Introducing Short Lever Still Technique, a New Variant

Richard L. Van Buskirk, DO, PhD, FAAO

CLINICAL PRACTICE

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Abstract

A new variant of the Still Technique is described involving the use of a local force vector applied directly to the restricted tissue during the passive movement of the tissue from its ease through its restriction. This new "short lever" version is easily taught and, based on classroom experience, can be readily mastered by students of osteopathic manipulative medicine at all levels.

Background

In 1996 an osteopathic manipulative method derived from one of Andrew Taylor Still's original manipulative methods was reintroduced to osteopathic medicine. Termed the Still Technique by its rediscoverer,¹ the musculoskeletal manipulative method was simple at its core. As described by Dr. C.P.E. McConnell, an early student and colleague of Dr. Still's at the America School of Osteopathy (ASO) in Kirksville, Missouri, the method was "indirect then direct".² To treat a musculoskeletal restriction, the restricted element was first positioned in its ease (indirect initial positioning) and then carried through its area of restriction (directly to or through the area of restriction).

Although Dr. Still had described manipulative applications in his book *Osteopathy Research and Practice*,³ the descriptions were often incomplete and presented in the context of treating non-musculoskeletal problems. Attempting to treat a patient's musculoskeletal restriction according to Dr. Still's descriptions was only occasionally successful. Because Dr. Still himself was known to produce consistent and complete successes in his patients using osteopathic manipulative methods, it was obvious that something was missing.

In reading an osteopathic textbook published by Dr. Charles Hazzard, another student and colleague of Dr. Still's at the ASO, four quotes were discovered that began by explaining "this is how Dr. Still does it."

Dr. Still, in the case of lateral spinal lesions, stands in front of the patient, who is sitting. He passes both arms around the body and clasps his hands over the point of the lesion. (He) sinks the spine down upon this point, bends the patient toward the side of the deviation of the vertebra, then with the hand makes pressure upon the vertebra to force it back to place while he rotates the body toward the opposite side.^{4(p16)}

From Van Buskirk Osteopathic in Sarasota, Florida (Van Buskirk).

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Correspondence address:

Richard L. Van Buskirk, DO, PhD, FAAO

2900 S Tamiami Trail

Sarasota, FL 34239

(941) 685-5004

RLVanBuskirk46@gmail.com

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Each description included the indirect initiation and then direct movement, but also included something like the phrase "sinking it down." By including a directed force focused on the restricted tissue throughout the movement of the tissue the indirect then direct method worked consistently. This led to the conclusion that a compressive force introduced toward the dysfunctional tissue was critical to this manipulative method. This directed force element was subsequently codified as a "force vector." The implication of the phrase "sinking it down" was that the force vector was to be applied at a distance from some other part of the body.

The Still Technique Manual ⁵ describes the methodology and its applications that evolved as the Still Technique. Jerry L. Dickey, DO, FAAO has taught another version of the same methodology as the "Still Exaggeration Technique". For more than twenty years, the Still Technique has been described and taught as an indirect then direct manipulative technique using a force generated towards the tissue from a distance. In its most compact form, a modern statement of the Still Technique includes the following steps:

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- 1. Place the restricted tissue in its position of ease.
- 2. Introduce a force vector from some other part of the body directed towards the restricted tissue. The force vector only requires a couple of grams or an ounce or two of compression or traction if it is well directed.
- 3. Maintaining the force vector toward the restricted tissue move the tissue from its position of ease toward and through the area of restriction.
- 4. As it moves through the area of restriction a crack or bump may be heard or felt. However, neither is necessary.

The development and maintenance of the force vector from the operating hand to a restricted tissue is probably the most difficult part of the Still Technique. Identifying operating positions for a restricted tissue that would allow the proper ease and subsequent movement through restriction was a primary focus of two editions of the book describing the technique and its applications.

Typically, the Still Technique has not been easily mastered by either those just learning osteopathic manipulation, or those returning to osteopathic manipulative treatment (OMT) after a hiatus in use. Being able to introduce a force vector from a distance and maintain it throughout the movement sequence imposes a significant learning curve for those who wish to utilize the technique; however, it is not impossible. It takes time, repetition and good coordination to achieve, which has likely limited the Still Technique's broader acceptance.

