

PHASED
REFLEX
TECHNIQUES

An illustrated exposition of a
new approach to osteopathic
corrective techniques.

FOREWARD

The first publication of Dr L. H. Jones's work on spontaneous release by positioning was in 1963, the paper being reprinted in the "Osteopathic Year Book" for 1967. Few practitioners in the U.K. took note of these advances, but an early and enthusiastic exponent of S.R.P. was the late Dr Reginald Oakes, who demonstrated the techniques to all who would listen and ensured that Jones's work did not pass unnoticed by the profession.

In 1972, I was demonstrating S.R.P. together with some modifications of my own, to a class which included A. L. Pauls. Of an interested and enthusiastic class, Arthur Pauls was the most keen. From that moment, his studies of techniques were dominated by the drive to develop this aspect of the therapeutic approach.

Conscious that there is no past and no future but only an ever-changing present, I believe that the world will come to know the great debt it owes to the initiative, dedication and inspiration of Arthur Lincoln Pauls.

The principal credit for the work described in the following paper belongs to A. L. Pauls. The principal responsibility for any defect in the presentation of this paper is mine.

K.D.A.B.

January 1964. He arrived at his conclusions after 10 years of experimentation, and he summarises S.R.P. in these words: "Osteopathic spinal and appendicular lesions occur in positions more eccentric than that found by the examining physician. They are in a state of strain because the natural position of the patient holds him away from the eccentric position. The strain is relieved by exaggerating the deformity found upon examination. The lesions will release and correct spontaneously if held relaxed in the exaggerated position for 90 seconds. The correction itself is restful and comfortable."



The investigators - a new phase of the technique is worked out by Dr Basham and Arthur Lincoln Pau

Experience by the authors in the competent employment of the S.R.P. technique in daily work raised the problem of reducing correction time to less than 90 seconds, but still retaining the uniform results. As Jones had already found, holding the exaggeration for less than that time, resulted in irregularity of result. At about this time, our attention was drawn to the work of Travell on "Myo-fascial Triggers".

The conviction grew that the whole problem had to be looked at in new light. The time reduction could not be achieved by continuing with the same techniques. This is how the Phased Reflex Technique came to be developed.

The term "phased" is used because the work has developed in phases. The term "reflex" because these appeared to be the constant factors: whilst Sutherland emphasised ligaments, Jones emphasised muscles, and Tyrell the myo-fascial "triggers".

PHASE 1

Thus, the appellation Phase 1 is applied by us to the work of Jones which we call S.R.P.

PHASE 2

This came as an idea which was a slight modification of the original technique of Jones. It reduced the time factor, but it lacked a certain practicality as it was more difficult to perform and demonstrate to others. Observers of actual demonstrations of Phases 1 and 2, and especially those attempting them, will understand the reasons why this was so.



PHASED REFLEX TECHNIQUE for resolution of upper cervical lesion.



Resolution of a lower cervical lesion by P.R.T. No sudden adjustment, no forceful movements. The only movement is that which is needed to place the parts in a state of relaxation.

PHASE 3

This phase was developed in an attempt to get away from the original concept. Again this was an advance on Phase 2 in that it was easier to perform and uniform results were obtainable in around 60 seconds.

At this stage, we were still not satisfied that the technique could not be advanced still further. Many ideas were tried and failed. The search seemed likely to end in frustration until, as so often with past discoveries, an accidental incident revealed the concept which had been hidden so near to hand for so long.

PHASE 4

The revealing incident occurred when one of us (A.L.P.) received a patient with a neck condition. Upon examination, it was found that there was practically no movement in the cervical region.

On attempting a normal S.R.P. correction, A.L.P. found that the patient's pain prevented even this non-traumatic approach to correction. He decided he had a choice. Either he could resort to the old and tried methods used by most practitioners (lots and lots of soft tissue manipulation and the orthodox thrust technique), or attempt to advance the Phased Reflex Technique. He chose the latter.

As he worked on the patient's neck, there came into his mind the fundamental truth for which he had been searching so long.

Accepting that the technique of S.R.P. works by exaggerating the lesion and thereby reducing the tension. The question was: how much exaggeration? It seemed to A.L.P. that the greater the exaggeration of the lesion, the longer it would take to correct it.



Resolution of a lesion in the mid thoracic region by means of P.R.T.



Resolution of a Sacro-iliac lesion by means of P.R.T.

So this was Phase 4, in which, using a different technique of exaggeration plus another innovation involving approximation of articular facets, the best correction to that date was achieved. It was found that 30 seconds was the maximum time taken for correction with uniform results. It must be remembered that in using Sutherland, Jones or P.R.T. the necessity for extensive soft tissue preparation is ruled out, thus reducing treatment time and practitioner fatigue.

We already knew that with S.R.P. there was no trauma connected with correction of the lesioned articulation, and that the correction held better than that with thrust adjustment, but with Phase 4 it was found that the corrections held better even than those experienced with S.R.P. The following is an attempt to explain this phenomenon.

