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EDITORIAL

Soft and hard evidence

Anyone familiar with manual methods of treatment, of whatever discipline, is aware of the differences in perspective involved in what can be termed the 'soft' and 'hard' ends of the particular therapeutic approach.

Clear examples exist even within subdivisions of disciplines. Take cranial manipulation for example, with the 'hard' structural, biomechanical, approach dominating the thinking and practice of many practitioners, who attempt to identify and treat flexion, extension, rotation and other restrictions between the cranial bones and sutures. On the softer edge of cranial methodology we find the biodynamic, subtle energy, fluid-electric, 'breath of life' model, in which practitioners and therapists view cranial treatment quite differently, and treat with extreme gentleness.

McPartland and Skinner (2005) explain aspects of that softer approach:

'The formative, resorbative, and regenerative fluid forces that organize embryological development are present throughout our life span, ready for our cooperation in harnessing their therapeutic potency. In other words, the forces of *embryogenesis* become the forces of *healing* after birth.'

To be sure these models, biomechanical and biodynamic are not mutually exclusive, and it is perfectly possible for practitioners to incorporate both into their work, and this is true throughout all health provision since similar hard and soft edges exist almost everywhere in healing.

Take another example. Compare the western model of acupuncture with the Traditional Chinese Medicine, energy (chi) balancing, model. Both approaches use needles (or manual pressure) to achieve their effects, however the methodologies vary greatly depending on the model being employed. For example, where needles are placed, as well as how deeply they are inserted, and how long they remain, and whether or not they are manipulated, rotated etc. during their placement in tissue, depends on whether the effects being looked for aim to influence neural ('gate theory of pain') and/or endocrine (endorphins, etc.) functions, or whether the objective is toward ensuring that chi is more balanced and flows more freely.

In chiropractic there are straight ('hard) practitioners, whose main tool is the high velocity thrust based on precise determination of structural deviations and restrictions. While on the softer edge of chiropractic we find Applied Kinesiology (AK), Sacro-Occipital Technique (SOT, and a range of other subtle methods.

And to stay with chiropractic, we find an emerging middle ground, in which traditional 'straight' chiropractic has evolved toward what has come to be known as chiropractic rehabilitation (Liebenson, 1996). In this approach, the evidence base emerging out of European physical medicine (Lewit, 1999) and worldwide physiotherapy (aka Physical Therapy) has merged with aspects of chiropractic and osteopathic medicine to create a functional approach to care of musculoskeletal dysfunction that is becoming increasing difficult to distinguish from the model of care of many modern PTs or DOs.

Compare any aspect of manual therapy, and similar 'soft' and 'hard' extremes can be discovered, often alongside a middle ground in which combinations of methods merge.

A step back into the wider world of health care shows that such contrasting approaches permeate the entire spectrum of medicine. In herbal medicine, there are those whose use of plant-based materials matches almost precisely the pharmacological methods of mainstream medicine. In the same profession there exist those who collect dew from the surface of petals in early morning sunlight, in order to make Bach Flower Remedies.

This is comparable to the use of medical drugs as distinct from homeopathic remedies.

And as will be clear to anyone working in that field, similar divisions exist is psychological medicine.

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What can we learn from these examples?

We are probably all agreed that recovery (total or partial) from illness or dysfunction, depends on self-regulation, homeostatic mechanisms, self-healing.

There is a certainty that some of the benefits noted as a result of any treatment method depends on placebo effects, a powerful and under-rated assistant to all our efforts.

And there is also the chance that the therapeutic method ('hard' or 'soft'), of whatever sort, may be achieving one of two things:

- removing obstacles to normal homeostatic function, or
- enhancing self-healing, protective, mechanisms.

Or a combination of both of these desirable effects may take place, accompanied by placebo influences.

In some instances, it seems as though the softer edge of any therapy *offers the opportunity* for physiological change, whereas more invasive 'hard' edge approaches commonly *oblige* changes to occur, whether structurally or chemically.

Whether a therapeutic intervention operates on a biomechanical, psychological or biochemical level, or by involving a combination of these broad influences on health, if it is to be helpful to a patient the intervention should encourage and not obstruct the repair and recovery processes.

Matching the therapeutic method to the patient's particular needs is the art of healing, and fortunately the choices are wide.

It may be that only when the therapeutic methods employed match the needs of the person to whom they are applied, will research evidence unequivocally emerge in support of many forms of treatment, manual or otherwise, whether 'hard' or 'soft'.

References

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