findings, the researchers advised that manual therapy should be part of the therapeutic regimen for TMD (Gębska et al., 2023). However, research into the effectiveness of the treatments beyond 11 days is needed.

Previous Jing™ students who undertook 16-week studies with interventions combining manual therapy and therapeutic exercises also recorded positive results.

Davies's research showed a 65.2% decrease in symptom frequency among seven participants using the instrument TMD-7 (Davies, 2024). The intervention combined three hands-on treatments and three self-care (TrP, massage, acupressure, stretches).

Gompertz noted a 48% reduction in symptom frequency with TMD-7, and a 42% decrease in symptom pain according to a NRS also in seven participants (Gompertz, 2025). The intervention comprised six hands-on treatments plus self-care (TrP massage).

Clarke reported a 59.9% reduction in pain with three participants using a revised GCPS (Graded Chronic Pain Scale) (Clarke, 2024). The intervention consisted of six hands-on treatments plus self-care (guided relaxation).

The Jing Method™

The Jing Method™ was developed by Rachel Fairweather and Meghan Mari as a curation of various Eastern and Western bodywork and therapy practices (Fairweather and Mari, 2015). The approach can be summarised by the acronym HFMAST (Heat, Fascia, Muscles, Acupressure, Stretching and Teaching), and these

six modalities correspond with techniques proven in trials and reviews to be effective.

Heat

The Jing Method often uses stones to supply heat. The literature review by Garstka et al (2023) noted analgesic benefits on TMD from applying heat. Nakano et al's (2012) systematic review of heat applied with stretch to increase the ROM in the body found it beneficial for acute and sustained gain of ROM after multiple treatments in healthy people.

Fascia

The types of fascial massage employed by Jing and possibly suitable for TMD work include direct/indirect and rolfing/structural integration. The effects of MFR on TMD were tested in a 2021 comparative study of 60 participants divided equally into two groups and treated over 10 days (Urbá Nski et al., 2021). The former, Group 1 (G1), received MFR techniques and the other, Group 2 (G2), PIR (post-isometric muscle relaxation). Pain scores according to a 1-10 VAS scale were taken on the day before starting the treatments and on day 10. Pain fell in the masticatory muscles from a score of 29 to 17 in G1 (41%) and 27 to 12 (56%) in G2.

A follow-up four days later found the levels about the same, but a later follow-up is needed to show a lasting effect.

Furthermore, a RCT in carried out at Istanbul Medipol University Dental Hospital to study the effects of MFR on TMD and co-occurring chronic low pain on 45 participants (38 women) concluded that MFR was more effective than physical therapy. Participants were divided into three groups. The first received 10 MFR sessions (on TMJ and lower back muscles) over four weeks; the second followed a structured exercise programme for four weeks; the third, the control group (CG), received no treatment (Şenel Topaloğlu et al., 2025).

The Istanbul study showed that MFR produced significant gains in orofacial pain and LBP-related disability ($P \leq .004$), as well as oromotor function, including maximum mouth opening and lateral excursions. On the other hand, the exercise program improved pain-free mouth opening ($P \leq .012$). There were no significant changes in

the CG. The results also suggest biomechanical and neuromuscular links between the jaw and the lumbar region (Şenel Topaloğlu et al., 2025).

Muscles

In the Jing Method, this refers to TrP or muscle knots. These form when a muscle is overloaded, often through exercise or poor posture, thus becoming damaged and causing certain points to tighten and shorten (Friedman, 2024).

TrP therapy was one of the modalities strongly recommended for chronic pain associated with TMD by a panel of experienced clinicians (Busse et al., 2023).

Acupressure

There are many studies showing the effectiveness of various types of acupuncture for TMD, but fewer for acupressure. Acupressure, however, has the advantage of patients being able perform it themselves. A recent study carried out in Malaysia of 110 southeast Asian TMD sufferers reported that about 70% used complementary and alternative medicine, and acupressure was one of the most effective techniques (Yap et al., 2025).

Stretching

The main forms of stretching used in the Jing Method™ are passive, PNF (proprioceptive neuromuscular facilitation) and AIS (active isolated stretching). Stretching not only has a positive effect on ROM but can also reduce pain by increasing fluid in the surrounding tissue, allowing everything to “to slide and glide” (Friedman, 2024).

A panel of experienced clinicians strongly recommended jaw stretching and mobilisations (Busse et al., 2023), and these techniques can be given as self-care.

Teaching

In the Jing Method™, this refers to the therapist educating their client about their condition and giving them self-help activities (e.g. TrP treatments, breathing/relaxation techniques, stretching/mobilisation exercises). The client thus feels more empowered and less anxious about their condition, which can affect pain levels. A systematic review of 14 trials into the effectiveness of self-management in adults with orofacial pain found physical and psychosocial self-regulation and education beneficial (Aggarwal et al., 2019).

Since Covid 19, more therapists have been offering online self-care exercises to their clients. Therapeutic exercise delivered online was found to be as effective as face-to-face interventions of a similar 10–30-minute duration in a literature review of 11 studies (Muñoz-Tomás et al., 2023).

Online TMD studies

A Jing™ researcher carried an online study of 18 TMD sufferers, and the six-week intervention included teaching self-massage, trigger point therapy, stretching, myofascial release, plus the application of hot and cold (Lindsay, 2023). Participants were given pre-recorded online videos and enrolled in an online community group. Pain levels, measured using a Graded Chronic Pain Scale (GCPS), dropped by 50% by the end.

However, some participants can have issues with accessing online content. This could be due to incompatible software/hardware, poor signal, lack of resources or training. Also, some clients may not want to increase their screen time.

Furthermore, meeting face-to-face can help foster the therapeutic relationship (Rotger and Cabré, 2022). The instrument CAF-P can be used to measure the effectiveness of the therapeutic alliance between clients with chronic MSK pain and their therapists (Linares-Fernández, La Touche and Pardo-Montero, 2021).

In-person interventions also allow the body to be massaged, eliciting a parasympathetic nervous system response (Diego and Field, 2009).

Therefore, blending online and in-person may be the optimal way of treating TMD sufferers if the e-health component is well designed, according to a study of 11 orofacial physical therapists and 9 clients (van der Meer et al., 2022).

METHOD

For this paper's literature review, the search engines Pub Med, Google Scholar and Mendeley were used.

The study was in-subject design evaluating the effectiveness of the Jing Method™ on TMJ pain in women. This methodology, where each participant was given the same treatments, is suitable for small groups and allows the subjects to serve as their own control.

Recruitment was carried out in August/September 2025. Subjects were mainly recruited through the clinics the researcher worked at: Weymouth Acupuncture and the Hewson Clinic in Verwood. Posters were displayed, and leaflets distributed in reception areas. Furthermore, the study was publicised on the clinics' social media accounts (Instagram and Facebook). The researcher also posted adverts on her Facebook and Instagram page.

Six people expressed an interest, but only three committed by returning completed ethics forms (Appendix A). These three women (aged 35, 45 and 67) were contacted, and diagnoses were carried out to gather more information about their issues and suitability for the study. They all met the inclusion criteria, and once the study was explained to them, consented to participate and completed the 16-week programme.

The study began at the end of September 2025 and finished in January 2026. For the first 12 weeks, each participant completed the TMD-7 questionnaire (Appendix B). The researcher chose this instrument because of its validity for assessing TMD and because its brevity might encourage compliance. The questionnaire was sent out in pdf and word format via email or WhatsApp, according to the participants' preferences.

