Dynamic Chiropractic

Direct/Indirect Manipulative Therapy

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Recently, I was treating a whiplash patient whose main complaints were cervical pain and occipital headache. She showed continual improvement, but after three weeks, although she was neurologically intact, her headache still persisted. Her MD thought she was suffering from a posttraumatic concussion syndrome. I was thinking of referring her for a neurological consultation, when I remembered that there was another healing tool in my healing box that I'd failed to use. I'm referring to Jones' strain/counterstrain (SCS) or what D'Ambrogio and Roth refer to as positional release therapy (PRT).[1]

I examined her cervical spine and there was a moderately tender point at the right C2 on the articular process over the rotators, multifidus and interspinalis muscles. Over the previous few weeks, I had already established normal ranges of cervical motion by adjustment and treatment of all the fascial areas, both local and distant from the cervical spine. Yet this particular area of tenderness remained. Pressure on the area did not refer pain to the occiput or anywhere else. It was a local area of tenderness. After using what is known as an indirect method of treatment, the patient remarked that she felt much better. At her next visit, she stated that her headache was completely gone; since then, it has not returned. I have had similar results using this technique in the past.

The reason techniques such as PRT and SCS are considered indirect is because you are not directly applying a force to release a barrier. Techniques such as high-velocity thrust, myofascial release, ART® Graston technique® NMR or muscle energy techniques attempt to "directly" release restricted joints or soft-tissue barriers. Leon Chaitow, in an excellent book titled Positional Release Techniques, queries, "Is it possible for self-regulating, homeostatic mechanisms to be encouraged to act when the load on dysfunctional tissues is temporarily eased? Can a restricted joint release without force? And can pain sometimes be relieved instantaneously, merely by holding the painful tissues in an 'eased' position?"[2]

The answer is a resounding yes! Indirect techniques are very effective after acute trauma or inflammation. At times, it is useful for chronic problems, too. Marc Heller, DC, has been writing excellent articles on low-force techniques.* With indirect methods, treatment is directed away from restrictive barriers and directed toward ease and looseness.

For example, in the above patient, using SCS or PRT, I touched and held the tender point at C2 on the right with about a pound or two of pressure and moved the patient's head (patient is supine with the head and cervical spine off the edge of the table) into a position to cause a slackening or ease of the dysfunctional tissue. You want to reduce the palpatory pain to at least 70 percent. I have the patient report that the initial palpation should be designated as a "10" and I want to reduce the pain at least to a "3" or even a zero. In this case, you realize that by bringing the head and cervical spine into extension, there will be more ease in the posterior cervical tissue. As I bring the head and neck into extension, you can feel the lessening of tension under your finger and the patient will respond that there is less pain. Since the multifidus is a contralateral rotator, if the extension position has not reached three or zero, you can fine-tune and relax (ease) the tender

point even more so by (while in the extension position) contralaterally rotating the head (shortening the multifidus even more). Often, the patient will say the pain is gone. This is called fine-tuning.

Sometimes in this case, you might fine-tune by laterally bending away or toward. Jones' SCS method wants us to hold the position for 90 seconds. There are times, according to the PRT method, when even 20 minutes may be necessary. After 90 seconds, it is important to slowly bring the patient's head back to the original neutral position. At this point, if necessary, you could follow up with a direct method. Jones has determined the location of tender points throughout the body and the ideal position necessary to reach the point of ease. Sometimes, the direction of ease is opposite what you might think. Sometimes, the position recommended for ease might not even work or it may be a point not on the list. Therefore, this indirect technique, while excellent for most points, may not be the particular answer for other tender areas, and the practitioner should rely on his/her palpatory skills and positioning to accomplish a final resolution of pain. Other methods of reducing tender points that have been devised by Goodheart, Bowles and Hoover, McPartland and Ziegler, Schizoids, and Chaitow are discussed in Chaitow's text.

There are several theories as to how SCS works, such as Korr's proprioceptive model3 and a nociceptive hypothesis.[4] The actual mechanism of how the technique works is unknown, but it definitely works.

[*Editor's note:* To read some of Marc Heller's articles on low-force manual adjusting, visit www.chiroweb.com/archives. Dr. Heller is a regular columnist for *DC*.]

References

1. DAmbrogio KJ, Roth GB. *Positional Release Therapy*. St. Louis, Mosby, 1997.
2. Chaitow L. *Positional Release Techniques*, 2nd.ed. www.harcourt-international.com. 2002.
3. Korr I. *Collected Papers of Irvin M. Korr*. American Academy of Osteopathy, New York, Ohio, 1976.
4. Bailey M, Dick L. Nociceptive considerations in treating with counterstrain. *J Amer Osteopathic Assoc* 1992;92:334-341.

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