Manual Therapy and the SLP — BLOG POST

By Walt Fritz, PT / March 1, 2020

I frequently am asked if the work taught in my Foundations in Manual Therapy: Voice and Swallowing Disorders Seminar would be of value to the clinician working in a particular setting or with specific diagnoses. They will often state a work setting or patient population, ask about specific diagnoses, and want to know if the seminar would be relevant to them. While they sound like an easy question to answer, at times, I struggle.

In my work as a physical therapist, I've used a manual therapy primary intervention style for the past two decades, mixing in a reasonable amount of exercise and movement recommendations. Other PTs may reach first for exercise, dosed as strengthening, and leave manual therapy for last, if at all. I reverse the order. I strongly believe in empowering my patients and discouraging dependency. I feel that if my services allow them to move more normally and with less fear, they will leave my office and begin to move that way. There will not be a built-in dependency unless I foster that (which I don't). Toward that end, there is a strong influence in my interventions by the current understanding of pain and movement dysfunction, as well as a deeper understanding of current concepts relating to a biopsychosocial approach to patient care.

When a prospective patient makes contact to ask if I can help them, my response might be, "I'm never sure until we meet." While this may sound like a way to try to get everyone in my door, it is more a reflection of the complexity of patient care. We will need to meet to see if we get along; to see if there is a building of trust; to determine to them if I am a good listener and if I seem to know what I am doing; and finally to see if I genuinely can work with them to meet their goals. There are diagnoses and conditions that I am reasonably confident I will not be able to impact. However, even patients with diagnoses that should not be impactable by manual therapy, such as arthritis, frequently find that both the work we do and the suggestions that I make help with their pain and movement issues. Pain and movement disorders are indeed biopsychosocial conditions, vs. merely a problem with the tissues (biology). Many issues that would not seem amenable to being helped by manual therapy often are.

As a relative outsider, I see the range and complexity of patients and diagnoses with which an SLP works with as profound. Trying to fit one modality or intervention strategy into such a varied caseload would be difficult, and I make no claims to such a one-size-fits-all type of work. But similar to the patients who walk in my door, SLPs who learn manual therapy begin to add it into the mix of treatments regardless of the diagnosis. Will it work with every patient? Certainly not, but many times we won't know until we try. For example, one might ask how manual therapy could help someone with a progressive neurological disorder? It may make little sense to someone who looks at the diagnosis and prognosis and negates mixing manual therapy into other interventions strategies. But when one reviews the literature and sees that manual therapy, in the form of neurodynamic techniques, was shown to have promise in the treatment of Parkinsonian's dysarthria (1), manual therapy may make sense in a broader range of conditions than seems initially possible.

I'm a guy with one tool, albeit a broad tool, so I use that tool with anyone that walks in my door. Earlier in my career, when I used what was described as myofascial release, I did much less work with movement and exercise and I treated primarily from my experience and training. I seldom included my patient's

experience and feedback to influence treatment decisions. Today, I apply manual therapy as a means to progress my patients back into movement, be it exercise, strengthening, dancing, or simply living more actively. And I allow an equal partnership between myself and my patient, allowing them to be a full partner in the therapeutic process.

Most of you have many tools and talents, and your training and experience often guide you into choosing the proper tool for the job (diagnosis or patient profile). Using evidence to support your tool choice is mandatory, and there is a reluctance by many clinicians to stray too far from a script that the evidence seems to dictate. But what if you tried touch-based interventions with every patient? How might that look?

I call what I use and teach manual therapy, but it is merely a type of touch. Might touch be simply another means of communication, not unlike verbal communication? While we need to be informed by evidence, are there aspects of our work that are driven by the preferences and feedback of the patient that may have full validation in the evidence? Patient preferences and perspectives constitute a full 1/3 of the evidence-based model (EBM). Still, in my view, this aspect of the EBM is often either ignored or relegated to lower importance. My approach to manual therapy elevates patient perspectives and preferences to a place of equal weighting with the clinician's (me) experience applying the evidence and the actual published evidence. This power-sharing is an expectation of our practice and the EBM, however, is that reflected in your practice? We must start with the evidence, but how we move from that point into intervention takes many different shapes.

Professional, we use touch to convey many messages, from reassurance to establishing control. One primary way that I use and teach touch is as a means to determine if what touch replicates is a sensation that the patient relates to in a meaningful way. This allowance on the part of the patient is the core of my approach. The goal of my manual therapy is not to manipulate a targeted tissue/structure, but rather is an attempt to establish a meaningful connection to the patient's complaints and concerns. I do see it as simplistic and overly reductionist to believe that one can manipulate, for example, an individual muscle through the jungle of skin, nerves, connective tissue, and other structure. My skepticism is shared by many in the manual therapy community. I also believe that simplifying an issue to a particular muscle (or any other structure) ignores the psychosocial aspects of the owner of that body. So instead of trying to establish the tissue in distress, I use touch and manual therapy to develop a sense of connection with my patient's complaints. If I can replicate or calm a familiar problem with touch, be it pressure, stretch, or any other type of manual engagement, then we stand a good chance of remediating the problem. In short, manual therapy is a means of expression; one intended to determine the possibility for a positive correlation made on the part of the patient.

I discourage using manual therapy as a stand-alone intervention; instead, it should be embedded alongside the other treatment strategies. If used in isolation, the chances of creating a dependency-driven patient/therapist relationship are strong, as it will most frequently make the patient dependent on the clinician for continued improvement or if future needs arise. If used as a subset of broader strategies for intervention, including self-stretches, exercise, etc., self-reliance is built for the patient to become independent in their care and follow-up needs.

I trust that by reading through this article, you might have a better view of how I use manual therapy with each of my patients. Can you see the possibility of the same for you and your patients?

1. *Ateras, B., von Piekartz, H*. (2017). Integration of a *neurodynamic approach into the treatment of dysarthria for patients with idiopathic Parkinson's*disease: A pilot study. Journal of Bodywork & Movement Therapies xxx (2017) 1e9. https://doi.org/10.1016/j.jbmt.2017.12.004.

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