Two years ago, it became apparent to the author that there is another way to perform the Still Technique that takes the issue of a force vectored from a distance out of the equation. To understand the genesis of this alternative approach, one can look at the applications of the Still Technique in the cranial field as described in the second edition of *The Still Technique Manual*⁵. In those applications, the restricted tissue is placed in its position of ease. The force vector is applied directly to the restricted cranial tissue and the tissue is then carried in the direction of the restriction. It took the author many years to realize that the force vector here was significantly different from the force vector from a distance that was initially described as essential to the Still Technique. It was nonetheless successful in reducing cranial tissue restrictions.

With this realization, the author decided to determine whether a different version of the Still Technique might work. In this new version, the force vector is applied directly to the restricted tissue from the sensing hand or digit. As is the case with the force vector at a distance, the amount of force necessary is minimal. Generally, 1-2 ounces or a few grams of force is sufficient. Because the force is minimal, it does not get in the way of sensing what is occurring in

the tissue. Additionally, the question of maintaining the force vector on the tissue during movement is minimized, as the sensing and force vectoring digit is directly over the tissue.

To make a distinction between the two styles of force vector, the author now uses the term "long lever techniques" for those using a force vector applied from another part of the body towards the restricted tissue. The method of applying the force vector directly to the tissue after positioning the tissue in its ease is termed a "short lever technique."

Interestingly, some of Hazzard's descriptions⁴ include introducing a firm pressure to the tissue in addition to "sinking it down." This direct compression was dismissed because it was determined to be unnecessary and because such pressure was a part of Hazzard's own manipulative method, a form of high velocity direct then indirect musculoskeletal manipulation not in use currently. Dismissing the direct compression to the restricted musculoskeletal element was in fact an error.

Treatment

What would an amended description of the Still Technique look like?

- 1. Place the restricted tissue in its position of ease. This is not the normal neutral position but is a new easy neutral that develops in the direction of the original injury. Typically, it is in a opposite direction from the restriction in motion.
- 2. Introduce a force vector to the tissue. It may be from another part of the body directly focused on the restricted tissue (long lever) or it may be directly applied to the restricted tissue (short lever). The force vector is measured in ounces or grams of force.
- 3. Maintaining the force vector to the tissue, move the tissue from its ease toward and through the area of restriction. The movement may be introduced from the long lever contact point or it may simply be from a part of the body that will, if moved, produce movement in the restricted tissue.
- 4. As the restricted tissue moves through the previous area of restriction a crack or bump may be heard or felt although neither is necessary to effect release of the restriction.
- 5. Move the tissue back to its normal neutral position and retest.

To see how the short lever Still Technique looks in action, we will go through four applications.

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(continued from page 32) Superior First Rib Treatment Seated:

- 1. The patient is seated.
- 2. The physician stands in front of or behind the patient.
- 3. Place the sensing hand so that the pad of the index finger is on the head of the affected first rib.
- 4. Place the operating hand on the top of the patient's head.
- 5. The head and neck are sidebent and flexed toward the opposite side. This position produces tissue relaxation over the rib head *(See Figure 1A).*
- 6. The sensing finger introduces compression (a couple of ounces or 3-4 grams) to the rib head.
- 7. Maintaining the compression vector on the rib head, carry the head and neck along an arc into sidebending and extension on the side of the affected rib *(See Figure 1B).*



Figure 1A. First rib treatment. Initial position.



Figure 1B: First rib treatment. Final position.

8. Return the head and neck to neutral. Retest.

Treatment Of Cervical Segment Type II-Like, Extended:

- 1. The patient is supine on a table.
- 2. The sensing finger is on the articular pillar of the affected cervical vertebra. The neck and basiocciput above the affected segment are supported on the palm and wrist of the sensing hand. The other hand cradles the opposite basiocciput.
- 3. The head and neck are extended, rotated right and slightly sidebent toward the side of ease *(See Figure 2A)*.
- 4. Introduce and maintain a direct force vector to the articular pillar of the affected segment through your sensing finger.
- 5. Now rotate the head and neck toward the opposite side while simultaneously reducing extension and carrying the segment into flexion *(See Figure 2B).*
- 6. Once the position of the original restriction has been transversed, return the head and neck to neutral.
- 7. Retest the segment.



