

More questions than answers?

Consider what is actually happening when ischaemic compression/ inhibitory pressure/acupressure/local myofascial release techniques are applied to painful, contracted, muscular areas. What is taking place in the recipient tissues?

- Are they being deprived temporarily of their blood supply so that a 'flushing' of fresh oxygenated blood can occur subsequently, after release of the pressure, so easing the ischaemia assumed to be contributing to pain and restriction? (Travell & Simons 1992)
- Or are neurological influences being brought to bear, so that pain messages are blocked or modified via gate control mechanisms? (Melzack & Wall 1988)
- Or are energy factors involved, with the degree and duration of the pressure applied determining whether energy is added to or deducted from the equation? (Academy of Traditional Chinese Medicine 1975)
- Or is myofascial elongation occurring as a result of sustained pressure on the tissues? (Barnes 1990)
- Or are all four, and perhaps other physiological processes – such as endorphin release (Baldry 1993) – at work simultaneously in response to sustained digital pressure applied to dysfunctional soft tissues?

An osteopath, chiropractor, physical therapist, acupuncturist, Rolfer, shia tsu practitioner or neuromuscular therapist might each take different views as to what it is that they were doing as such pressure was being applied, despite the fact that to the observer they would appear to be doing precisely the same thing. What does science say?

At present answers are few and questions many in areas such as this, for although research has examined aspects of the benefits of such treatment approaches, no comparative studies have been published. Logic would suggest that elements of all the concepts described are involved in whatever benefits derive from direct manual pressure approaches.

It should be emphasized that there are also other ways of dealing with local

dysfunction. Jones (1981) showed that applying minimal pressure to painful 'points' and then using the pain as perceived by the patient as a monitor while the area, or body as a whole, was positioned in such a way as to remove the pain being experienced, allowed a self-generated resolution ('spontaneous positional release') of the pain to take place. At the same time an easing of whatever stress pattern was producing/maintaining the pain would occur.

While manual pressure is a direct, somewhat invasive and potentially traumatising approach, which demands an adaptive response from the body, indirect, functional approaches (such as Jones strain/counterstrain) avoid demanding a response and instead offer an opportunity for change. Many find these methods more acceptable both philosophically and in practice, but are these feelings justified (Chaitow 1996)? Once again we await research to show what seems to be indicated by clinical experience.

Consider also the question of the relationship between joint and muscle problems. In order to normalize a restricted joint should the soft tissues which support and control its motion receive attention to release, stretch and normalize them – so helping to restore joint function (Stiles 1984, Janda 1988)? Or should the joint be manipulated/adjusted to restore more normal motion, at the same time beneficially (reflexively) influencing the soft tissues (Liebenson 1990)? Ask this question of an osteopath or a chiropractor and you will probably receive conflicting answers. Which view is correct? Or are both correct?

As chiropractors adopt an increasingly receptive view in respect of the importance (at least in rehabilitation settings) of soft tissue techniques, and as osteopaths incrementally utilize an ever wider range of soft tissue approaches (as well as applying high velocity thrusts when these are deemed appropriate) the distinction between osteopathy and chiropractic in practice blurs somewhat, even if there

remain philosophical distinctions rooted in the histories of these two professions. For a chiropractor the need to mobilize a joint which is restricted in motion would usually seem to be a primary and paramount objective, with high velocity thrust-type adjustments as the predominant tool. For the osteopath, while one objective would be for restricted joint mobilization to take place, this would be as part of a comprehensive normalization of function in which soft tissues would receive at least as much attention as the joint (Greenman 1989). Many modern osteopaths would, as likely as not, avoid active joint manipulation, opting instead for positional release or muscle energy type approaches to achieve these ends (Stiles 1984, Greenman 1989).

Many physical therapists adopt an eclectic middle ground between these positions, using both approaches according to individual preferences. Who is correct? Or are all such approaches likely to achieve

similar results? Studies of each system seem to show benefits, but they have not been compared in studies that evaluate the relative benefits of skilled soft tissue (MET, myofascial release, positional release, etc.), normalization of joints as compared with high velocity thrust mobilization approaches (Brodin 1982).

So why not integrate the methods?

As the *Journal of Bodywork and Movement Therapies* develops, these and other issues will be addressed and hopefully answers will begin to predominate instead of questions.

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