

Therapist as operator or interactor? Moving beyond the technique

We very much enjoyed the excellent article by Bialosky *et al*¹ regarding the placebo effect in manual therapy. This is an important article that provides an opportunity for the physical therapy profession to reconceptualize the role of the therapist in the provision of manual treatment.

Most human commerce involves a contractual nature of agreement to solve a problem. A problem can be an actual object, or it can be an objectification of a situation. Hairdressers cut hair. Dentists work on teeth. Lawyers argue cases.

Some actual object (or objectification of a subjective situation) is involved. The definition of the object or objectification is made clear, and the parties who have contracted to solve the problem work together to solve it.

In manual therapy the objective frequently involves helping a fellow human with a painful problem, but the pain experience is complex and incompletely understood and therefore the actual object in the contract is not and never has been entirely clear. Pain, although ubiquitous, is a subjective experience and has long eluded precise definition.² Great strides have been made in recent years in understanding the pain experience: once thought to be a specific sense or input to the brain from the body, pain is now regarded as an output from the brain in response to a perceived threat.³ This understanding of pain moves beyond nociception alone and provides a foundation for understanding the many factors the authors review in their article.

Traditional instructional books and courses on manual therapy often refer to the therapist as an 'operator'. The implication of this terminology is that the patient is a passive recipient of the manual act. This seems at odds with not only the common practice of physical therapy,⁴ but the balance of research evidence which favors active over passive approaches. We feel a more current understanding of the mechanisms and processes of manual therapy^{1,5,6} leads naturally to a different understanding of the therapist's role – that of an 'interactor'. This *interactor model*⁷ of manual therapy is consistent with the authors' statement that 'the context of the treatment including the technique, the provider, the

participant, the environment, and the interaction between these factors may contribute to patient outcomes.' It is precisely this interaction between various factors that we need to consider, and not simply the performance of one or more techniques as an 'operator.' We believe this interactive model to also be scientifically congruent with the emerging explanatory model of the multifactorial, biopsychosocial pain experience, the neuromatrix.⁸

As a result, we feel it is now incumbent upon the manual therapy community to acknowledge and embrace factors beyond the performance of a particular given technique as critical to clinical care, and to include these considerations in our educational curricula, research designs, patient education, and our therapy culture. The authors' article serves as an excellent introduction to factors and considerations in manual therapy that are beyond the technique.

Directly to the subject of technique, the authors note '...spinal thrust manipulation appears to be more effective than ... joint mobilization in some individuals with low back pain.' The authors cited the work of Cleland *et al*⁹ to support that statement. However, that study did not directly compare techniques based purely on speed of movement, used different positioning methods and technique performance, and there were (as noted by Dorko¹⁰), 'marked differences in patient-therapist positioning and context when directly comparing mobilization to manipulation.' Consequently Cleland *et al*'s study design doesn't permit us to draw conclusions on the effectiveness of thrust versus nonthrust manipulation in general for low back pain – only to compare three different techniques in one established subgroup. If in fact there are superior clinical outcomes associated with the use of a thrust versus a nonthrust manipulative approach to patient care, we've yet to see evidence of it in the literature, and secondary analyses of clinical trials (such as those in the cervical spine^{11,12}) support that contention. In fact, the many factors and considerations reviewed in the author's outstanding paper may help us understand why that continues to be the case, and why the manual therapy community needs to move beyond the technique¹³ to

progress our foundational science and provide the best outcomes for our patients.

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