Weeks 1-6 were the control period with just the TMD-7 given; weeks 7-12 were the intervention with the questionnaire sent out 6 days after. The participants completed the final questionnaire in week 16, after no treatment for four weeks, to record any lasting effects.

In Week 7, visual and palpatory assessments as per the Jing™ TMJ protocol were carried out (Appendix C). Weeks 7, 9, 11 comprised a 50-minute hands-on treatment, as per the Jing™ protocol (Appendix D), plus a self-care exercise based on Oxford University Hospitals TMJ exercise (Appendix E), which was previously demonstrated at Jing™ on a TMJ training course. This exercise was chosen because it was quick and easy to learn and perform, and because it strengthens and relaxes the jaw muscles (Lawson, 2024).

The hands-on massages were carried out at locations convenient for the participants, i.e. the Weymouth clinic, their homes, and the researcher's home. The researcher demonstrated the self-care exercise to the participants and gave them a handout telling them to practise the exercise for 5 minutes a day.

Weeks 8, 10 ,12 the participants carried out TrP self-care using the Jing™ TMJ handout (Appendix F). They were emailed a handout and a 90-second instruction video in MP4 format, which the researcher filmed, and were told to do the exercises for 5 minutes a day. Again, this intervention was chosen not only for its effectiveness (TrP therapy has been shown to help chronic pain (Busse et al., 2023)), but also for its brevity.

RESULTS

The results came from the TMD-7 questionnaires sent to each of the three participants weekly. The scoring system used was:

Rarely or never = 0

A few times a month = 1

Once or twice a week = 2

Nearly every day = 3.

Figure 1: Total TMD-7 symptom frequency over 12 weeks (average)

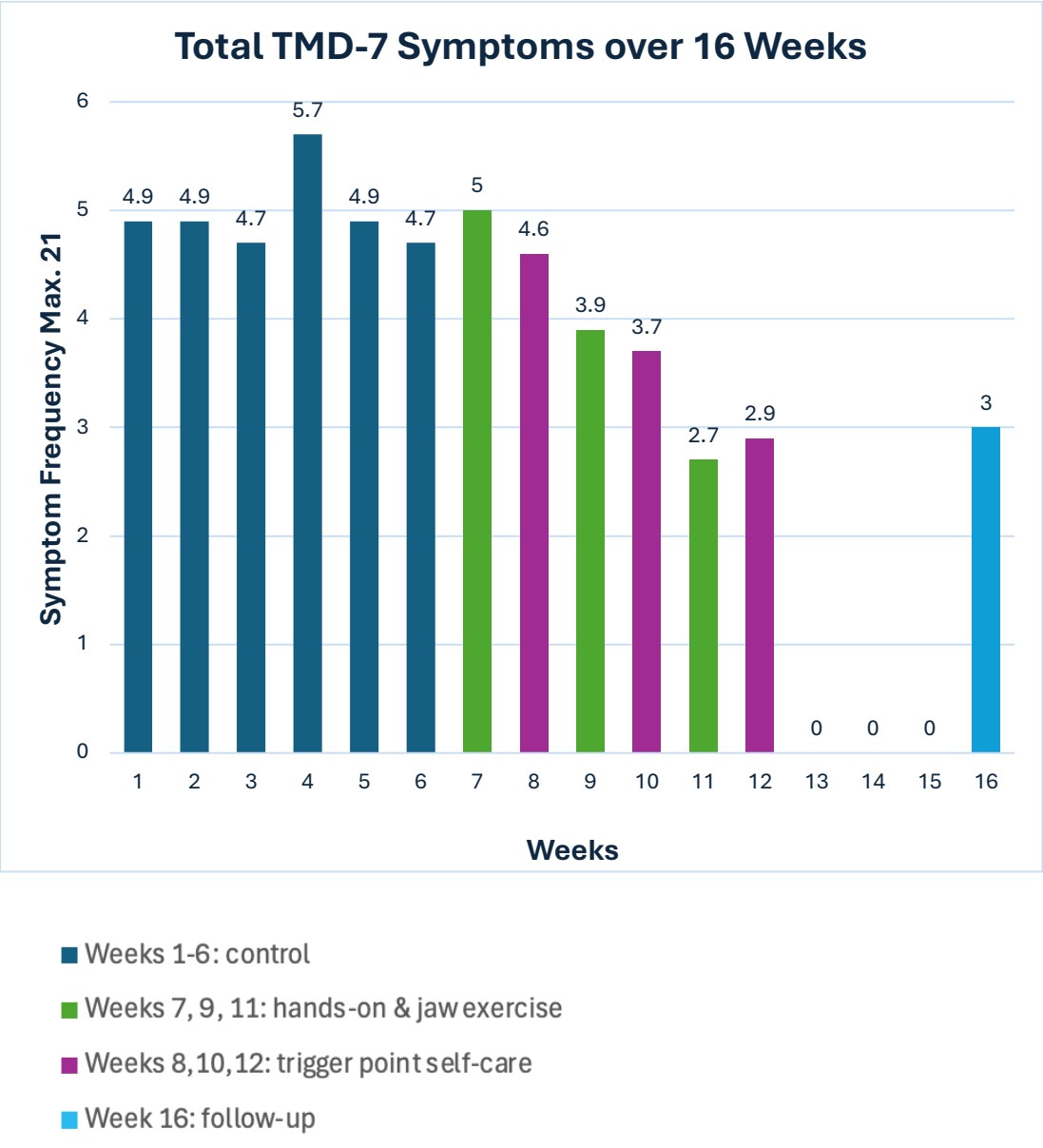
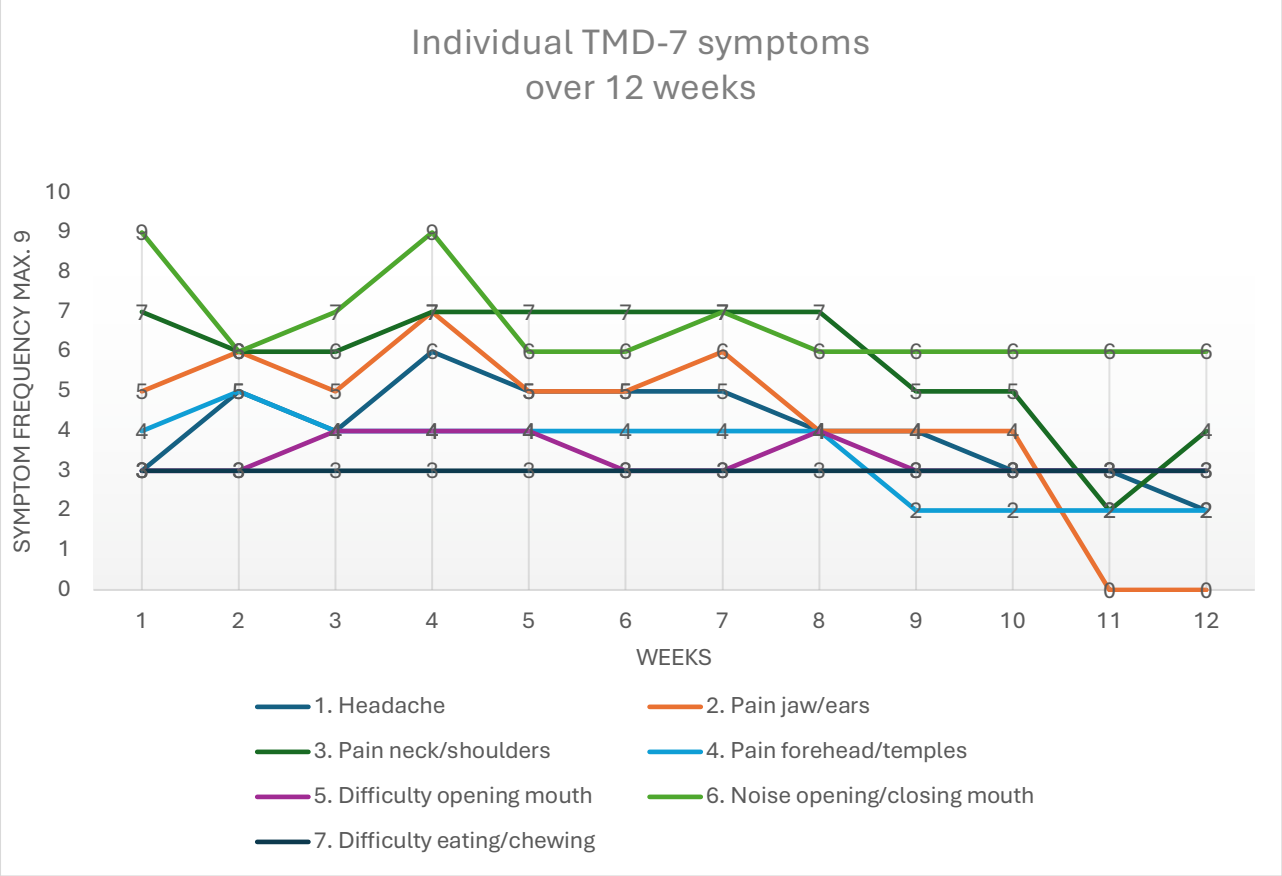
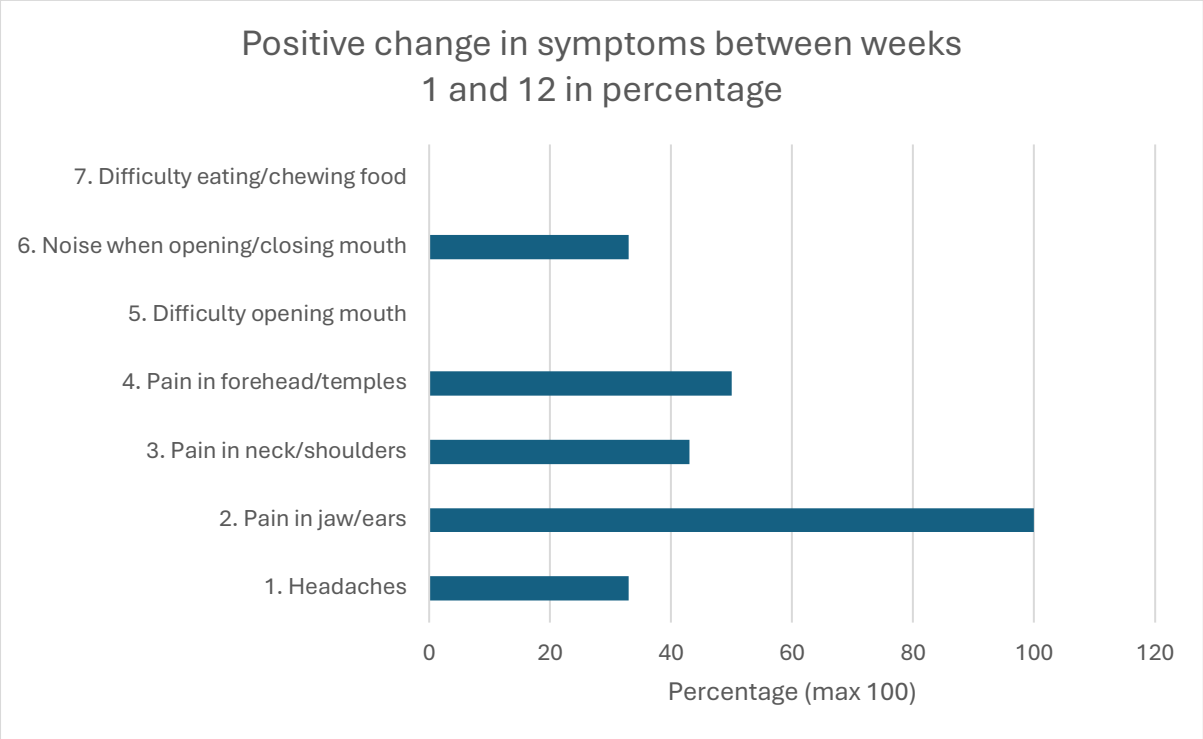


