Applications of manipulative techniques

There is good evidence that the style of manipulative treatment used by Andrew Taylor Still, MD, DO, changed as he developed his thinking and evolved his practice. In the earliest accounts of his treatments, before the founding of the school at Kirksville, it was apparent that he often used a type of high-velocity, low-amplitude thrust that resulted in the "pop" that we associate with such treatments today. Later, he evolved his techniques to a gentler type that almost never resulted in the joint cavitation or "pop." In addition, in his later years, he certainly used a great deal of soft tissue techniques and activities designed to restore tissue function and health before introducing a corrective maneuver that would finally restore motion to the region. He did not put techniques into categories or types, insisting that the osteopathic physician develop the technique to fit the patient and the situation.

Later, for teaching and practical purposes, techniques began to be categorized and systematized. The practice of teaching and practicing techniques quickly spread throughout the profession, and the number of techniques multiplied (we have characterized some of these in earlier installments of this series). However, it was still necessary to look at overriding considerations for osteopathic manipulative treatment.

The three articles reprinted here provide different overviews of how to use manipulative techniques. The first article is by Louisa Burns, DO, and was written in 1945. She was nearing the end of her career and had published many research papers on various aspects of the osteopathic lesion or somatic dysfunction. In this article, she gives her views on what she characterizes as "brisk and snappy" or "soft and gentle" types of manipulative techniques. She follows Still's admonitions in stating that the treatment must be fitted to the patient and goes on to suggest through the use of several case reports that it is necessary to find the treatment type that has the best results. In most of the cases, it appears that "brisk and snappy" treatments are used when autonomic stimulation is called for, and the "soft and gentle" types when autonomic inhibition is called for. However, she points out that the physician must be sensitive to the patient's response as the treatment is given and be willing to change the style as the treatment progresses.

The second article, published in 1947 by J.S. Denslow, DO, was written fairly early in Denslow's career. He had already performed some of his germinal research on reflex thresholds in humans. He points out that the changes found by the experienced osteopathic physician are complex entities that are functional entities that indicate the location, severity, and progress of osteopathic lesions. He also points out that often the tissue alterations can be altered rapidly, showing their functional characteristics. He suggests that some osteopathic physicians are using sulfa drugs and penicillin for bacterial infections, and manipulative treatment only on those who do not respond well to the drugs. Denslow's response is that manipulation should be used first, then if the patient does not overcome the infection, drugs should be provided. It is possible that his admonition should be heeded now more than ever. Under the section on "Localized Lesion Pathology," he makes the observation that it is not necessary to return a lesion to absolutely normal function, but only to that function that is within the limit of adaptability of the patient, so that the body can handle the problem. He also cites a case in which the major part of a patient's problem was psychologic stress at home that resulted in a disabling facial neuralgia. This case was interesting in that it was in line with Denslow's studies showing that spinal lesions could be made worse by psychologic stressors. He summarizes the article by following the advice given by Burns that the treatment must be controlled by constant evaluation of the tissue textures during the treatment.

Paul Kimberly, DO, wrote the third article in 1949. Kimberly was at the Des Moines Still College of Osteopathy and Surgery. He makes the case for using the inherent respiratory motions of the body as an aid in using manipulative treatments. He even makes the case that the failure of any tissue to move freely in its normal "orbit" of motion was the beginning of disease. Interestingly, Kimberly inserted a section on Sutherland's primary respiratory motion. It had been at Des Moines that Sutherland had first been successful in teaching his theories and techniques of cranial motion and manipulation. The emphasis placed on respiratory motion of both the cranium and the skull in the article helped establish the basis for respiratory models in the profession. In his usual thorough way, Kimberly described the basis for movement in the vertebral column, the appendages, and the soft tissues.

These three articles provide an intriguing view over four years from the viewpoint of an older practitioner and two younger ones, of how to use overarching principles in the application of various manipulative techniques. Students would do well today to follow the principles set forth in these articles.

Michael M. Patterson, PhD
Associate Editor