Photo: Walt Fritz

Say Nothing

Manual therapists are expected to be good with their hands and often with the story that accompanies their work, but is telling that story the best thing to do?

Recently, I was addressing complaints of lateral neck and shoulder pain in a patient who was well-known to me. While myofascial release (MFR) is my stated modality, many of you may know that my approach to MFR — at least the explanation of my approach — bears little resemblance to many of the traditional fascia-based approaches.

This client had complaints about pain on the right side of the neck and shoulder and trapezius region, and I was employing some gentle skin stretch to help reduce the sense of apparent threat and pain.

At one point early in the session as I lightly dragged the skin away from the neck, my patient said to me, "This may sound odd, but it feels like a worm is unraveling up in my temple area." It did sound odd, but I encourage my patients to feel safe in saying when it seems relevant with no fear of judgment. I had not heard a comment like that in the past, but novel stimulation often provides just that — novel stimulation and how one interprets that stimulation is very subjective.

After acknowledging her comment with an affirmative grunt, there was a silence between both of us, a silence that is often not left that way. It is this silence I wish to address.

As a physical therapist, my schooling provided me the basic foundations in science, neuroscience, anatomy, and physiology, as well as prerequisite coursework in normal, abnormal, and developmental psychology, leaving confident in being able to explain how most of the basic body process operated. As massage therapists, and other professions reading this article, I suspect you have gone through core science education in a similar fashion.

My university education is long-past, but gave me a grounding in basic treatment interventions, expected responses, and plausible explanations for the actions, at least plausible from early 1980's perspectives. We were taught the basics of therapeutic interaction and communication, but in a very basic form. Scientific knowledge grows and advances daily and the need to stay abreast of these changes was my responsibility. Continuing education (CE) was one avenue for advancement, and I was fortunate to have employers who were generous in continuing education reimbursement.

After sampling many different course works in the 80's and early 90's, I came upon myofascial release and craniosacral CE's and dove deep into those models, both offering what appeared to be good scientific perspectives on pain and remediation of pain, along with some pretty nifty methods to engage people in pain. I had read the negative reviews coming from my professional publications at that time about MFR and was quite reluctant to pursue any of this form of training, but my teachers encouraged to ignore them as those folks were simply "behind the times."

I may have slept through the lectures in PT school on critical thinking, as in hindsight I seemed to have lost all capacity for such thinking and assessing as I became an MFR convert. The hands-on work seemed quite effective and the classes became quite compelling, but the explanatory models seemed to take on some pretty strange dimensions. Today, my hands do much of what I was taught back then, but my brain is actively thinking vastly different things than I was originally taught.

During the silence that occurred after my client's revelation of the worm-like experience, I had one of those experiences where a dream seems to go on forever, remembering much of my past CE experience. I thought of all of the different words and phrases I may have said to my client in the past as I attempted to educate her about what she had just experienced. These attempts would have been well-meaning and thought to be presented with accuracy, but I now realize that these attempts at educating her would have been really an attempt to persuade or even coerce her to adopt an alternative explanation for her experience, one that may have had no grounding in reality.

What might I have told her in the past? I may have told her about the far-reaching nature of fascia and fascial restrictions, which transcend the origins and insertions of individual muscles and how they are responsible for much of the pain and movement dysfunction from which we suffer. I would have told her that fascia is very strong, and if the restrictions were left untreated, they may cause problems throughout the body. I may also have

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described how fascia slowly releases, or that emotions were stored in the fascia; unless these fascial restrictions were properly released, she may never truly heal.

I would have spent that aspect of the session indoctrinating her into the beliefs of fascial restriction and fascial change based on my beliefs, education, and experience, all of which I am now fairly certain to be completely wrong. This may sound exaggerated, but I am being conservative in the recollection of stated agendas. All of this may have been said, but none of it may have been true.

Not only was I probably inaccurate, I may have inadvertently caused her to pathologize her experience where no actual pathology existed. The basic science of myofascial release was not being addressed. Nearly all of the many published studies perpetuate the old, unproven theories of fascial change.

If you polled a few dozen manual therapists, asking them what the target of their interventions was, you'd receive a very wide range of responses, most very specific things (pathological tissues) that really cannot be validated by those in the general medical community. Can all of these pathological tissues really be present and be the core problem or cause?

Then ask a second question to that few dozen therapists. Ask them how they think they are affecting those pathologies from outside the body. How can so many things be said to be done from outside the skin? Are there simpler explanations to both what might be wrong as well as what we are doing? Is there a potential harm in implying tissue pathology when none may exist

Does converting someone's world view of pain into our small, possibly inaccurate, world view have benefit for them?

Professional relationship can improve indirect (placebo) effects, which include the strength of the narrative you tell to your clients. At some level this makes sense, for if we sound knowledgeable, our clients will have greater faith in the potential outcomes of the interaction. But the research on this aspect of the placebo effect seems not to take any consideration into the validity of the narrative. Telling a story that sounds technical and science-y but is completely inaccurate may have the same outcomes as a similar science-y sounding narrative that is entirely factual and with greater experience and training our story tends to improve. This may partially account for some of our successes. This leveraging of the placebo effect troubles me, as there are some pretty bad and inaccurate narratives that accompany the various modalities to which I am referring. But storytellers can be persuasive, and not just in the manual therapy world.

