Welcome to the Beyond Trigger Point Seminars, Neck & Head Unit, Module 3, on the sternocleidomastoid, anterior neck and temporalis muscles. You won't need your study guide for the next few moments. Instead, just sit back and listen now. Pretend there's no place to go and nothing to do. We will begin by reviewing treatment protocol as it relates to these very important and often encountered muscles being studied in this module.

When a therapist consistently follows a four part treatment protocol, patients can expect measurable results within 3-6 treatments. The four part treatment protocol consists of taking an intake, choosing an appropriate modality of treatment, identifying perpetuating factors and designing a home program. An intake answers the question, "How can I help you?" or if you're the patient, "How can this therapist help me?" As is true for any relationship, establishing trust is the foundation on which the therapist/client relationship will grow. In my practice now, the initial evaluation is thirty minutes which allows me enough time to record the pain pattern, gather description and history of the pain, determine perpetuating factors, pitch a self-help program, establish goals through active listening and finally to determine the contraindications.

Ask yourself now, during your last intake with a new client:

- Did you draw the pain complaint onto a scan sheet?
- Did you ask enough questions about the onset, quality and duration of their problem?
- Did you determine what helps their problem and what makes it worse?
- Did you make educated guesses about which perpetuating factors are preventing the client from recovering on their own?
- Did you ask the client what they would like to accomplish with your treatment?

It's not enough for them to say they want to be pain free. If they tell you they want to get out of pain then ask, "If you were out of pain, then you would …what?" Determine what the emotional component of their goal is. For example, I want to be out of pain so I can turn my neck when my husband hugs me, or I can bend over to pet my dog or

sleep the night through, or to be off the pain medication. Help your client prioritize their treatment goals and then motivate them to make appropriate changes.

A story I often tell my clients is one I heard from Dr Travell. To illustrate the domino effect of injury, she used the story of a car crashing into a telephone pole because of a blown out tire. Not only will the tire need replacing, but also the windshield, bumper and alignment. Like chronic pain, no longer can you just go back and fix the blown tire; other areas of a person's life have been affected by the blow-out. In Dr Travell's autobiography, *Office Hours: Day and Night*, she draws attention to the importance of giving patients something to do after each session. When a person has been traumatically injured and they are hurting, fixing their sense of control about their recovery can be the most important thing a clinician does to help their client. During intake, ask the question, "What do you do to help the pain and what makes it worse?" Then based upon muscle involvement, design a self help program geared towards restoring the muscles to their normal, rested, pain-free state. Start off small; add one piece of homework at a time.

In this module and the next on the other masticatory muscles, we will be discussing temporalmandibular joint management and treatment. Sometimes the question to ask in this region is, "What other health care provider has already helped and who else is currently helping this person?" Developing a confidence in your role and your strengths of treating jaw problems will help you define your position in your client's health care team. The *sternocleidomastoid* is another amazingly complex muscle often creating symptoms of imbalance and dizziness. By the end of this lecture, you will be able to make educated guesses from your intake on whether or not your client needs to be treated by another medical provider.

The second part of our treatment protocol is choosing which modalities to employ. For many of us, the anterior neck is an endangerment zone we were trained to avoid. During the workshop, we will be expanding your awareness and treatment choices while working around the anterior neck and increasing your comfort levels of working inter-orally.

The third part of our treatment protocol is identifying perpetuating factors. You will discover quite a long list of perpetuating factors as we begin studying the sternocleidomastoid, so keep your pencils sharp. Identifying and correcting the factors preventing a muscle from healing on its own, keeps our work exciting.

The fourth part of our treatment protocol is educating and then motivating the client to follow a home program on the corrective actions**.** In order to maintain and enhance the therapeutic gains from your treatment, it's critical the client follows a self help program. To summarize, the four part treatment protocol is to:

- Take a detailed intake
- Develop a treatment plan
- Identify perpetuating factors
- Educate the patient on corrective actions

Let's turn to page 21 of our student study guide. When we look at the actions of the sternocleidomastoid, we begin to see why this muscle is nicknamed *Amazingly Complex*. The six bilateral actions of this muscle are:

1. Flexes the neck, when both heads are working simultaneously.

2. Check reins hyper-extension, which keeps the head attached to the neck.

3. Fixes the head when the mandible is moving, so when we're talking and chewing, your sternocleidomastoid is active.

4. Assists in inhalation, the SCM is a secondary muscle of inhalation.

5. Assists in swallowing.

6. Assists spatial orientation, weight perception and motor control.

The unilaterally actions are:

1. When one head is working independent of the other, it rotates the nose to the opposite side.

Take a writing break, put your pencils down and place a hand over each of your SCMs, slowly rotate your head to the right. Do that a couple of times. While rotating your head to the right, do you feel the contraction of the SCM on the left? Unilaterally the SCM rotates the nose to the opposite side. I emphasize the action because the stretch position often confuses students. To stretch the right SCM, look right.

