Verbal communication/dialoguing
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To some, the perfecting of manual therapy hands-on skills is the key to positive outcomes, which often involves the sequencing of many continuing education seminars to achieve such proficiency. While important, the application of a technique without feedback from the patient driving the intervention is incomplete. Verbal interaction is the key to my approach, both in the evaluation as well as during subsequent intervention. It is one of the key aspects of building a therapeutic alliance.

The utilization of open-ended questions is vital to avoid leading the patient in any way. "What do you feel?" (open-ended) is preferred over, "Do you feel this?" (closed-ended), as the first allows the patient to respond in any variety of ways and doesn't limit them to sensation or awareness felt only around intervention. The second, by nature, limits the possibilities of responses, as attention is drawn to a specific area/pressure, and the response is limited to essentially yes/no. Some other examples of open-ended questions, or closed-end questions with an open-ended follow-up that may help you determine if your findings have relevance are:

- What do you feel?
- How does this pressure feel?
- Is that feeling familiar? In what way?
- Have you felt this (feeling) before?
- Is my pressure recreating something you feel like a part of your (issue)? (The engagement could replicate the symptom or reduce the symptom. All can be meaningful.)
- How intense is the feeling that I am replicating, on a 0-10 scale?
- At what number would you stop me? At what level would the feeling, my pressures, your discomfort, etc. become too much?
- Does my pressure feel like it could be helpful, useful, or productive?
- If the answer is yes to the last question: Would you like me to hold this stretch to see if it is helpful? (If yes, then continue)
- If the answer is not to the previous question: Is there anything about this stretch that feels like it could be harmful? (If yes, then stop immediately and continue to seek)
- Another question that I like to ask is "Does it feel like I (we) are doing something?" This gives them to respond deeply from their beliefs and preferences. So often we think we are hitting the right notes, but they are feeling nothing.

When your patient gives you a response, it may be in the form of a question, as they may not completely understand what you were asking. "What do you mean is that familiar?" is a common one that they might ask, to which I may reply, "Is the feeling you have something you had felt before, as a regular part of what brought you in to see me? Is it familiar?" Many times, the response will be negative, as either, they have not made a correlation between the sensation you are producing and their symptoms. The context may be disjointed. Lightly sustain the pressures to give them a bit of time, allowing them to process the information and sensory input.

One of the basic principles of my work is that I believe that my patient should understand why I am doing what I am doing at any time during the session. If not, then I am not doing my job correctly. They should be able to feel that I am always connecting with familiar aspects of their symptoms and that they are engaged in an activity that they understand and feels useful. That may seem like a high bar to set, but those are my expectations. None of my work is so-called "preparatory" work; work that must be done before we get to their issue. This is not to dismiss manual therapy methods that come from a perspective of body-wide or protocol base, as within that methodology, there is logic. But the logic I follow is that there should always be relevance noted by the patient. I may be bringing their symptoms to their awareness, which is not the same as making them hurt, or I may be calming/quieting their symptoms. I may also be connecting with another more obscure aspect of the issue, but there should always be relevance. I am always on the continuum of relevance. The point of the intervention is to eventually reduce/remove the negative sensation and improve the quality of movement.

The purpose of dialoguing should not be to probe into their psyche or personal/emotional past but to simply establish that what is being done feels, to the patient, as important. I need to know if my pressures are relevant, for if not, then there may be no reason to work in that location. Many would argue that it is our responsibility to use our skilled palpatory abilities to uncover the *problem* and that we should know what is relevant. But I can poke around throughout

the body of any random person and find areas that, to me, feel tight and problematic. But to that random person, my findings may not be an issue. Insisting that the tightness is or may become a problem is a sure way to create a sense of pathology in the mind of the patient, which, while good for business, is simply wrong and unsupportable. These basic principles of establishing relevance can make this approach effective for the remediation of pain/movement dysfunction and improvement of performance and can be applied to almost any form of manual therapy, as well as non-touch-based interventions.

Dialoguing in the manner described above may feel awkward, at least at first, but will quickly become quite easy and a natural part of your sessions.

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