Figure 2: How individual symptoms progressed over the 12 weeks



It is important to note that by looking at Figure 2, the symptoms that showed no benefit from the treatment (#5 and #7) had the lowest scores from the start of the study (at 3). The symptom which eased the most (#2) had the second highest score at the start of the study.

Figure 3: Change in frequency of symptoms between weeks 1 & 12 (%)



All the data from the study showed either no change or a positive change in symptoms as expressed in Figure 3. Zero results indicates that there was no overall change in symptom frequency throughout the study.

DISCUSSION

The study shows the effectiveness of the Jing Method™ for TMD, as it records relevant increases well above the benchmark of 8% for large effect (AbdulRaheem, 2024). However, as this was a small-scale study, the results need to be viewed cautiously.

Overall symptom frequency decreased by 41% from an average of 4.9 in week 1 to 2.9 in week 12. Week 16 showed the results could last at least four weeks, with an average of 3 reported, i.e. a fall of 38%. Anecdotally, two of the three participants contacted the researcher for follow-ups after the study ended.

The gain was cumulative over the six-week intervention period, for hands-on and on-line, with levels falling each week except week 12. This shows the effectiveness of combining hands-on treatment with online teaching, as concluded by Meer et al (2022). The in-person work allows for the therapeutic alliance to develop (Rotger and Cabré, 2022), and for the body to be worked on by the therapist, which aids relaxation by eliciting a parasympathetic nervous system response (Diego and Field, 2009). Online teaching empowers the clients, plus gives them flexibility as to their treatment.

When the symptoms are compared with those in Table 1 and their corresponding diagnoses, it could be deduced that those possibly due to inter-articular issues (#5 difficulty opening/closing mouth and #7 difficultly eating/chewing food) were the most likely show no change. In comparison, those which were a result of myalgia, arthralgia and headache (#1 headache, #2 pain in jaw/ears, #3 pain in neck/shoulders, #4 pain in forehead/temples) were the most likely to improve.

Symptom #6 (noise when opening/closing the mouth) could be said to be an interarticular issue, but it improved by 33% during study. However, it still had the highest score (6) by week 12, which showed that it could be difficult to erase entirely. Anecdotally, one of the participants who suffered from symptom #6 (the result of an injury) said she thought she would always have it and did not notice a change in that symptom throughout the interventions.

The instrument TMD-7 is very general; therefore, the results from this study are broad, only recording symptom frequency and not intensity. When recruiting for the study, the researcher noted that some prospective participants expressed concern for how much was required of them, so she chose an instrument which could be completed in less than a minute. Other studies used more detailed instruments, often in combination. Gebska et al (2023) used sEMG (surface electromyography) to measure muscle activity, plus a numeric rating scale (NRS). Alagia Thiruvevenkadam et al. (2021) measured mouth opening and severity of symptoms (Fonesca Questionnaire). Jing™ therapist Gompertz (2025) added an intensity score for each of the symptoms in the TMD-7

Some of the symptoms on TMD-7 might not be due to TMD — particularly headaches which can have numerous triggers e.g. hormones (menstrual migraines), food and drink (or lack of). One of this study's participants wrote on the TMD-7 form in week 12 that she had had a headache, but she thought it was probably due to alcohol rather than TMD. This could affect the results for symptom #1 (headaches) in week 12.

