Integrative Treatment Using Still-Laughlin Technique

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Organizing Principles

I approach the osteopathic concept as if the body is a biomechanical, electrochemical machine:

- If a part is not working quite right then the body will find a compensating balance or fail.
- The compensation will not be as efficient or stable mechanically, physiologically, biochemically or in terms of energy consumption as the optimal state.
- Over time the inefficiencies will spread.
- Eventually the inefficiencies may lead to the system announcing the impending failure or increasing cost as pain, restriction of function or failing health.
This is simply a restatement of Dr. Still’s original concept.

A.T. Still initiated osteopathy with the insight that most disease comes from restriction in neural and/or vascular function. Today we might add immunological and genetic function. The best handle Dr. Still could find to leverage and remove these dysfunctions was treatment of restrictions in the musculoskeletal system. Initially the disease-musculoskeletal restriction was conceived as localized restrictions in specific tissues.
The integrated musculoskeletal, fascial and organ functionality is often termed holistic or when speaking of the musculoskeletal-fascial system tensegrity.

It is extraordinarily difficult to carry the whole interactive scheme in our head and analyze the abnormal variations that lead to what is termed disease.

Pragmatically all we can do is try to analyze a particular dysfunctional body for its restrictions and genetic, biochemical and multi-organ dysfunctions. Finding them we employ every tool at our disposal to restore normal anatomical and functional states.
The Still Technique

What has been termed the Still Technique has been redeveloped from limited descriptions of Dr. Still’s methods in his writings and those of his students and colleagues.

The grounding principles derived from Dr. Still’s methods are:

- Start with a restricted tissue at its position of ease;
- Introduce a force vector from another but connected body part focused on the restricted tissue;
- Use the force vector as a mechanical connector to carry the tissue from its ease through the restriction.
The redeveloped Still Technique is focused on the treatment of each tissue restriction.

It uses the technology Dr. Still developed and used from the time of the founding of osteopathy.

It is gentle, fast and effective.
Hunting in the Fascia

- Used to treat the whole body, Still Technique can require as many as 60 individual treatments. Needless to say, this is not very efficient.
- Treating each individual somatic dysfunction as it is found, but treating throughout the body is successful in producing a decrease in musculoskeletal load, concomitant decrease in pain and improvement of systemic disease manifestations.
- This has been the strategy for most of my years of practice.
It appears that by the end of his life Dr. Andrew Taylor Still was using a new variation of his method that provides a single whole-body treatment.

Dr. Ed Stiles reintroduced this Still-Laughlin method after years of struggle trying to learn it from Dr. George A. Laughlin, A.T. Still’s grandson. Apparently Dr. Laughlin received it from Dr. W.G. Sutherland.
Nature of Still-Laughlin Technique

- It uses the same technology as Still Technique.
- It focuses on treating only dysfunctions that have been variously called “key lesions,” “areas of greatest restriction,” or “primary dysfunctions.”
- I am going to use the term *Key Dysfunction* for reasons that will become apparent.
Treatment involves stacking each key dysfunction at its position of ease and then using a force vector that transfers over the course of treatment from one to the next to unwind each through its restriction.

The interesting point is that it will successfully treat the whole body by treating only two or three key dysfunctions.
For instance, suppose a patient presents with the following list of somatic dysfunctions:

- OAEr
- C1 Rr
- C3FSrRr
- C4ESIRl
- C5FSrRr
- C7FSrRr
- T1ESrRr
- T3ESrRr
- T4FSIRl
- T5ESrRr
- T7ESrRr
- T8FSIRl
- T11ESrRr
- Rib 1 superior left
- Ribs 3,7 anterior right
- Ribs 4,6 posterior left
- L2FSrRr
- L3ESIRl
- L4FSrRr
- Sacrum unilateral R
- Right upslipped innominate
- Numerous cervical, gluteal, and leg muscles with tension
Key dysfunctions are:
- C3FSrRr
- T7ESrRr
- L3ESIRI

Starting with L3, position each key segment at its ease, stacking the thoracic and cervical segments at ease on top of the lower segments. Introduce compression from the top of the head toward the cervical Key and unwind it through its restriction. Shift the focus to the thoracic Key and unwind it, followed by shifting the focus to the lumbar Key and unwind it. Unwinding may be direct from ease through restriction or it can follow and amplify the tissue as it unwinds.
Treating key dysfunctions individually typically removes most of the somatic dysfunction in a particular body area but does not seem to have much effect on other body areas.

For instance if there is a key dysfunction at T6 (FSrRr), treating that will reduce a whole series of thoracic dysfunctions including some rib dysfunctions but typically not all. It does not seem to treat other dysfunctions in the cervical or lumbar spine or those of the pelvis and legs.
Suppose we predefine not only all the segmental, rib, pelvic and limb dysfunctions and the key dysfunctions as they present before any treatment.

If we then treat only a key dysfunction in the thoracic spine, most of the thoracic dysfunctions do resolve.

We also see the cervical and lumbar key dysfunctions shift to other vertebrae.
How is it that treating each somatic dysfunction individually does not cause a sudden drop in the number of sites needing treatment when the key dysfunction in that area is treated?

