Manual Adjusting, Instrument Adjusting, and Treatment Reactions

By Joseph D. Kurnik, DC

I derive my beginnings in spinal adjusting from instruction directed entirely to manual dynamic-thrust adjusting. My evolution as an adjustor was to experiment with different technique approaches regarding spinal analysis methods and adjusting methods. My experiences evolved my methodology to include an individualized motion palpation approach to analysis of spinal dysfunctions, and to adjusting of those dysfunctions. I regarded adjustable dysfunctions as applying entirely to hypomobile joint complexes. A misalignment factor, called subluxation, might or might not be present.

Along the way, I learned, through experience alone, that even with the identification of hypomobile (fixed) joint complexes, adjusting those fixations not always end with acceptable results. Patients did and do have "bad" reactions to adjusting. I also learned that it did not apply only to me. I have had many patients who received treatment from other chiropractors, and who complained bitterly of unpleasant adjusting reactions, going far beyond normal 24-hour posttreatment soreness.

I can accept 24- to 48-hour post-treatment pain/soreness reactions, which settle down to an increased level of improvement. Unpleasant reactions that go beyond this time frame, or lead to increasing levels of discomfort, are not comfortable or acceptable to me. Such reactions tend to drive patients away, unless they are hardcore chiropractic patients. Such patient reactions often end up in a MD’s office, where anti-inflammatories, muscle relaxants and pain suppressants are prescribed. After being prescribed and used, these drugs quite often cause post-adjusting inflammatory reactions to calm down. The MD gets another bad opinion of chiropractors, and the patient may or may not return for chiropractic care.

The technique approaches that cause uncomfortable reactions can be found whenever a manual dynamic thrust is delivered. Doctors who have pride in specific adjusting methods, scientifically delivered, are not exempt from bad adjusting reactions. I am not exempting myself, especially.

I do not intend to imply that bad reactions to adjusting are the rule, for they are fairly uncommon. Obviously, beneficial reactions and results are the rule, or else chiropractic would not be succeeding and growing. The successes of chiropractic, however, cannot be an excuse for preventing increased effectiveness
and safety in the chiropractic delivery system.

When I was a chiropractic student, I went to certain seminars and picked up pamphlets on "recovery symptoms." This meant that, as the pamphlet put it, a certain percentage of patients would experience unpleasant reactions after adjusting. These unpleasant reactions were called "recovery symptoms." This made me feel a little better when patients I treated felt worse. (This subject, by the way, never was mentioned in the chiropractic courses in school or during seminars, except Gonstead seminars.)

After years of seeing such experiences, I concluded that such reactions were inflammatory in nature, sometimes involving damage to joint structures, and requiring extended healing periods. I tried to determine when extended adjustive reactions would be most likely to occur. I submit the following list as examples of such conditions conducive to undesirable treatment reactions:

1. Hypermobile joints (i.e., wrong adjustment site).
2. Inflamed joints:
   1. certain arthridities; or
   2. fibromyalgia
3. Highly stressed individuals:
   1. someone undergoing divorce or marriage;
   2. someone undergoing relationship breakup or dysfunction;
   3. someone buying a house and assuming a large and uncomfortable mortgage; or
   4. someone with a high level of financial stress
4. Tired people. Someone who is tired from overwork.
5. Someone who routinely sleeps poorly.
6. Acutely injured people.
7. Elderly people, especially those not receiving chiropractic care routinely.

If I am unaware of these conditions, I can and have made adjustments, resulting in depressingly unacceptable reactions. We all know, ultimately, when a treatment has been unsuccessful. We can hide the truth with rationalizations, but such an approach is not good for patients, the doctor’s reputation, or the profession.
The cervical spine in particular is a risky region, with less latitude for error. The mobility created and risk to vertebral arteries make manual adjusting a huge responsibility. There is responsibility in assessment, as well as in the decision-making regarding correction of subluxation/fixations. Because of the large number of clinical situations involved, I realized ultimately that the manual dynamic thrust should not be the only tool of the adjusting chiropractor. There was every reason to believe that lighter force adjusting methods should be utilized. I worked with Activator and Activator-like instruments, using motion analysis as my assessment method. This proved to be successful when I felt that a dynamic thrust was contraindicated or when there was patient fear of adjusting. I never did abandon, however, dynamic-thrust manual adjusting.

Next, I added a multiple-thrust instrument. This was applied when manual adjusting was contraindicated and when individuals requested a lower force instrument. The end result is that I now have a choice. When there are, in my assessment, contraindications to manual adjusting, I use a multiple-thrust instrument. I can also ask a patient if he or she would like a manual adjustment, or one done with an instrument. Generic instruments can be used with a variety of assessment processes.

Even with instrument adjusting, treatment reactions can occur. One may thrust too hard or too many times with an instrument, resulting in unpleasant patient reactions. There is no guarantee that all such treatments will be acceptable, but the choice of instrumentation and lighter adjustive methods is a step forward in allowing a choice for method of treatment. In my case, I use a multiple-thrust instrument totally on some people, not at all on some, and mixed with manual adjusting dynamic thrusts on others. I have the discriminative choice to function in this capacity.

There is another category of usage for instrument adjusting. Chiropractors who have been injured, and those of smaller stature or with susceptible preinjury status, may use instrument adjusting. If the choice is not available, the doctor may quit chiropractic or be forced to perform nonadjustive chiropractic procedures. I do not criticize the use of therapies or other healing and treating methods, but I am disappointed when I see them used because of an inability to utilize adjusting methods.

I urge you to assess your delivery system and determine if some improvement in choice of adjusting is conceivable. Could you and your patients profit from the addition of generic instrument low-force adjusting?
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