Chiropractic and techniques have had a long history and have tended to be good bedfellows. Of course the word technique can be applied to virtually any activity as it is defined as a practical method (or art) applied to a particular task. In creating a means to better disseminate new methods and clinical insights in Chiropractic it appears to make sense to term the exploit a "technique."

We have opted to create a Decompression technique based on several important points not the least of which is to counter the idea of machine magic...that is to say to offer some objectivity based on reasonable scientific standards. Misinformation regarding the differentiation between traction and decompression is almost sacrosanct. The hope of our technique is to eliminate the misperception and codify what it is we do know in regards traction therapy into a reasoned and reasonable patient classification and treatment algorithm...and apply that treatment to virtually any type of system.

It’s important to understand traction (tractico: to pull or draw toward) as the mechanical action and decompression as an outcome (though obviously never completely provable in typical daily practice). We have deduced three responses to traction therapy. These are definitional for clinical reasoning and would be assumed to be dovetailed and/or overlapped...but they allow us important clinical insight as to classification and outcome assessment.

1. **Decompression** (osmotic, centripetal/vacuum effect): an enhancement of the potential for healing via diffusion/imbibition of nutrients (molecular solute transport) and a theoretic possibility of pulling extruded nuclear material centrally from peripheral fissures. The disc must be hydrostatic, intact and only minimally degenerated in order to have a real decompression effect, and this is often dubious in older adults. Additionally though global decompression (lessened compression) occurs during traction and recumbent positions, an increase in intradiscal pressure from the osmotic in-flow of fluid can also be a distinct spinal stressor (e.g. diurnal height increase/morning pain syndrome). The extreme morning stiffness/pain many arthritic suffers experience may be from fluid imbibition elongating, and thus creating stress in the axial plane on the sensitive spinal structures. This imbibition reduces the neutral zone intersegmentally and increases resistance to torsion and bending. Within 1-2 hours, 75% of the fluid is "squeezed" out and stiffness reduced. This same phenomena can occur post traction as IDP is increased via diffusion (so decompression may not always be a preferred outcome).

2. **Traction/stretch**: stretch-of-structures in the axial plane creates an improvement not only in mobility but also pain perception via mechanoreceptor modulation pre and post synaptically (as with manipulation). There has been the suggestion that it is the distracted joint surface which is operative in the relief garnered with manipulation (and why line-of-drive appears so impor-
tant); thus its not surprising traction can reduce pain as well. Mobilization of shortened structures, though temporary, can have a positive effect on pain perception and the feeling of well-being. Axial compression is endemic, thus axial stretch can be extremely comforting (at least in the short-term) irrespective of whether discal decompression occurs.

3. **Directional preference**: as defined by McKenzie a derangement syndrome (disc) amenable to mechanical intervention will have a preferential motion that will diminish pain (or centralize symptoms), and a direction that will incite pain (peripheralize symptoms). Very often that direction is in extension/hyperextension, though can be flexion/lateral or combinations. These directional preferences are often able to be directed by the patient themselves...however the axial plane is an accessory motion and must be induced/created for the patient (most often by traction). A directional preference may include both an axial component and either flexion or extension. There may be greater benefit to extension (or flexion) with traction. It is important to fully grasp this concept as well as having a traction system with sufficient adaptability (prone/supine/lateral) for the various patient presentations.

Over the last decade decompression has been able to resurrect traction therapy to a more desirable, interesting and profitable package. The downside is some misinformation of what is actually possible. By some estimates only 8-12% of the profession is actively utilizing decompression/ traction therapy. However, that number is undoubtedly going to grow and with it the quest for viable, scientific answers.

The idea of a decompression technique is to side-step machine-dependant education, embracing both the distinct value and the real limitations of traction therapy.
We must properly position it in relationship with an understanding of mechanical movement disorders, static and dynamic instability, disc provocative classification analysis and realistic, empirically proven examination-to-treatment algorithms. Just as we try to do with our chiropractic adjustment procedures and modalities.

We want our technique to perpetuate the best in the long history of Chiropractic and move decompression out of the shadows and into the light of reason, uniformity and predictability.

About The Author:
Over the last decade Dr. Kennedy developed, tested and taught what has proven to be a highly effective and easy to learn Chiropractic Decompression Therapy Technique. His protocols have been taught to over 4,500 chiropractors and physical therapists throughout the United States and Canada.