Comparison with other Jing studies

The decline in symptom frequency in this study (41%) was slightly lower than in the two other Jing Studies using TMD-7: 65.2% (Davies, 2024) and 48% (Gompertz, 2025). However, direct comparisons are not possible because of a lack of homogeneity. The other studies were on adults, rather than focussing on women, had more participants (7), and employed different interventions. Like this study, Davies' was blended, but the self-care was significantly longer — a 45-minute routine to be practised three times a week. Gompertz gave hands-on treatments every week during the six-week intervention.

TMD-7 symptom trends were different in this study compared with those of Davies and Gompertz. In Davies' research, the biggest fall occurred in #5 (opening mouth), dropping from 1.62 in week 2 to 0 in week 9 and staying there until week 16. Anecdotally, only one of this present study's participants suffered from symptom #5, and she scored her symptoms as a 3 (everyday) throughout the 12 weeks.

For Gompertz, the largest fall occurred with symptom #7 (neck and shoulder pain) from 8.23 in week 1 to 4.86 in week 12, rising slightly to 5 in week 16. Symptom #1 (headaches) had the least improvement for both Davies and Gompertz

Comparison with other studies

Trials of techniques comparable to the different modalities of the Jing Method™ as mentioned in the literature review also showed remarkable improvements from the start of each study to end, i.e. therapeutic exercises, therapeutic exercises and massage, MFR and PIR.

It is also worth comparing the studies to those of pharmacological medicine. In the diazepam trial, pain levels decreased by 48% (7.70 to 4.01) (Hassan et al., 2022), which is less/similar to than the other Jing™ studies and many of therapeutic exercise and massage studies. However, these drugs can have significant side-effects (including addiction and sleepiness), whereas massage and exercises have none.

Limitations

The number of participants in the study was very small. Two of the participants were not known to the researcher. One participant was and was also a Jing™ therapist (qualified at Advanced Clinical Massage Training level); therefore, she could be invested in showing the Jing™ method in a positive light. However, her questionnaires did not appear to be biased, recording the Jing Method™ as not influencing a particular symptom (#6).

The study does not consider the effect of bio-psycho-social issues (BPS). TMD is known to be affected by stress, and a stressful event may negatively influence the client's symptoms. The instrument TMD-7 does not record the consequence of the treatment on the client's stress levels, so perhaps it should be combined with one which does. For example, Pundkar et al (2021) used the Fonesca questionnaire, which has a question asking whether the participant is tense/nervous, and OHIP-14, which measures on how oral health problems impact quality of life, focusing on functional, physical, and psychological discomfort.

The therapeutic relationship is important to the effectiveness of massage treatment (Kennedy and Munk, 2017), and this could also affect the study's outcomes. To measure how much influence the alliance has, the CAF-P can be used (Linares-Fernández, La Touche and Pardo-Montero, 2021)

Although adding more instruments might make the study more accurate, it could affect participation. This study was devised to be effective yet not demanding; the questionnaire and self-care exercises were deliberately brief. It achieved good results, with no dropouts and high compliance.

CONCLUSIONS

This study adds to the growing research showing that the Jing Method™, a multi-modal approach outlined in the HFMAST protocol, is effective for TMD. The researcher recorded a 41% decrease in TMD symptom frequency using a blended treatment of hands-on and short, simple self-care, partially delivered online, to encourage compliance.

Results were recorded using the instrument TMD-7, which was chosen for its focus and brevity. Symptoms in TMD-7 were correlated with diagnoses in DC/TMD Axis I (Table 1). The study also found some symptoms responded better to the treatment than others. The researcher hypothesized that the TMD symptoms of muscle and joint pain (which correspond to myalgia and arthralgia in DC/TMD Axis I), plus headache may respond better to the Jing™ TMJ pain protocol than those caused by inter-articular disorders. However, more research is needed to confirm this.

A recommendation for further research is combining the Jing™ TMJ pain protocol with that of the hip and pelvis. The trial combining the Mulligan exercises and clamshell had promising results (Faizan Waheed et al., 2025) and anecdotally, the participants in this present Jing™ TMD study said they suffered from tight hips. Another suggestion is combining the Jing™ TMJ and lower back protocols as Istanbul study (Şenel Topaloğlu et al., 2025) produced positive outcomes on TMD from MFR on muscles in these areas. Furthermore, one of this study's participants said she had pain in this area.

Collaboration for further research might be possible with a non-profit association like the Orofacial Pain Project: orofacialpain.org.uk.

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APPENDIX A: Ethics Form

Jing BTEC Research Ethics Form

BTEC Level 6: Professional diploma in Advanced Clinical and Sports Massage

Section 1: to be completed by student

Student's name:	Charlotte Couse
Student number:	ND57664
BTEC Year-group:	2024-26
Date of application:	5/5/25
Student e-mail address:	charlotte.couse@mac.com
Title of research project:	Evaluating the effects of The Jing Method™ on TMJ symptom frequency in women aged 35 to 67 years

Section 2: Does your project involve any primary research using human subjects?

Please indicate as appropriate.

	YES	NO
Does your project involve any primary research using human subjects?	**X**	
If yes, does it involve children under 16?		**X**

If yes, does it involve children under 18?		**X**
Other vulnerable populations (i.e. mental illness, aged subjects)?		**X**
Does your project involve NHS patients, NHS staff or Local Authority Service Providers?		**X**
Are you planning to use deception?		**X**
Are you collecting sensitive personal data e.g. sexuality, mental health data, etc.?		**X**
Does your study involve paying participants or an alternative incentive to participate		X
Could the study put you or someone else at risk of injury?		X
Does your project make use of a validated questionnaire?	**X**	
If yes, please specify the name of the validated questionnaire you are using and attach a copy here. TMD-7		

Section 3: Research premises

Where is your research being undertaken?

Clinics I work at:

Weymouth Acupuncture

17A Trinity Rd, Weymouth, DT4 8TJ

The Hewson Clinic

4c Ringwood Road, Verwood, Dorset BH31 7AQ

Home Clinic: White Tara Acupuncture

21 Ropers Lane, Wareham, BH20 4QT

If your research is being undertaken outside of your own premises, do you have written confirmation from the establishment involved? If yes, please provide evidence.	Already asked owners. Will provide evidence

Section 4: Recruitment

How will you recruit subjects for this research study?

1. Primarily through the clinics I work in: asking other therapists to refer suitable clients, posters in the clinics, notices on their social media.
2. Local business/community Facebook groups: Verwoodians (for Verwood clinic) and Wareham and Purbeck Business and Community Pages (home clinic).
3. Email to current and past client base
4. Ask friends, relatives, yoga class for suitable participants.
5. Local dentists

Section 5 Outline your project procedure

This is effectively a draft of your method, include information on when questionnaires will be used, what your intervention will involve, any stimuli used, etc.

This study aims to investigate the effect of the The Jing Method™ on TMJ pain.

Recruitment stage: face-to-face / Zoom consultation with participants to ensure they meet the inclusion criteria, understand the research study and provide consent to take part. Confirmation of their suitability for the study will follow.

Weeks 1-6 control period. Establishes a baseline of the client's pain/wellbeing/stress

- Participants will complete the TMD-7 form once a week. No intervention.

Weeks 7-12 intervention period.