After those moments of silence, my client commented on my lack of responding in regards to offering an explanation for the worm-like experience. This comment provoked some discussion about the inherent problem with what I may have said. I mentioned that my responses may have been more about beliefs than fact. That my responses may have identified a tissue or believed tissue-response and that I may have introduced the sense that something was wrong (pathology) when in fact there was no evidence to support such views.

This particular client had been to a number of practitioners in the past, including physicians, chiropractors, massage therapists, and physical therapists. She had spent a lot of time online researching her condition and came to see me at the recommendation of her pain physician. She came based on that referral but also under the hope that I was different, as to date no one had been able to help her.

Our first few visits together were spent exploring what both flared and soothed/calmed her pain. We spoke of what she was able to do in terms of activity and again what activity flared or soothed her. She talked of the failed approaches used in the past, consisting of work to address suspected postural and skeletal imbalances, trigger points, fascial restrictions, scar tissue, weaknesses, inhibited muscles, spinal subluxations, weak core, etc.

Initially she was hoping I would be the one who would able to identify the pathology or aberrant tissue that was creating her pain, the one the others had missed. This scenario may be a common one for you, as it is what drives much of our therapeutic interactions. Most of us were taught that there is a problem with the tissues (fascia, pelvic torsions, trigger points, viscera, joints, cranial bones, energetic body, inhibited muscles, etc.) that needed fixing and the modality training was directed at teaching us how to fix them. Her questioning my lack of response offered me an opportunity to help understand that there may not be a pathology in the tissues and to begin educating her on what current research says about pain.

While I do not profess to be an expert in pain science, I have learned to avoid pathologizing the things we cannot see or prove. We spoke about her accepting the

possibility that there was no pathology in her tissues, which is not always easy to accept. She was having very bad pain, so there must have been injury to the soft tissue from her car accident. While it is a possibility that there was actual tissue injury/damage, it may not be the case.

The concept of tissue damage/pathology as being the cause of pain is reinforced by the media, Dr. Google, and other practitioners, as that is what they were taught. Fascia restrictions, trigger points, scar tissue/ adhesions, visceral restrictions, cranial bone lesions/torsions, inhibited muscles, etc., are all examples of assigning pathological beliefs to a person's complaints. The practitioner's evaluation findings may confirm the pathology, but these evaluation tools are often biased considered invalid or irrelevant by external sources.

So how did I respond?

I told her, "I would rather simply acknowledge your experience. I would search my brain to determine if what you said may be a red flag to refer you back to your physician, but in the absence of that I would rather not try to convince you of anything being the cause. I would prefer to say nothing rather than lead you down the expected path." If she insisted a medical explanation, I may have state a peripheral nervous system origin of the worm-like sensation, but the tell that I really do not know with certainty why she felt what she felt. (I have gotten very comfortable with saying, "I don't know".

So after this deconstruction of beliefs, what should be done?

Say nothing. It's not easy, but you may be acting in your client's best interest. Do not introduce but yet another pathology into the possibilities of what might be wrong. Try to be less wrong in the words you speak and write. Realize your training was under the bias of the teacher and the modality's inherited narrative reinforced by your peer group and further reinforced by the positive outcome you saw as a result of acting on the beliefs you were taught. The full ability to explain what happens under the skin when we touch and engage is still incomplete, but evolving.

Say nothing. Be open to the possibility that what you were taught is incorrect, no matter how good the apparent outcomes.

Say nothing. Be open to learning new models of pain and intervention. Consider joining the Skeptical Massage Therapist Group on Facebook or SomaSimple, another source for less-wrong thinking. Read what has been posted on those forums without taking offense or becoming defensive. Having one's beliefs challenged can be difficult but freeing. Enjoy jumping down the deep rabbit holes of the posted links and references.

Say nothing. Consider other sources of learning and training. There are many continuing education opportunities available to advance your understanding of the scientific method and new advances. One can be the San Diego Pain Summit, Rajam Roose's excellent venture that brings in experts from around the world with lots of relevant information at your disposal.

I used to find talk such as this as a bit self-superior. But I now understand that I was simply being defensive about what I knew, or

thought that I knew. Trying to be less-wrong need not be condescending, but a basic statement of effort and belief. It is a worthwhile way to go through life, with a stated quest for better and deeper credible understanding on how the body (and the world) works.

Saying nothing need not make you sound ill informed, though some clients may wish you to prove that you are not a dullard who knows nothing about anatomy, physiology, neuroscience, and more. As such I will often give a few plausible ideas and possibilities that might pertain, trying to avoid the tissue-based explanations, but make it clear that while there may not be a consensus as to which is the better or more accurate response the more important thing is to get back to the topic at hand; "No matter which or what is the cause, let's try to see if we can make you more comfortable and move easier."

Say nothing (or very little).

Walt Fritz is a physical therapist in private practice in Rochester, New York and teaches a simple science-informed approach to myofascial release and manual therapy through his Foundations in Myofascial Release Seminars.

Further Reading

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4. Noy, Monica. Osteopathic Palpation – A Tale of Cognitive Dissonance.