

Viewpoint: The State of Our Art

THE ART OF THE CHIROPRACTIC ADJUSTMENT: PART I

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This author acknowledges the value of reflexology and numerous physiotherapeutic applications (along with nutritional supplementation, counseling, "bloodless surgery," and standardized rehabilitative procedures) in chiropractic case management. Yet, they all stand in the shadow of the basis for and the proper administration of the chiropractic adjustment. This column and others throughout the year will focus on the need for the development of our unique art. Certain basics seem to have become lost in the teaching of "technic" during the last decade or so.

Depth of Drive

Besides patient positioning, the type of contact selected, and direction of drive, the depth of drive also must be accurate. It is sometimes taught that it should be to the anatomical limit, but this is not always true. Adjusting a strong ligament fixation immediately to the anatomical limit may rupture degenerated tissues -- resulting in the development of even tougher scar tissue. The object is to progressively stretch but not rupture shortened fibers. Adaptation takes time.

The opposite should also be recognized. An attempt to mobilize further after a fixation has been released will produce a new defensive contraction and inflammation, and therefore predispose the development of a new fixation. Over-adjusting is not beneficial; it is trauma.

The Articular Snap

Spinal adjustments often involve the breaking of the synovial seal of the apophyseal joints, resulting in an audible "snap." While some feel this is of little significance, most authorities feel that breaking the joint seal permits an increase in mobility (particularly that not under voluntary control) from 15-20 minutes -- allowing the segment to normalize its position and functional relationships as much as possible, if post-adjustment rest is allowed. Unsuccessful manipulation resulting in increased pain rarely produces an audible joint release, while successful adjustments usually produce an immediate sense of relief (though some discomfort and spasm may remain). A reduction in palpable hypertonicity and an improvement in joint motion are typically followed by a gradual reduction in symptoms.

Segmental Distraction

An extension (distraction) or separation of joint surfaces and elongation of shortened soft tissues should be a component of every adjustive thrust. Articular pressure is thus reduced to a minimum at the moment of joint movement. In this manner, articular friction with its accompanying trauma and pain will be reduced and taut tissues, contributing to the fixation, will be stretched. Instruction in adding intersegmental traction to all adjustive procedures was a fundamental principle in pioneer chiropractic, and it's still valid.

Timing the Thrust

Somewhere at some time somebody taught another DC that the best time to deliver the thrust is at the end of patient exhalation. This erroneous idea has spread throughout the country like an epidemic to infect hundreds of DCs to the detriment of their patients. The advice, "Take a deep breath, and then let it out" is extremely poor counsel if the adjustment is delivered at the end of exhalation. Patients soon learn the doctor's tricks and consciously apply muscle splinting mechanisms just before the thrust is delivered. Nobody likes their lungs to be shockingly overdeflated.

Relaxed exhalation is a passive mechanism; inhalation is not. At the end of relaxed exhalation, respiratory muscles prepare to contract by increasing their tone. Thus, the best time to deliver the thrust is immediately after the beginning of exhalation. The effect on the patient's lungs, then, is only to increase the rate of normal passive exhalation. If the thrust is made at the end of exhalation, forced exhalation results and the effect is a sharp, automatic, protective contraction of the diaphragm, thoracic muscles, and perispinal musculature. The latter is likely to return the segment immediately to its abnormal but habitual position. Such poor timing is painful to the patient, and patients who suffer unanticipated pain are not inclined to refer their friends, relatives, and neighbors for such abuse.

Nobody enjoys unpleasant surprises. It is always wise to carefully explain to patients new to the practice (before they are placed on the adjusting table) exactly what you are going to do; why you are going to do it; how you are going to do it; what sensations they may feel during this "operation;" and what benefits they should look for as the day progresses. In this manner, there are no surprises and no shocks to one's expectations. This explanation builds a logically designed image within the patient so that the patient's psyche is working with you, not in a contrary fashion.

The adjuster need not tell the patient how to breathe. The patient knows how. All the adjuster has to do is feel the patient's thoracic cage rise and fall as the contact is taken to time the thrust properly. A more efficient adjustment will be achieved, and the patient will feel little discomfort and no painful surprise.

"Drop-Support" Tables

Drum rolls, trumpets, or "gunshot" theatrics have no place in a clinical atmosphere. A colleague recently remarked, "Those who set a circus stage soon become known as clowns."

Adjusting tables producing a loud "crack" when the adjustment is delivered are not recommended for three reasons: no biomechanical principle justifies their use, the "gunshot" noise frightens many patients, and the extraneous noise prevents patients from personally sensing the deep articular release that so often accompanies an adjustment. This latter factor destroys the psychological value of having the patient feel that something has moved in their spine. For many patients, this is a positive affirmation.

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Editor's Note:

You can take advantage of the special pre-publication price of Dr. Schafer's latest textbook, *Clinical Chiropractic The Management of Pain and Disability Upper Body Complaints*. Please see the Preferred

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