- Weeks 7 ,9,1 1 participants will receive a 50-minute clinical massage once a week.
- The treatment will include:
  - Amma work on the back

- MFR upper back, neck and check
- Muscular and trigger point work on shoulder, chest, neck, temporalis tendon
- Intraoral work: masseter, temporalis
- Acupressure points: SI19, TB23, GB2, St7
- Stretches: SCM & thoracic release

- Sessions will follow the Jing TMJ protocol (see Massage Fusion, pp. 345-353), i.e. the *HFMAST approach which includes: Amma, indirect and direct myofascial release, effleurage, trigger point work, acupressure, stretching and teaching. Details on each weekly treatment will be added as an appendix*
- Background music played throughout the treatment, unless the client asks otherwise.
- Weeks 7, 9, 11 the participants will be given an exercise to improve jaw function (from Oxford University Hospitals) to be performed every day.
- Weeks 8, 10, 12 the participants will be given the Jing TMJ TrP self-massage handout. The self-care will be demonstrated beforehand and a video recording given.
- Details of each weekly treatment plus self-care routine will be added as appendices to the study.
- Six days after the hands-on treatment treatment/TrP exercises, the TMD-7 questionnaire will be sent to participants to complete and return before next treatment or within 24 hours.
- At the same time, participants will inform the researcher how many times they performed the self-care that week.

Week 16

- a follow up of the TMD-7 questionnaire will be sent to participants to assess if there were any longer term changes as a result of the intervention period.

Section 6: Describe what your participants need to do

Participants required to initially attend a face-to-face / online meeting to:

- Check they meet the inclusion criteria.
- Have the study explained to them so they consent to take part.
- Collect information required for the consultation process.
- Participants are required to inform the researcher of any manual therapy, medication or other relevant treatment they receive for TMJ throughout the study.
- Weeks 1-6, Participants are required to fill in TMD-7 questionnaire once a week for 6 weeks with no intervention.
- Weeks 7, 9, 11, participants will receive a 50-minute Jing clinical massage treatment once per week.
- The treatment will include:
    - Amma work on the back.
    - MFR upper back, neck and check.
    - Muscular and trigger point work shoulder, chest, neck, temporalis tendon.
    - Intraoral work: masseter, temporalis.
    - Acupressure points: SI19, TB23, GB2, St7.
    - Stretches: SCM, thoracic release.
- They will also perform a 5-minute self-care routine comprising a jaw exercise. A handout and a video demonstrating these techniques will be given.
- Weeks 8, 10, 12 participants will have to perform a 5-minute TrP exercise. The self-care video will be sent at the start of week 8.
- Six days after each treatment and before the next treatment or within 24 hours, each participant is required to fill in the TMD-7 questionnaire and return it to the researcher.
- The participant will inform the researcher how often they performed the self-care routine.
- A final submission of the questionnaire will be required at week 16.

Section 7: Respecting confidentiality and ethical issues for participants

How will you manage participant confidentiality? Ensure that the information refers to GDPR and is compliant with this legislation. What ethical considerations are there?

Ethical Issues

- **General:** Not working with children or vulnerable adults. The study doesn't involve specific conditions or focuses on sensitive topics such as sexuality, trauma etc.
- Minimal risk of injury but might be some localized bruising, especially if participant presses too hard during self-care or transient muscle aches that can occur after a massage. This will be explained to participants before consenting to the study
- **Information:** Participants will be fully informed of what to expect and given a PDF detailing basic information when they start.
- **Withdrawal:** Participants can withdraw at any time, without explanation and with no consequences for deciding to withdraw.
- **Confidentiality:** In case any participants know each other, they will be requested to always maintain confidentiality and to respect the confidentiality of other participants.
- **Trauma, mental & emotional health issues**
    - always treat participants with sensitivity
    - Green Cross coding during treatments
    - during consultation and throughout the study observe participants' emotional well-being and signpost to talking therapies and additional resources if necessary
    - ask other experienced practitioners for advice/guidance if necessary
- **Injury/Accident:** fully qualified and insured therapist with up-to-date emergency at work first aid training certification.
- **Personal Risk:** I will be mainly working at clinics with other therapists and their clients. Both clinics are in busy town centres.
- **Confidentiality/GDPR:**
    - Record basic data such as name, age, employment, address, basic health, and lifestyle information
    - Privacy Policy: copies given on request

- Security:
  - Soft Copies: files will be either double security protected (open and modify) with passwords/fingerprints allowing it to be opened.
  - Hard Copies: Weymouth Acupuncture requires hard copies of patient notes, which are kept in a filing cabinet in a locked clinic.
- Anonymisation:
  - Each participant will be assigned a number.
  - All data stored in separate files under numbers only
  - All data stored deleted or destroyed after study is completed.

Section 8: Inclusion and exclusion criteria

What sort of people will the subjects be?

The study will include:

- Adults able to commit to the 16-week study and travel to the clinics in Weymouth, Verwood or Wareham.
- Adults with long-term pain from three or more of the following TMJ symptoms:

  Pain related:
  - Headaches
  - Pain in jaw/ears
  - Pain in forehead/temples
  - Pain when eating/chewing

  Non pain related:
  - Difficulty opening your mouth all the way
  - Noise when opening or closing your mouth
  - Difficulty when eating or chewing your food
  - Jaw locking, clicking or popping
  - Teeth grinding or clenching
  - Tinnitus, dizziness or facial twitching
  - Difficulty speaking, swallowing, or sleeping due to jaw tension.
  - Sensitivity to light or sound

- Regular medication: any regular medication needs to have been taken for over 12 weeks to ensure stabilisation.
- Any on-going medical issues/medication may affect suitability for the study and will need to be discussed.
- If participants start a new medication, therapy, or develop a medical condition during the study, they should inform the researcher.

The study will exclude:

- Adults without long-term pain and less than 3 TMJ symptoms from the list above.
- New medication: taken for less than 12 weeks as these may not have stabilized for the participant.

Section 9: Student declaration:

I understand that I can only start my project, once this ethical application has been approved. This applies to ALL projects, whether using human participants or not.	YES	NO

Student's handwritten signature:

Charlotte Couse

(To be completed, once ethical approval has been provided)

Print Name: CHARLOTTE COUSE **Date:** 7.7.25

APPENDIX B: TMD-7

TMD - 7

How often are you bothered by any of the following problems … *Check (✓) one box for each item below*	Rarely or never	A few times per month	Once or twice a week	Nearly every day
1. Headache				
2. Pain in your jaw or ears				
3. Pain in your neck or shoulders				
4. Pain in your forehead or temples				
5. Difficulty opening your mouth all the way				
6. Noise when opening or closing your mouth				
7. Difficulty when eating or chewing your food				

APPENDIX C: Visual & Palpatory Assessments

Examination of the Jaw - Palpation Assessment

The palpation assessment below is a summary of the test a dentist would use to assess TMJ. As massage therapists it is not within our role to diagnose but the below will help you to assess which muscles are involved.

Client seated: Stand behind with flat fingers resting with light pressure on each cheek directly in front of ear

- Ask them to open and then close the jaw.
- You are looking for:

  Clicking: May be in just one side or both

  Deviation on opening.
  May be to right or left. This will indicate tight pterygoids on side where deviation occurs.

  Pain: They will tell you where they feel pain and the intensity.

  Limited opening: known as a *trismus*

- Ask client to open wide and with gloved hand place index finger gently in buccal surface with thumb on outside. Ask them to half close then clench. You will feel anterior fibres of masseter.