Figure 2A. Cervical segment treatment ESrRr. Initial position.



Figure 2B: Cervical segment treatment ESrRr. Final position.

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Treatment Of Thoracic Segment Type II, Flexed:

- 1. This version is usable for all thoracic vertebrae below T1. The example will be T4FRSr.
- 2. The patient is seated on a table with the physician standing behind.
- 3. The sensing hand is that of the same side as the ease of the somatic dysfunction (e.g., the physician's right in the case of $T4FRS_R$). The pad of the index finger of the sensing hand is placed over the prominent transverse process of the affected segment.
- 4. The physician's operating arm (left in this case) is passed over the patient's opposite (left) shoulder around the superior chest wall and the physician's operating hand is placed on the shoulder on the side of the somatic dysfunction. This gives the physician adequate leverage to introduce the necessary flexion or extension, sidebending, and rotation.
- 5. The patient's thorax and spine are then flexed (in this case) and rotated toward the side of the somatic dysfunction (right) until the affected segment relaxes. Introduce light compression to the segment's transverse process with the sensing finger (*See Figure 3A*).
- 6. The operating arm simultaneously reduces flexion and rotates the spine through neutral into the previously restricted range (left sidebending and rotation with extension) (*See Figure 3B*).
- 7. Release compression on the segment and passively return the patient to neutral.
- 8. Retest.

Posterior Iliosacral Dysfunction (Posterior Innominate) Treatment Supine:

- 1. The patient is supine on the table. The physician stands on the side of the dysfunctional innominate.
- 2. The patient's knee and hip on the side of the dysfunction are flexed to a little more than 90° and slightly adducted.
- 3. The physician's sensing hand (the hand closer to the patient's head) is placed under the patient's pelvis so that a sensing and compressing finger can be placed on the cephalad portion of the sacroiliac joint.
- 4. The physician's operating hand is placed on the patient's flexed knee *(See Figure 4A).*

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Figure 3A. Thoracic segment treatment FSrRr. Initial position.



Figure 3B. Thoracic segment treatment FSrRr. Final position.



Figure 4A. Posterior rotated inominate. Initial position.



Figure 4B. Posterior rotated inominate. Final position.

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- 5. Introduce and maintain light compression to the SI joint with the sensing finger.
- 6. Now draw the patient's knee lateral towards the physician, abducting the hip.
- 7. As the patient's knee reaches its most lateral point in the arc *(See Figure 4B)* extend the leg.
- 8. Reassess with ASIS motion and relative ASIS placement.

Over the past couple of years, the short lever version of Still Technique has been used successfully by the author as an alternative method of treatment in a busy, full time musculoskeletal medical practice. More to the point, it has been demonstrated and taught in several courses successfully. It has several distinct advantages over the more "traditional" long lever version of the Still Technique.

Unlike the traditional long lever form of the Still Technique, the short lever version is easily mastered by physicians at all skill levels. It does not require maintaining long-distance focus during movement. If one can diagnose a tissue as restricted and can determine its position of ease, the short lever version is easily mastered. The ease is typically the starting position for indirect manipulative techniques like myofascial, counterstrain, and balanced ligamentous tension (BLT). The restrictions are those of the direct manipulative techniques like the high-velocity, low-amplitude (HVLA) technique and Muscle Energy. Learning to move smoothly from ease through restriction takes some time but is not particularly difficult. The Still Technique Manual ⁵ contains many iterations of the technique applied to most of the tissues treated by OMT. Modifying these applications is a simple matter of directly applying the force vector directly to the restricted tissue using the sensing hand rather than at a distance from the operating hand.

There are a few applications found in *The Still Technique Manual* that are listed as "unmonitored." These applications and the Still-Laughlin advanced technique will not work using the short lever version. The rest of the applications work equally well using the long lever and short lever versions of the Still Technique. Those trying to master this variant technique may show a natural tendency to put more force than is necessary into the local force vector and the movement. They may initially have trouble mastering the smooth arching movement that typifies a good application of the Still Technique. Other than that, this variant of the Still Technique has few limitations.

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