2. Unilaterally the SCM side bends the neck with the help of the trapezius.

3. The SCM compensates for a head tilt due to structural imbalances along with the trapezius and scaleni. It's a fantastic muscle to read in a postural assessment because it's one of the last muscles to compensate for structural imbalances.

When we consider how this muscle is injured and what its correctives are, the importance of knowing the anatomy becomes clearer. Again, a nickname for the SCM is Amazingly Complex.

On page 310 of your text book or on page 24 of your study guide, do you see the pain pattern for the *sternal* and the *clavicular* division? Let's start by drawing in the four documented trigger points of the more anterior sternal division. Draw "X's" on your handout to represent the trigger points. Are you drawing a pain pattern to the back of the head? There's a heavy pattern there, above the eyebrow and behind the eye. Did you draw a one sided throat pain pattern? To the best of my knowledge it's impossible to have a viral sore throat on only one side. The patient describes the cheek pain by taking all of their fingers and spreading them from the cheek bone onto their cheek. There could also be a pain pattern to the vertex of the head and to the tip of the chin as well.

Okay, I hope you were able to finish your coloring. Last module, we looked at a study of 100 healthy folks who presented with trigger

points following a motor vehicle accident. Of the people in a front-end accident, 58% developed one or more trigger points in their sternocleidomastoid. The pain patterns you just drew are very common complaints for someone who has had a whip lash injury.

Let's move now to the clavicular division. We see in the book or the study guide, three documented trigger points. Begin drawing those now. There is a primary pain complaint or sensation; it might not be described as a pain, into the ear and behind the ear as well. This is one of the few muscles in the body referring pain across mid-line. The arrow on the forehead is denoting the spillover across midline that might occur when your client presents with a frontal headache.

The clavicular division trigger points can cause spatial disorientation as well. This leads to dizziness and imbalance, causing them to veer more to one side. When queried, the client can usually tell you if they are walking funny by remembering which wall they are hitting in route to their bathroom, for example.

Let's turn to page 26 of our study guide and name two findings for the trigger points in the clavicular head:

1. In the clavicular head and in the fill-in is a frontal headache. From this day forth, when you are presented with frontal headaches, I want you to consider the clavicular head of the SCM.

2. The fill-in is dizziness during postural changes. Dizziness due to trigger points can last from several seconds to several hours, commonly occurring when rolling the head off the pillow or when doing a quick rotation of the neck. Hopefully, a doctor has already ruled out inner ear problems before seeing you. If you ask your client to quickly rotate their head one way and whoosh, the room starts to spin, then you may be dealing with vertigo due to a myofascial pain syndrome. For many people, the symptoms of postural dizziness and imbalance are more incapacitating then the headaches.

List some findings indicative of trigger points in the sternal head. The trigger point presentation may be with or without pain. Some of the

other symptoms of a myofascial pain syndrome due to trigger points in the SCM are: profuse tearing, visual disturbances, hearing loss and again the one sided sore throat. It is common to see a local twitch response, an LTR, when you press on any trigger point in the SCM. An LTR is a temporary contraction of the taut band harboring the trigger point and is a confirmatory sign you are stimulating the trigger point. Because the SCM is superficial, it is easier to see this response. The SCM rarely causes a decrease in range of motion, though it might be involved with other muscles like the trapezius or the levator which do restrict cervical movement.

Let's move on now and name differential diagnoses that may have been given for symptoms caused from sternocleidomastoid trigger points. The first one that pops in my mind is a tension headache. Atypical Facial Neuralgia is another diagnosis your patient may have been given because of the pain pattern into the cheek and around the eye.