- Open again, half close and insert little finger into buccal space moving posterior and superior. You will feel the upper posterior insertion of masseter and the descending fibres of temporalis at coronoid process.(feels like the fin of a shark)

- Place finger firmly just in front of ear and open/close. If you feel a click or they yelp this indicates problem with anterior joint capsule

- Place finger in ear and push cartilage forwards. Ask client to open and close mouth again. Pain/click indicates the problem is with posterior joint capsule.

- Palpate above zygomatic arch. Ask client to open/close/clench - you will feel the fibres of temporalis.

- Resisted pressure using hand on one side of jaw get them to push one way then same opposite side. Any pain will suggest problem is in pterygoids. Alternative way is to get them to relax the chin then use your thumb to push back and get them to close.

APPENDIX D: TMJ Pain Protocol

18

Temporomandibular joint pain protocol

Introduction

The techniques **in** this chapter stem directly from clinical experience as outlined in the quote:

During my 15 years experience as a dental nurse I had watched so many people suffer with TMJ and its associated symptoms (including toothache, migraine, visual disturbances and ear disorders) while the usual orthodox treatment protocols seemed to be ineffective at best, or painful and potentially damaging at worst.
Then almost 14 years ago after training in massage, and with the support of my dental surgeon and a willing group ofTMJ patients I developed a massage and trigger point protocol that saw sufferers move out of pain and misery, and back into enjoying their lives. Many clients were reporting a reduction in symptoms from their first treatment and every one of them were either completely resolved if not dramatically improved within 4-6 treatments. Thatprotocol became the basis for the techniques outlined in this chapter which has now been taught to hundreds of therapists around the UK and Europe, who are freeing people from the misery ofTMJ.
Trigger Point Therapy is changing people's lives. It is that simple and that powerful.

TRACEY KIERNAN, Ex-DENTAL NURSE AND JING MASSAGE THERAPIST AND TEACHER

The techniques in this chapter have been used to great effect for a variety of common jaw disorders including:

- Temporomandibular joint (TMJ) disorder
- Bruxism (extreme teeth grinding)
- Migraines
- Headaches
- Unexplained face and jaw pain.

For maximum effect, the techniques can also be com- bined with those from the neck and shoulder protocol (see Chapter 13).

Heat and preparatory work over the drape

- The client is in a prone position. Start with heat application over the neck and shoulder area.

Figure 18.1
Paddy pawing of the trapezius

- Begin with a few minutes of still work over the towel. One hand rests between the scapula and the other on the sacrum.
- Palm and compress the upper trapezius from the head of the table. Use an alternate rocking motion using your body weight to lean into the tissues - like a cat doing 'paddy pawing'. **See Figure 18.1, p. 345**

Muscular and trigger point work

Posterior cervicals

- In forward t'ai chi stance facing the head, knead the posterior cervical muscles using pick up petrissage. Grasp the tissue at the back of the client's neck with a broad grasp: your thumb is one side and your fingers the other. Knead the tissues slowly and rhythmically. The hand that is not working rests on the top of the client's head. Move from your Hara so that your stroke is dynamic, with involvement from your whole body. **See Figure 18.2**

Suboccipitals

In the same position, work under the occipital ridge with the same side thumb (see description for posterior cer- vicals). Use static pressure first then cross fibre friction with the pressure in one direction only. Treat any trigger points you find. Trigger points in the sub-occipital muscles located under the skull are a common cause of headache and migraine pain. **See Figure 18.3**

Upper trapezius

- Undrape the upper back. Apply wax or oil at this point.
- In kneeling stance, use a soft fist or forearm effleurage to open up the upper trapezius. Support the head at the occiput with one hand and lean in with your bodyweight at the end of the stroke to give a slight stretch to the trapezius. **See Figure 18.4**

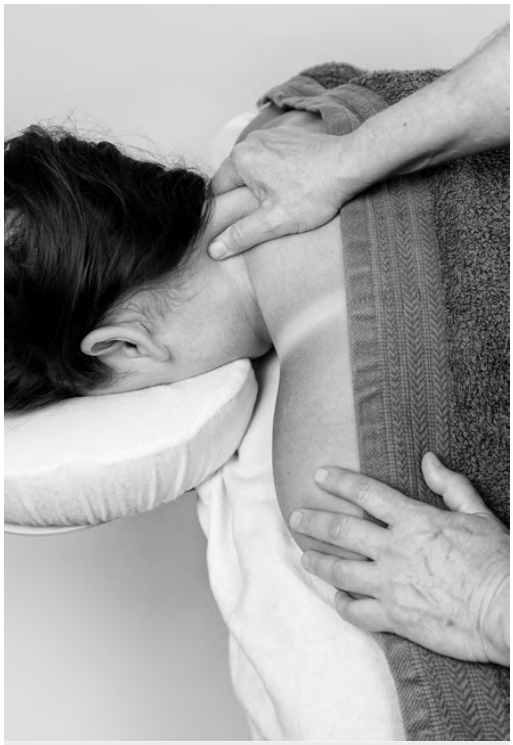

Figure 18.2
Kneading the posterior cervicals

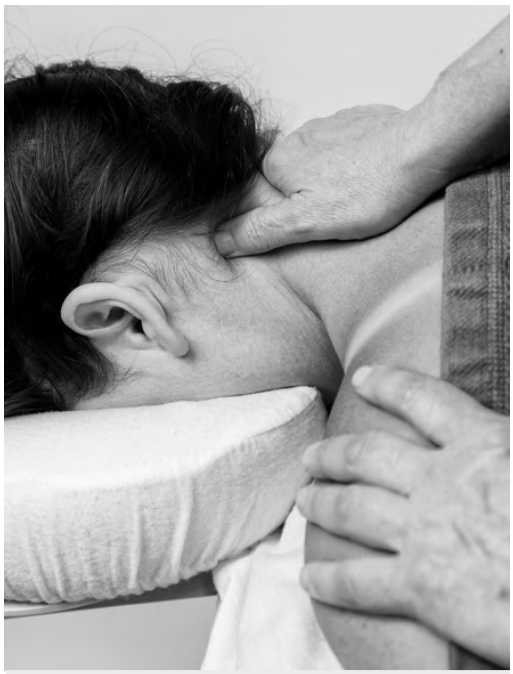

Figure 18.3
Treating the suboccipitals

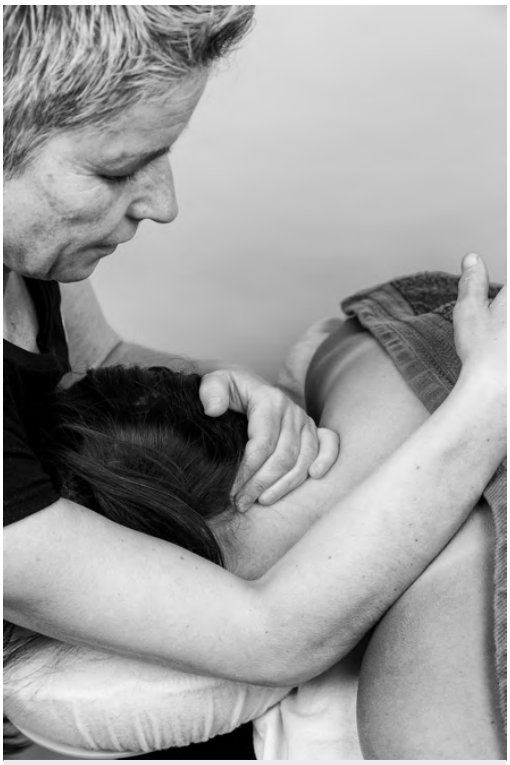

Figure 18.4
Broad work to the upper trapezius

- **Trapezius:** using supported thumbs, muscle strip the upper trapezius. Stand or sit at the head of the table at the opposite corner to where you are working. Use body weight to apply deep muscle stripping from the occipital ridge to the acromioclavicular joint. Treat trigger points using thumb over thumb or supported fingers. **See Figure 18.5**
- Repeat on the other side and finish with forearm work to both trapezius muscles.

