

Framework: Low-Force Manual Adjusting

Adjusting Techniques, Part Two

by Marc Heller,DC

I want to outline for you an approach to low force adjusting that is quite different from most of the low-force techniques chiropractors use. Very little of this work is original to me. It's a compilation of methods I have learned, primarily from the influence of both American and French osteopaths.

I've seen so many patients who have come from their previous chiropractor who said, "I can't adjust you today, you are too spasmed, too tight, in too much pain." **We always adjust our patients!** No matter how osteoporotic, how fibromyalgic, how spasmed, how much pain people are in, or whether they can lie down or not, there are low-force adjustments that can be effectively applied. If you are familiar with low-force methods, you can help these folks. We need to redefine our limited view of the adjustment.

The principles of this type of adjusting are simple. I will contrast them with some other low-force methods used by chiropractors.

- **Palpation-based** (not based upon muscle testing, x-rays or leg checks): I believe that you only get really good at palpation with experience. Both muscle testing and leg checks are wonderful short cuts for beginners, but do not develop the fine motor skills needed to fully understand what is happening in the joints and tissues. X-rays or postural analysis can give you an overview, but only your hands can tell you what the tissues need.
- **Three-dimensional, and changing moment by moment:** Those of you with myofascial release experience will know what I mean. An activator is a two-dimensional instrument, and can only apply a linear force. Your hands can give you instant feedback on what is changing in the patient's tissues, and make variations in their exact direction and amount of force. Instruments can never do this.
- **Adjust at the beginning of the barrier, proximal to the "hard-end" feel:** I talked about this at length in my July 30 article in DC. You have access to more information, and the joint retains greater mobility at the point just before the hard pack. All of our low-force techniques can be applied at this point in space, and are much more effective here. This is another skill that took me a long time to master. Most of us tend to push right through this "feather edge" to the fully locked part of the barrier.

- Use "just enough" force: **Again**, based on palpation, we can evaluate how much force is necessary to initiate a change in the tissues. When the tissues start to tighten and resist our force, we either lighten up or change our angle slightly.

Low Force Adjusting - ELF, Recoil, and Muscle Energy

OK, enough theory already. How do we do these adjustments? Here are three main methods.

Engage, Listen, Follow (ELF)

This is the primary method used by Jean Pierre Barral, author of *Visceral Manipulation*. This is a variation on myofascial release. Dr. Warren Hammer uses a similar method on soft tissues called integrative fascial release, which was detailed in his article in *Chiropractic Technique*. For ELF, just push into the beginning of the barrier, exactly lining up and maximizing your three dimensional tensions without jamming the joint. **Engage this line of drive, then follow the motion that is happening as the release occurs.** To follow the motion means you will follow and engage the tissue tensions that occur as you feel things release, subtly changing your line of drive as the area releases. You will feel the vertebrae rapidly begin to unlock under your gentle pressure, reaching completion within 10 to 30 seconds. Follow to completion.

Once you have engaged the barrier in 3-D, listen with your hands and follow. Let the release occur. You are using a direct and toward-the-barrier method as you engage and hold the barrier. Simultaneously, you are doing an indirect method, following the release as it occurs. It's probably best to drop the thoughts of direct and indirect and just do it.

Recoil (Engage-Release)

Our second technique is recoil, which we could describe as "engage-release." (I learned this from Paul Chauffour, author of *Mechanical Link*). Again, don't push all the way to the most rigid part of the barrier. You don't want to lock the joint. A double thumb contact is usually ideal for this method. **Your adjustment is to engage the barrier, followed by a rapid release.** Your engagement of the barrier has an exact direction, and incorporates all three dimensions of the restriction, restrictions of flexion-extension, rotation, and lateral bending. The outward direction, the release of your contact, is applied suddenly and quickly. **The change occurs in the sudden release of the pressure. Let the patient's body do the work.** You are the facilitator; you don't need to force anything. You are creating an oscillation, or a piezo-electric effect. Let go of your need to move the bones.

The recoil has many qualities similar to our thrust techniques. It is sudden, quick, and very focused. When you first start using it, you may be skeptical whether you've really done anything. Do a reality check afterward to satisfy yourself and your patient. Does the joint move better? Is the area less tender?

Muscle Energy (Postisometric Relaxation Applied to the Joints)

Muscle energy is an excellent low force method for any joint. Muscle energy is a direct technique, which means that you are releasing in the direction of the resistance, finding the motion barrier and going toward it. **We are using minimal contractions of the small spinal muscles to help release the joint.** Craig Liebenson has done a wonderful job of teaching our profession how to use these same principles applied to key muscles.

There are three basic steps:

One: Position and/or move the patient in a 3-D way up to the edge of the barrier. Your monitoring contact can be with your thumb or any convenient part of your hand.

Two: The patient uses a gentle isometric contraction, pushing against your resistance. You have to match the patient's push with your resistance; no gross motion occurs here. The patient's isometric push is linear, usually into lateral bending.

Three: The patient relaxes, and you follow or gently push to the new 3-D barrier. You will feel the barrier recede away from you.

In all three steps or phases, don't push all the way to the barrier. Remember, we are working at the "feather edge" of the barrier - the first place we begin to feel the joint begin to bind. Don't let the patient push too hard, and don't try to push too hard yourself. Virtually every patient, until trained, will tend to push excessively. Virtually every chiropractor goes too far into the barrier, and uses more force than necessary. Let the small muscles' activity and the positioning do the work. Small contractions focus on the small intersegmental muscles. A vigorous contraction uses the longer and larger muscles, which we are less interested in for this technique.

The written word is not the ideal venue for teaching technique. Still, I want to let you know that these methods exist, and are available to you. Learning new ways to help your patients is rewarding. Continuing to learn keeps me fresh and excited about my chiropractic work, even after 21 years as a doctor. I hope I can transmit some of the excitement that I feel about these methods. I am very appreciative of the teachers that have broken down some of the barriers between chiropractic and osteopathy, and between the American and European practitioners. We all have so much to learn from each other.

References

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