Another common symptom would be swollen lymph nodes. A lot of lymph nodes lie along the medial side of the sternal division of the SCM. When the muscle is tight, it's not uncommon for the lymph nodes to be backed up as well. In the workshop we learn to milk the lymph nodes first and then apply trigger point compression. Another differential would be vertigo caused by vestibular, meaning inner ear, dysfunction.

Finally, let's talk about wry neck, W-R-Y neck. Another name for this is spasmodic torticollis. Keep in mind this diagnosis is due to a disease and a dysfunction of the nervous system that affects the sternocleidomastoid. I've had a number of patients in my office with this condition and frankly have seen little to no results using the techniques I employ. Again, there's an underlying disease process affecting the nervous system and they need to be seen by a doctor.

Let's answer this question**,** "How is the SCM muscle activated and perpetuated?" Are you ready to write? Here we go…

1. Excessive forward head posture. We've talked about all the different ways a person can develop this forward head posture in our

last class. Sleeping with two pillows is another way to create a forward head position which adversely affects the SCM.

2. Excesses head rotation. We are going to test which eye is dominate for the purpose of determining if you have a same hand to eye dominance or a cross hand to eye dominance. Which hand you write with is already known and for those of you who have shot guns or bows and arrows, you know which eye you keep open to naturally line-up your target. But for those who can't answer the question, "Which eye is dominate?" we will experiment now.

   With one hand, make an "okay" sign. Hold the closed circle you created with your index and thumb about 12 inches in front of your face. With both eyes open, look through the hole and focus on something directly in front of you. Look at it and focus on the object you see through the hole and then shut the right eye. Without moving your hand, do you still have that object in focus? Switch eyes. Shut the left eye now without moving your hand. Can you see the same object through the hole or did it move when you closed the other eye? Whichever eye was open and focusing on the object is your dominate eye. You already know your dominate hand. So here's the next question; how many of you are right handed and left eye dominate or left handed and right eye dominate? This is called cross hand-eye dominance.

   Regarding neck mechanics, it's more difficult for cross hand eye dominant individuals to keep their heads in a neutral position. Their sternocleidomastoid has to work harder because the eyes tend to follow your dominate hand around in life. When you are writing, particularly if you are left handed and right eye dominate, the neck has to rotate more to compensate for the cross hand-eye pattern. In a classroom or a movie theatre or in church, if the main point of focus is front and center, the right eye dominate folks will tend to sit on the left side of the room. This keeps the focus point closer to their right eye. When you get stuck sitting in the less comfortable position for your neck, you have to squirm more in your seat or rotate

your head to compensate for your dominate eye. This is something our brains are born with and it's difficult to rewire.

If you are a marksman, the cross hand eye dominance is trouble. If you are a baseball player you have an advantage having the dominant eye closer to the pitcher and batting with the other arm. I hope I impressed upon you how easy it is to test your client on this and to alert them to situations when the position of their necks will be compromised. Let's move on.

3. Overloading the check-rein function of the SCM. Some examples include, having a neck whip-lash or painting a ceiling or being short and continuously looking up.

4. Falling on the head. How many of your clients have dived into shallow water and hit the top of their head or smacked the top of their head on something when standing up?

5. Compensatory neck movement due to imbalances in the structure. A lower limb length inequality or a small hemipelvis are structural anomalies creating imbalances up into the neck. Now, if you're new and haven't done the low back and hip unit where we study these in depth, a lower limb length inequality is just like it sounds, one leg can be functionally or genetically shorter than the other. A small hemipelvis implies one hip bone is smaller on one side. Either condition causes a compensatory curvature of the spine. Earlier we said the SCM's action is to keep the eyes even with the horizon by compensating for a tilting head. When people are cocking their heads to compensate for hearing loss, for example, one side of the SCM will work harder.

6. Finally, chronic infection like herpes, sinusitis, and dental abscesses can activate and or perpetuate trigger points in the sternocleidomastoid.

Okay, if we talked about this some more we could probably come up with another dozen factors, but I think you have the idea. So, let's turn to page 27 of the student study guide and answer the question, "What

are the corrective actions?" You might need the back of the page to write them all down.

1. At the top of your list, write "good posture!"

2. Keep the neck in an anatomical neutral position by keeping the object of focus in front of the eyes or sleeping with the neck in a neutral position as the picture on the bottom right shows.

3. Roll the head to the side and push up with the strength of the arm when rising from a bed. Teach this important correction when they are coming off your massage table. Pulling the neck straight up off a pillow, particularly first thing in the morning, can be traumatic for the SCM.