Why does treating an individual key dysfunction treat only part of the body when using the Still-Laughlin version produces a whole body release?
A somatic dysfunction is characterized by an abnormal asymmetry in position and range of motion, along with tissue texture changes and possibly tenderness.

Regardless of the type of tissue and whether joints are involved there is a torque within the local fascia. The tissue is imbalanced. It requires extra work (muscle activity). There are also answering torques elsewhere to compensate.
The sum of the fascial torques in an area seems to result in focal areas of torque that are more resistant to movement and only respond when positioned for ease in three dimensions, not one or two. These are key dysfunctions.

Treating a single non-key segment would likely cause a shift in the overall pattern and therefore in the local key. Hence the key dysfunction might shift to another site.
Since key dysfunctions are the result of the overall pattern of dysfunction they are not constant.

When we look for key dysfunctions they amount to momentary foci of larger stress patterns in the fascia.

Used individually key dysfunctions allow us to treat larger areas rather than single dysfunctions.

Used collectively key dysfunctions allow us to treat the whole body in one complex dance sequence, the Still-Laughlin Technique.
1. A.T. Still initiated osteopathy with the insight that most disease comes from restriction in neural and/or vascular function. Today we might add immunological and genetic function.
2. The best handle Dr. Still could find to leverage and remove these dysfunctions was treatment of restrictions in the musculoskeletal system.
3. Initially the disease-musculoskeletal restriction was conceived as localized restrictions in specific tissues.
4. Logically then Dr. Still emphasized specificity in anatomical diagnosis and manipulative treatment.
5. Nature of Still Technique
   a. Determine exact tissue restriction.
   b. Determine nature of restriction and position of ease
   c. Set tissue in ease
   d. Introduce compression from another site toward the tissue
   e. Using the compression as lever carry tissue from ease thru restriction
6. Early Still Technique
   a. Characterized by students & colleagues as indirect then direct
   b. Had 2 variants
      i. More ore less direct motion, often curved
         1. Used by Still, McConnell, Hazzard
         2. Redeveloped by Richard Van Buskirk, DO
      ii. Myofascial: following the tissue
         1. Used by Still?
         2. Used by Sutherland
7. Sometime after 1900 Still apparently developed a newer variant based on same principles but able to treat whole body at once
8. Still Techniques were apparently difficult to learn.
    a. Due to problems
       i. Understanding underlying principals
       ii. Rigor required in terms of knowing and understanding neural, vascular, fascial, muscular and bone anatomy and proper motions
    b. Initial Still technique clearly was hard to learn. Was therefore supplanted by HVLA developed by McConnell.
    c. If older technique was hard to learn the new variant was even harder
9. Provenance is uncertain but Still’s grandson, Dr. George Laughlin, apparently learned the newer variant after attending Sutherland's first cranial course.
10. Ed Stiles, DO struggled for years to learn the method used by Laughlin. When Dr Stiles began to teach this technique he termed it a “functional” technique
11. After recovery of original Still Technique Dr. Stiles and I came to realize that the underlying technology was the same. Dr. Stiles began calling his method Still-Laughlin.
12. Basic method of Still-Laughlin (with apologies to Ed Stiles)
   a. Diagnose whole body for medical problems and detailed somatic dysfunction
   b. Evaluate for the key lesions or areas of greatest restriction
   c. Evaluate key lesions for exact nature of restrictions and exact positions of ease
   d. Set body into position of ease for lowest key lesion
   e. Stack each additional key lesion in its position of ease on top of all lower one(s)
   f. Introduce compression from site above the top key lesion. Focus the compression on the top key lesion.
   g. Use this force vector to carry the top key lesion from its ease through its restriction
   h. Without removing the compressive force shift its focus to the next inferior key lesion
   i. Carry each successive key lesion from its ease through restriction
   j. Re-evaluate the whole body for somatic dysfunctions. Typically all will have been successfully treated.

13. The treatment protocol outlined above is a bit different from that used by Dr. Stiles.
   a. Typically my version identifies one to three key lesions
   b. Although they are stacked on top of each other in the ease for each, they are treated in an unwinding sequence from top to bottom but each is moved more or less directly from its ease through its restriction.
   c. Dr. Stiles emphasizes developing a hierarchy of areas of greatest restriction and setting the primary AGR’s in their position of ease, initiating a force vector to the most significant AGR and then following the tissues as they unwind.

14. Both versions produce comparable results.
   a. Both treat all somatic dysfunctions and their concomitant neural and vascular restrictions in a single rapid but complex dance.
   b. Still-Laughlin is very efficient, but treats everything the more fractionated methods like HVLA, Muscle Energy, Counterstrain, and Still Technique do.
   c. Still-Laughlin is not limited as to the type of tissue treated although its focus is on the musculoskeletal system.
   d. Accepting that most disease processes are due to body-wide dysfunctions, an integrated whole body treatment such as Still-Laughlin should be incredibly efficient in removing or reducing the musculoskeletal load contributing to disease and prevent the body from efficiently healing.