In S.R.P., the move is entirely passive, and the patient is asked expressly not to help. This leads to a sense of negative involvement on the part of the patient. So far as it goes, this is a good thing, because the patient's role is simply to relax as much as possible and be passively worked upon. Patients accustomed to orthodox osteopathic thrusting find this difficult at first, as they await the 'coup' which they momentarily expect and are astounded to rise from the treatment table with their problem solved during what appeared to be a quiet examination period.

However, satisfying as such apparent 'miracles' may be, and despite the fact that many patients in severe, acute cases have their problem cleared up in moments and permanently, there is another aspect. This refers more to the sub-acute and chronic cases where the body has begun to adapt to the presence of the lesion complex, affecting, as it does, the body's neurological, hormonal, and biochemical balance, in addition to the local articular changes

The postulate which we offer is that, because the patient is not involved with the lesion correction other than in a passive role, the correction has a lesser chance of holding because the lesioned area has not been able to appreciate the extent of the tension before correction nor the type of tension likely to appertain after correction. Thus the area involved does not fully understand the difference between the state of tension accompanying the lesion and the natural state of tension in a normal articulation.

The technique used in Phase 4 of P.R.T. makes suitable imprints upon the consciousness of the patient prior to correction.

The opposite from the passive role of relaxation is to have the patient find his own lesion correction position. This was tried for a while with good results in some cases. The difficulty appeared to be that not every patient was capable of understanding what movements were required for correction, or, if they did, could not express the requirement in a physically acceptable manner. This left only one other path to be followed. It was found necessary to have the patient conscious of the actions taking place, by having him become aware of the exaggerated position which would increase the pain, and the position he would adopt to secure relief. This method provides the imprint upon the consciousness and is incorporated in the two aspects of exaggeration and approximation involved in the corrective technique. This also makes the treatment one in which there is a more active involvement of the patient and because of this the lesioned area comes to appreciate not only the tightness of the involved segment but the relaxation which follows correction.

If a reflex arc manifests itself as a lesion, and is forgotten mentally, it is possible that the lesion may be corrected and also forgotten, thereby maintaining its original function and movement.

The reinstatement of a lesion corrected by the P.R.T. is less likely because of the memory response to what originally caused it.

This cannot be done as easily with the thrust technique: due to the speed of the move it is only confined to the attention of the subconscious. The conscious is unable to appreciate what is occurring in the same way that the soldier destroyed by shellfire can hardly have time to appreciate what has happened to him. In fact, the practice of adjusting by the thrust method is to catch the patient's musculature "off guard" and get in before his protective reflexes can react.

With P.R.T. we want the patient to react, but in a subtle, calculated manner to assist the correction of the lesion in a way which the patient will not only understand consciously, but will remember subconsciously. This is the reason why a much shorter time is ample for Phase 4 correction as compared with the 90 seconds of S.R.P.

A tremendous advantage which P.R.T. has over S.R.P. is that new techniques have been evolved to cater for the smaller practitioner; for example, so that a small woman may perform all the needed corrections upon a large, heavy man. This has always presented problems in thrust methods, and in Jones's paper some of the S.R.P. techniques for the thoracic and lumbar corrections are difficult if not impossible for the small or light-framed individual.

Teaching P.R.T. is relatively easy, because the practitioner can start with the original S.R.P. of Jones, and work his way up through the phases as his touch and natural ability increase with understanding, experience and practice.

These phases were created to be of use to the more subtle practitioners who are in the therapeutic energy fields. In fact they can be used by people such as Reichian therapists, Gestalt or Rolfing technique practitioners, and so on, who want to learn new techniques in drawing off excess energies and reducing tension in specified areas of the body.

PHASE 7

This phase, which is called 'Phantom Phase Reflex Technique' (PPRT), is in the research stage, but briefly stated involves absent diagnosis of the lesions and correction by radiation pulsation reflex. When fully evolved, it is anticipated that this will create an entirely new dynamic field in the diagnosis and correction of osteopathic lesions.



Resolution of a lower lumbar lesion by means of P.R.T. - both patient and practitioner are relaxed.

SUMMARY

This paper has presented an outline of the historical development of Phased Reflex Techniques and discussed the concepts and postulates relating thereto. No attempt has been made to describe the actual techniques which need to be taught by workshop methods in seminars.

It is argued that the time taken for correction by S.R.P. of 90 seconds is too slow for some practitioners who tend to lose patience, and cannot be used in certain patient and practitioner relationships. The P.R.T. technique takes a maximum of 30 seconds, and the authors generally use 10-30 seconds for uniformly successful results. Thus it is contended that P.R.T. is quicker, more efficient, and the least traumatising technique yet devised, more adaptable to allied manipulative techniques, and can be taught, and learned, to the level of individual skill and requirements.

ST PETER PORT
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