4. For your patients who read in bed; it's better to have the light shining directly behind them. While watching television or reading in bed, keep the neck and spine in a neutral position by sitting up or create a more gradual incline by placing a wedge under the shoulders as opposed to lying flat as shown in box "A" below.

5. Take breathes bilaterally when swimming the freestyle stroke. Olympian swimmers are rotating their heads to the left and right now which is certainly better neck mechanics.

6. Avoid sustained hyperextension. Michelangelo must have had an incredibly sore neck painting the Sistine chapel. Using scaffolding or climbing to a higher wrung on the ladder keeps the work directly in front of you.

7. Avoid the circumduction exercises of the neck often taught in exercise classes. Instead, teach the SCM stretch as a straight rotation left and a straight rotation right. Dr Travell points out the reason for avoiding circumduction are because the SCM doesn't know you know when to stop. So when we make large neck circles, the SCM has to put on the brakes by contracting.

8. Correct the lower limb length inequalities, which are explained in more detail in the Low Back Unit.

9. Sleep on a shredded Dacron or feather pillow. Though I have not seen the research on it, I think a memory foam pillow would be alright too for an SCM problem. Every time the head moves on a solid foam pillow, a mini whip lash occurs. In one study of subjects sleeping on a solid foam pillow, electrodes showed increased electrical activity in certain neck muscles. Every time the head is moved, the entire pillow shifts. A shredded Dacron or feather pillow doesn't jiggle as much.

10. Loosen tight collars. As is true for any muscle, clothing constrictions diminish blood flow.

11. Treat the chronic infection first. Before the SCM muscle is treated, suggest they see their doctor for resolution of any infection they have.

12. Diaphragmatic breathing is another corrective action to unload the SCM. This might be the most useful awareness you teach your client. There is a handout on the website, www.beyondtriggerpoints.com under the resource tab.

13. Google the "Epley Maneuver" and you will find an excellent resource for those suffering from dizziness.

14. Stretching exercises, of course, are always a corrective action for any muscle. To stretch the SCM rotate the head left and right.

Let's take a break now and stretch our own SCMs.

On page 28 of the study guide, describe the actions of the anterior neck muscles. Remember this; the digastric is in a relationship with the masseter muscle. The two muscles are partners in opening and closing the jaw. The digastric along with the superhyoids open the mouth and the masseter closes it. The infrahyoids muscles stabilize the hyoid, H-Y-O-I-D bone while this is occurring. There are several muscles attached to the hyoid bone and of course the muscles above it

are referred to as the superhyoids and the muscles below it are referred to as the infrahyoids. The digastric is strongly recruited during coughing and swallowing. So, we use it quite a bit. Keep in mind that the digastric is prone to weakness and inhibition in the same way that the rhomboids are overpowered by overly tight pectoral muscles. When the masseter muscle, which per square inch is the strongest muscle in our entire body, becomes hypertonic, the digastric can easily become weak. Moving down to the anterior vertebral muscles, make a note; their action is to flex the cervical spine, bringing the chin to chest, and to control head position.

Let's turn now to page 398 in the textbook or page 29 of the study guide, where you see the two documented trigger points of the digastric. One is in the posterior, the other in the anterior portion. Do you see how the anterior belly attaches indirectly through a fibrous loop onto the hyoid bone? That's the boomerang looking bone you're looking at from the front. Go ahead and draw the two pain patterns. This is one of many muscles referring into the teeth. Often a patient will have seen their dentist for this but nothing is wrong with this innocent tooth except it lies within the referral zone of the digastric. Draw the pain pattern along the edge of the throat too. We're going to nickname it *Pseudo SCM* pain because patients will be rubbing over the proximal attachment of the SCM to show you where it hurts. It's been my experience that the digastric isn't involved by itself. When you get rid of other major players like the SCM, the trapezius, the levator, the scalene, or the masseter muscles, then, what might be left is this digastric pain pattern. You know, clients may not even report pain, what they might report instead is a difficulty in swallowing. Or a phrase I've heard before is, "there's a *lump* in my throat." When the head is rotated to the involved digastric side, it becomes difficult to swallow. In fact, they avoid rotating to that side because the lump in the throat gets thicker.