Holding the head and grounding

- Now turn your client so that they are in a supine position.
- In a seated stance, sit and hold your client's head for a few minutes. This is an incredibly relaxing experience. If you tune in with your listening touch you may also be able to feel the cranial rhythm

Figure 18.5
Stripping the upper trapezius

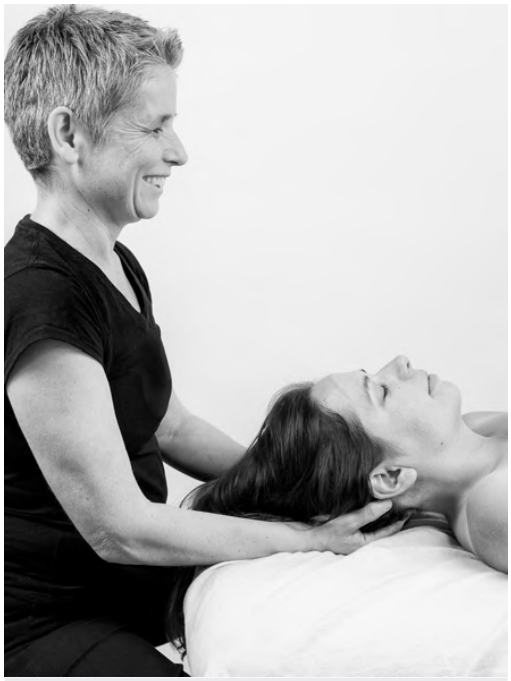

Figure 18.6
Holding the head and grounding

which feels like a very subtle filling and emptying of fluid in a water filled balloon. **See Figure 18.6**

Sternocleidomastoid **(SCM)**

- Sit in a seated stance at the head of the table. To work the right SCM turn the client's head slightly to the right and bring it a little closer to their shoulder.

This puts the SCM on a slack and makes it easier to grasp for the trigger point work.

- Rest your right forearm on the table and have your left hand on the client's head. Use a pincer grasp to gently squeeze and compress the SCM starting up by the mastoid process. Work slowly as this muscle can be exquisitely tender. As you work down to the clavicular attachment, where the belly gets thinner, you can pronate your hand to grasp the muscle. Work with care as the carotid artery is in this region. 'Don't press on anything that presses back at you!' **See Figure 18.7**
- **Working the attachment points:** to work these points on the sternum and clavicle you can hook in with a downward pressure.

Figure 18.7
Working the SCM with pincer grasp

- To finish off use a claw-like hand and rake into the muscle above the point where the sternal and clavicular heads divide. Sweep upward to the occiput (the cranial fascia anchors around the ear). Use static pressure to work the attachment points around the mastoid process.

Platysma and clavicopectoral fascia

- Use myofascial release (MFR) cross hand stretch over the pectoral area to treat the superficial fascia and platysma muscle (i.e. the superficial muscle you see when you make a 'monster face').
- **Thoracic release:** place one hand under the head and the other on the client's chest. Put the fascia on a stretch and use your sense of listening touch to follow the tissues. Wait and hold for any releases that may occur. **See Figure 18.8**
- In addition, you can place your upper hand gently under the chin, which provides a more targeted fascia! stretch of this area. **See Figure 18.9**

Intra-oral technique using gloves

The techniques below allow you to get to some of the attachment points of muscles inside the mouth. Explain to your client why you are doing this and ensure that they are comfortable with the techniques. Agree a sig- nal so that you will come out of their mouth if they feel uncomfortable. Use fresh gloves on each client and always check for a latex allergy firs t. Vinyl gloves are an alternative. Although the techniques are very safe you

Figure 18.8
MFT thoracic release

Figure 18.9
Thoracic release with hand under chin

Figure 18.10
Treating the masseter

Figure 18.11
Treating the temporalis tendon

may also wish to check with your insurance provider that you are covered to carry out intra-oral work. If you do not wish to carry out these techniques yourself you can show the client how to self-treat the muscles involved.

Masseter

- Sit at the side of the table on the opposite side to where you are working and ask the client to open their mouth.

- Wearing gloves, place your thumb against the buccal surface of the cheek and ask the client to half close their mouth. Move your thumb as far back between the cheek and the teeth as is comfortable. You should be able to feel the tip of your thumb touching the coronoid process, the fin shaped piece of bone rising from near the back of the mandible.
- Using the thumb and index finger, apply gentle compression to the masseter using a pincer grasp. Work slowly and carefully as the masseter trigger points can be very tender, so work with communication and keep an eye on your client's face. **See Figure 18.10, p. 349**

Temporalis tendon

- With the client's mouth open as far as possible without inducing pain, ask the client to shift their mandible towards the side being treated to allow more room to work. With the pad of your little finger of your right hand touching the inside cheek surface, glide your finger posteriorly very [illegible] until it runs into a fin shaped bony surface embedded in the cheek. This is the coronoid process.
- Place your little finger on the inside surface of the coronoid process and use gentle static pressure to examine where the temporalis tendon attaches. The tendon is very hard and will feel like a continuation of the coronoid process. Friction may be used if the tendon is not too tender. **See Figure 18.11, p. 349**
- Remove gloves.

External treatment of the temporalis

- With the client's mouth closed, work the temporalis tendon directly above the zygomatic arch (cheekbone) with transverse friction. Ask the client to clench their teeth and you will feel it move beneath your fingers. **See Figure 18.12**
- Repeat with the client's mouth open to stretch the tendon slightly. Less pressure is needed when the tendon is stretched.

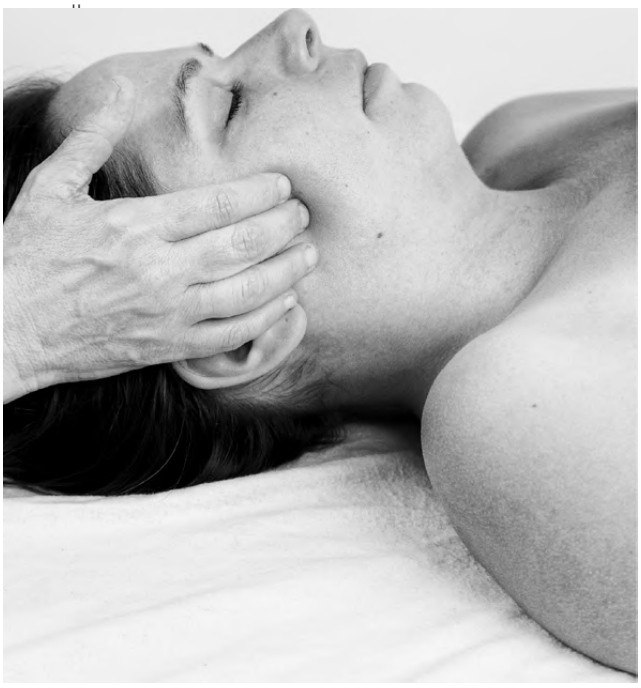

Figure 18.12
External treatment of the temporalis

- Use a 'shampoo' technique to relax the temporalis. Treat one side of the client's head at a time, working the muscle with soft relaxed fingers. You can also work the temporalis using deep thumb pressure by using the weight of the client's head to apply pressure to the muscle by gently turning their head onto a supported thumb . Work specifically and treat any trigger points you find.

