Journal of Bodywork and Movement Therapies (2006) **10**, 87–88

Journal of
Bodywork and
Movement Therapies

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EDITORIAL

Taking account of causes—Are you sure?

I imagine that most practitioners and therapists subscribe to the idea of dealing with the causes of their patient's problems, rather than simply the symptoms. Just how much effort we apply to searching for causes (aetiological features) to a great extent defines the nature of our dedication to this ideal.

Historically in osteopathy the term 'engine wiping' was applied to those whose work was superficial—not necessarily in terms of which tissues were being addressed, but more critically in relation to depths to which the patient's history and presenting characteristics, were being addressed. The classic 'engine wiper' considers the area for primary attention to be the focal point of the patient's complaint—the painful shoulder, knee, spine or whatever.

Clearly a painful area requires consideration by the practitioner or therapist, however, in the absence of a history of direct trauma it is seldom the source of the problem (and even when it is there are commonly additional contextual features, possibly involving previous trauma to the tissues, or nutritional or psychosocial aspects that require consideration).

Most biomechanical problems represent a failure of adaptation—where the processes of compensation gradually (usually) move from discomfort to dysfunction to decompensation and often to degeneration.

Janda (1988) offered examples as to why focus on the obvious is clinically short-sighted. For example he described the adaptive changes resulting from the presence of a significant degree of leg length inequality:

- Leg length imbalance inevitably involves an altered pelvic position.
- This unlevels the sacral base and leads to scoliosis.
- As the spine adapts, a sequence of compensations is likely to lead to joint dysfunction at the cervico-cranial junction.
- This inevitable results in compensatory activity of the small cervico-occipital muscles and a modified head position.
- Further compensation occurs concerning most of the neck musculature, some of which will involve increased muscle tone and possibly muscle spasm.
- Janda also points to the existence of oculopelvic and pelviocular reflexes (any change in pelvic orientation alters the position of the eyes and vice versa) which further complicates the adaptive processes described above.

A sequence follows of compensation and adaptation responses in many muscles, ligaments and joints of the region, followed by the evolution of a variety of possible syndromes and symptoms, involving the head, neck, temporomandibular joint, shoulder and/or the arm.

Janda's point is that after all the adaptation that has taken place, treatment of the most obvious cervical restrictions, where the person might be aware of pain and restriction, would offer only limited benefit. 'These examples serve to emphasize that one should not limit consideration to local clinical symptomatology … but [that we] should always maintain a general view'.

Grieve (1986) explained how a patient presenting with pain, loss of functional movement or altered patterns of strength, power or endurance, will probably either have suffered a major trauma, which has overwhelmed the physiological limits of relatively healthy tissues, or will be displaying 'gradual decompensation demonstrating slow exhaustion of the tissue's adaptive potential, with or without trauma'.

As this process of adaptation to microtrauma progresses, postural adaptation, influenced by time factors, and possibly by further trauma, overwhelms repair potentials and leads to exhaustion of the body's adaptive capacity, resulting in

1360-8592/$ - see front matter
doi:10.1016/j.jbmt.2006.01.001

dysfunction and symptoms. 'Unless treatment is also focused towards restoring function in asymptomatic tissues responsible for the original postural adaptation and subsequent decompensation, the symptoms will recur'.

Over time adaptational modifications may progress from the production of dysfunction (e.g. low back pain) to the evolution of actual pathological changes. Gofton and Trueman (1971) found a strong association between leg length and unilateral osteoarthritis on the side of the anatomically long leg. They noted that all subjects with this type of OA "had led healthy active lives prior to the onset of hip pain", and few subjects were aware of any difference in leg length. They also point out that this form of OA has its onset around the age of 53, but acknowledge that many people with precisely this anatomic asymmetry failed to develop an arthritic hip, suggesting that factors other than the leg length disparity are also important.

This underscores the importance of the context in which this mechanical adaptation was being processed by the tissues under stress—with some people's joints becoming arthritic and others not. So if it's causes we are seeking we may need to ask what the other variables were operating when comparing those who did and those who did not develop OA on the long-leg side? Were these variables genetic, nutritional, gender or weight related, or were there occupational or other differences?

Causes are clearly not always obvious, but if we claim to be holistic in our work these need to be sought and, where possible modified.

References

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