Let's move on to answer this question: "How are the anterior neck muscles activated?" The digastric is activated commonly in conjunction with trigger points in the other masticatory muscles. So it gets pulled into the act because other muscles of mastication are involved.

Another way the anterior neck muscles become activated is through mouth breathing. So when we open our mouth to breathe, it pulls the whole head forward and causes strain on the anterior neck muscles. Finally, the anterior neck muscles become involved because of whip lash accidents.

I will name four correctives.

1. Postural training, I hope everyone is increasing their ability to educate their clients on standing tall. If you do not have the five point stance handout yet, please download it from the resource section on the website. I want you to have this.

2. Correct the mouth breathing, if there is a nasal obstruction from a deviated septum, and then this could be treated by a surgeon. However, it's surprising to me how many people, out of habit, will be breathing through their mouth until you train them otherwise.

3. Another corrective is to correct bruxing, a fancy word for clenching and grinding of the teeth. Bruxing often happens unconsciously, particularly when a person is sleeping. We'll talk more about night guards or occlusal splints in Module 4.

4. Correct the malocclusion; malocclusion is referring to an imbalance in the bite. For example, after having dental work, unevenness can be created at the surface of the tooth causing an imbalance when the teeth occlude. A name of a book on this subject is, "*Taking Control of Your TMJD.*" It would be a good recommendation for your clients with TMJD.

We'll continue to talk about the correctives as we look into the temporalis. So let's turn now to page 30 of the study guide. The three actions of the temporalis muscle:

1. Elevate the mandible which closes the mouth.

2. Bilaterally they retrude the mandible. Do you feel how pulling your lower teeth back contracts the temporalis?

3. Acting unilaterally they deviate the mandible to the same side.

On page 351 of the textbook or page 31 of the study guide, you will see four documented trigger points of the temporalis. All but the trigger point on picture "D" are attachment trigger points. I think the numerical listing of these trigger points is the order of prevalence in the population based upon the authors findings.

Go ahead and take out your coloring pencils and draw some of those pain patterns now. The temporalis, like the digastric, refers into the teeth. It might not be pain per say, instead your client might report sensitivity to pressure in the upper teeth, or when they bite down hard on the back molars, the maxillary teeth feel weak.

The nickname for this muscle is *Temporal Headaches*. You can see in all four of the documented trigger points- the spillover or primary pain complaint is in the temporal region on the side of the head. Look at picture "C", TrP_3. Some of that spillover pattern is going over the temporal mandibular joint. This is a muscle I'd consider when someone is presenting with temporal mandibular joint pain. Since the temporalis is one of the masticatory muscles, it has an important role on the TMJ. Now I will answer the question:

What activates and perpetuates the temporalis muscle?

1. Number one on my list is clenching and grinding. For some people, once a grinder, always a grinder. Grinding happens unconsciously, often during sleep. The amount of grinding can be affected by stress levels during the day.

2. Another would be jaw immobility. I have been seeing a patient recently who was hit twice in two separate bicycle accidents. What luck is that?! During the second accident she really injured her TMJ and had to have her jaw wired shut for nine months. Though I can't put my finger inside her mouth yet to do the interoral work, I have been working the temporalis muscle and the other muscles of her neck and face.

3. The temporalis is another muscle that compensates for a forward head posture.

4. Gum chewing aggravates the jaw because it requires a circular motion of the temporal mandibular joint. During gum chewing, the wad of gum is being thrown around the mouth potentially fatiguing the temporalis muscle. Most other types of chewing are just up and down so to speak. We'll talk more about the movement of the TMJ next module.

5. Direct trauma. It's not difficult to be whacked along the side of the head and have the temporalis injured.

6. Folic acid deficiencies- Dr. Travell talks about folic acid deficiencies. In one study, 16% of 57 patients with myofascial pain syndromes had low B12 levels. It's the same deficiency that can induce restless leg syndrome. Think of the temporalis muscle as the restless head muscle. It is to the head what B12 deficiencies are to the calf and the bicep femoris of the leg.

7. Chronic infection is another activation and perpetuation factor. For example, a tooth or gum infection can activate the temporalis.

When determining for temporalis involvement, what findings are likely? The temporalis causes the least amount of jaw restriction as compared to the other masticatory muscles. The patient may not be aware of any restriction in jaw opening. You'll see though there is a zigzag deviation of the mandible when opening and closing the jaw. The lower jaw deviates a little to the left, and then a little to the right, in route to opening and closing the jaw.