Acupressure points

There are three points in front of the ear (at the side of the face) that are very effective for treating TMJ disor- ders. The middle point, SI 19, is the easiest to find and locating this one first will help you to orientate to the position of the other two.

Small Intestine 19 (SI 19): Auditory Palace

- **Location:** anterior to the tragus (the pointy bit in the middle of the ear) in a depression formed when the mouth is opened. **See Figure 18.13**
- Ask your client to open their mouth slightly and palpate for the small depression just middle of their ear. Manipulate the point with thumbs or fingers and hold for 3-5 breaths.

San Jiao 21 (SJ 21): Ear Door

- Location: in another small depression just above SI 19.
- Manipulate the point in the same way as above.

Gall Bladder 2 (GB 2): Auditory Convergence

- **Location:** in another small depression just below SI 19 (located with the mouth open).
- Manipulate the point in the same way as above.

Stretches

Manual traction

- With the head in a neutral position, hook your fingers under the occiput. Gently traction the head back towards you with your fingers in the occiput and leaning backwards slightly. **See Figure 18.14**

SCM stretch

- Support the client's head on either side. Ask the client to breathe **in** and then on the out breath take them into a gentle rotation. Your upper hand

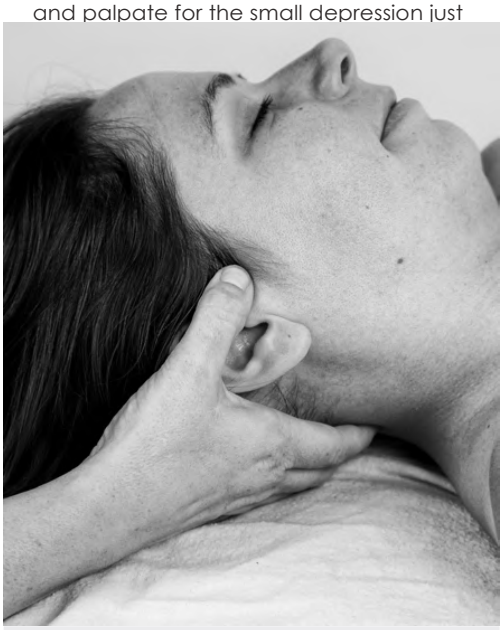

Figure 18.13
Location of acupressure point Small Intestine 19

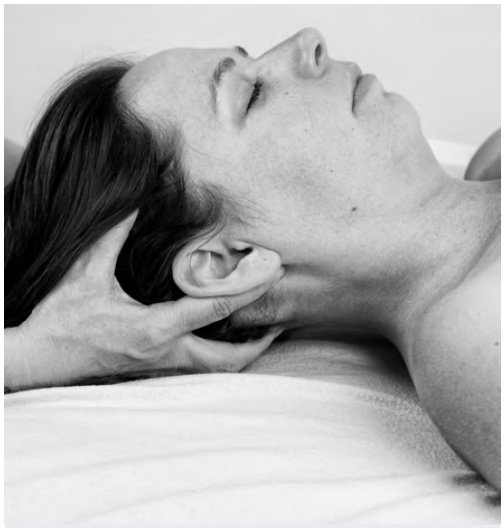

Figure 18.14
Manual traction

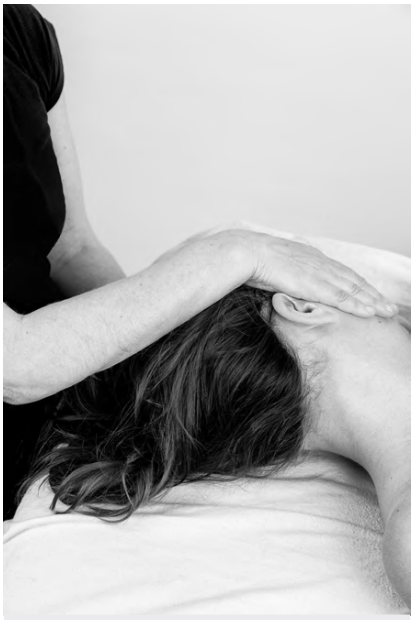

Figure 18.15
SCM stretch

Figure 18.16

Figure 18.17

gently presses their head towards the table to encourage maximum range of motion (ROM). Both your hands are working - like rotating a ball in your hands . Work with client communication so that they tell you when they feel the stretch . Wait and hold for 10-30 seconds.
See Figure 18.15

Stretch for the masticatory muscles

- Ask the client to open their mouth approximately 15 degrees. Place both of your thumbs on their chin.
  Ask the client to close their mouth while you provide resistance to the closure with your thumbs. Hold the masticatory muscles under isometric tension, for approximately 5 seconds. **See Figure 18.16**
- Finish the sequence with grounding and still work. **See Figure 18.17**

Teaching self-care suggestions

These can be found in the Self-Care Resources (available at htt p://www.handspringpublishing .com/ resources/self-care-resources-for-massage-clients /).

APPENDIX E: Oxford University Hospital's Exercise/

Controlled Jaw Opening

Purpose = prevent clicking of your jaw joint & strengthen the muscles which pull your jaw forward.

This will relax the muscles which close your mouth, as well as the muscles which pull the mouth forward & side to side. The jaw will act more like a hinge, & this will take the strain off it.

Set aside two five-minute periods each day at a time when you are relaxed e.g. before you get up or go to bed. Sit up to perform the exercise.

1. Close your mouth & make sure your teeth are touching. Do not clench your teeth. Rest the tip of your tongue on your palate, just behind your upper front teeth.
2. Run the tip of your tongue backwards towards your soft palate at the back of your mouth as far back as it will go. Keep your teeth gently together.
3. Hold your tongue back in this position to keep contact with the soft part of your palate & slowly open your mouth until you feel your tongue being pulled away. Do not open your mouth any further. Stay in this position for five seconds then close your mouth & relax.
4. Repeat this whole procedure slowly but firmly for the next 5 minutes.

As you open your mouth you should feel the tension in the back of your neck & under your chin. The first few times you perform the exercise, so it while looking in a mirror to check that your lower teeth move vertically downwards & do not go off to one side

If you are performing the exercise correctly, there will be no clicks or noise from your joints. If there is, re-start the exercise & continue practising, adjusting your position until it is click-free.

APPENDIX F: Jing™ TMJ Self-Care Handout

SHEET 15 Self trigger point treatment and exercises for temporomandibular joint (TMJ) pain

The following muscles can house sore spots that contribute to TMJ pain. This is how you can treat them yourself:

- You are looking for sore spots in the muscle, particularly those that re-create the pain you are experiencing.
- When you find a sore spot wait and hold until you feel the pain start to decrease.
- Go back to this point a couple of times until it is no longer tender on palpation.
- The pain you are experiencing from treating the trigger point should not be more than a 6 on a pain scale of 1–10. If the point is more painful than this you need to use less pressure.

Sternocleidomastoid (SCM)

- Stand in front of a mirror and rotate your head noticing the muscle that pops out on the side of your neck as you do so.
- Bring your head back to neutral and gently grasp this muscle near its starting point by the ear.
- Gently squeeze the muscle between your thumb and the soft knuckles of your first finger.
- Work the full length of the muscle to the collarbone, treating any trigger points you find. **See Figure S15.1**

Trapezius

- This muscle is found at the top of the shoulder.
- Work from neck to shoulder, grasping the muscle between your thumb and forefingers and treating any trigger points you find. **See Figure S15.2**

Figure S15.1

Figure S15.2