Because the temporalis lies in the zone of the SCM and trapezius pain patterns, the temporalis can develop satellite trigger points. You have observed how sensitive your client's temples are when they have a headache. If a trigger point develops over time in the temporalis muscle, you could say a satellite trigger point has been induced neurogenically or mechanically by the activity of the key trigger point in the SCM or trapezius.

All right, let's turn to page 32 of this module where you have space to write the corrective actions. I will name seven. You can probably think of others once you have a few examples.

1. Instruct on good neck and head posture. The five point stance is a good place to begin. This is covered in detail in our workshop. If you haven't already, download the handout for you and your clients under the resource tab at the website.

2. When checking for tooth alignment after a dental procedure, sit up in the chair. The dentist who wrote the section on good neck and jaw mechanics in the text points out the importance of having the patient sit up as opposed to lying back which causes the lower jaw to retract.

3. If there's no articulate dysfunction, meaning if there is no problem with the TMJ, the disk or the joint itself, yawning is a good exercise. This is a natural stretch to release tension particularly in the temporalis muscle. You see a picture of that exercise below.

4. Night guards or occlusal splints prevent bruxism. Mouth guards, like the sport guards football players wear in their mouth, are worn to prevent grinding. I've held a lot of peoples' hands as they go through the process of getting a night guard. Custom molded guards can range from $100 to $750. Frankly, that is an awfully expensive piece of plastic. If your clients shop on line, or check a local drugstore, they might find a generic night guard to wear.

5. Correct stomach sleeping. You cannot sleep on your stomach when you have jaw problems. It throws the jaw into misalignment. Period …end of discussion!

6. Another corrective is to keep the head warm. This muscle can chill, particularly if you don't have any hair.

7. Finally, avoid chewing tough items. I had a gentleman today who's right temporalis was tighter than the other, and he knew

instantly why this was. He's an ice chewer. Avoid chewing gum as well.

I saved the best case study for last in the few minutes we have together. Based upon the story, I hope you can now guess the muscles involved in this case study. Okay, you ready?

A woman in her mid 30's presents with neck and jaw pain. She has a high stress job working in a television station at a corporate level position. She has had vertigo for one week. She feels her ear is blocked on her right side and she refers to this as an echo chamber. From grinding her teeth at night, she has a history of two fractured molars, which is not uncommon with night grinders. She comes home from work exhausted and often falls asleep on the couch sideways with her head resting on the couch's foam pillows. On measurement, one of her hip bones is smaller than the other and her head is in a forward position. She also presents with signs of a sinus infection.

The headache pattern began years prior after tying balloons on top of her company's float for a parade. She always wore high heels and that day she spent all morning working overhead, securing hundreds of balloons, walking along the float and then being drenched in rain. By the end of the day, she had a significant headache, wrapping around her ear and into the temple. She has had this pain off and on ever since.

Ok, now *you* guess which muscles are involved, what the perpetuating factors are and what her home program would be. I hope you guessed her *right* SCM. That was causing the ear problem because when compressed it reproduced the blocked feeling in her ear. What else was involved?

The reaching overhead with balloons was the initial insult causing levator scapula tension, trapezius as well as suboccipital involvement. A trigger point in the trapezius reproduced her headache pattern. She did have a sinusitis that responded to seven or ten days of antibiotics. Years before, she had been fitted for a night guard she had hidden in her bed stand. So she started wearing it at night to help with her clenching.

What were some other things she needed to do to correct her SCM, suboccipital, levator and the trapezius tightness and restore the balance between her anterior neck muscles and masseter? She needed to stop falling asleep on the solid foam couch pillow with her neck cocked sideways. How do we correct the small hemipelvis? A Readers Digest book placed under her hip levelized her hip. She needed a "butt book", as Dr Travell would say. So she started carrying it in her purse and slipped it underneath her left hip when she sat. That kept her spine more even and her head more aligned. She responded well. She was still under a lot of stress, so once the ear sensation, headache pattern and vertigo abated she continued to be a client for three or so months because she enjoyed the relaxation benefits of massage.

I saw this woman in a voting registration line two years later. She had found a charming young man in church, they had gotten married, bought their dream house and were living happily ever after.

There you have it. Feel free to contact me at info@cathycohen.com. I enjoy hearing from you. As always, stay in touch!