

DOSSIER · THERAPY

Osteopathy and Manual Therapy

Osteopathy dates back to the US-American physician **Andrew Taylor Still**, who presented it in 1874. His basic idea: structure and function of the body are connected, and both can be examined and treated with the hands.

Manual therapy emerged later, mainly in Europe from orthopaedics and physiotherapy. Both are most studied in the **musculoskeletal system**, especially in chronic back pain; 336 of the 1,074 evaluated works are controlled studies in humans. Their results depend strongly on technique and comparison group: for some complaints short-term improvements appear, yet not consistently an advantage versus sham treatment or standard therapy.

2,569

STUDIES IN
TOTAL

1,915

IN HUMANS

824

OF WHICH
CONTROLLED

11

IN ANIMALS

1

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-15

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

Osteopathy and Manual Therapy at a Glance

ORIGIN:

Osteopathy and manual therapy are procedures of physical medicine that work with targeted manual techniques, mobilisations or manipulations of the musculoskeletal system. Osteopathy additionally includes visceral and craniosacral techniques, while manual therapy focuses on joints, muscles and soft tissues. Osteopathy dates back to the US-American physician Andrew Taylor Still, who presented it in 1874; manual therapy developed later, primarily in Europe from orthopaedics and physiotherapy.

EVIDENCE BASE:

1,074 evaluated papers · 336 controlled human studies · 424 observational studies · 47 review articles · 5 animal studies · 0 cell culture studies

STRONGEST INDICATIONS:

- **Chronic non-specific low back pain** Controlled studies show significant improvements in pain intensity (VAS) and functional capacity (SF-36, Roland-Morris) after osteopathic manipulative therapy (OMT) compared with sham manipulation or no intervention. Effects remain stable for up to 6 months, albeit with decreasing participant numbers and methodological limitations such as lack of blinding.
- **Neck pain** Manual therapy (MT) leads to significant improvements in the Neck Disability Index (NDI) and pain (VAS) after 4 weeks, especially in combination with exercise programmes. The quality of evidence is rated as moderate, yet long-term data and blinding of therapists are lacking.
- **Migraine and headache** OMT shows significant improvements in the Headache Impact Test (HIT-6), reduced medication consumption and fewer migraine days over 6 months compared with medication alone or sham. Effects remain stable, yet with a high drop-out rate and lack of blinding.
- **Safety and tolerability:** Systematic reviews show that manual therapies (MT) for neck and low back pain are not associated with increased serious adverse effects. Mild to moderate adverse effects (e.g. transient increase in pain) are common but rarely serious.
- **Central nervous processing** fMRI studies suggest that OMT reduces the BOLD response in interoceptive areas (e.g. insula, anterior cingulate cortex) after 1 month. Effects are detectable only after several sessions, however, and clinical endpoints are lacking.

LIMITATIONS:

- **Non-musculoskeletal indications** For applications such as infant colic, oncological pain or cardiovascular diseases, controlled studies are still outstanding or are of very low quality.
- **Long-term effects** Most studies measure effects only in the short term (weeks to months). Long-term data (> 6 months) are lacking or show no significant effects any longer.
- **Standardisation and comparability** Heterogeneous interventions (e.g. manipulation vs. mobilisation), lack of blinding and unclear comparison groups complicate generalisation of the results.

CLASSIFICATION:

Osteopathy and manual therapy are effective in the short term for chronic musculoskeletal pain. Further controlled studies are still outstanding for long-term effects, non-musculoskeletal indications and comparisons with established therapeutic procedures.

1. What Osteopathy and Manual Therapy Are

Osteopathy and **manual therapy** are procedures that work with targeted manual techniques, mobilisations or manipulations of the musculoskeletal system. Both approaches originate from **physical medicine** and are used to treat pain, movement restrictions or functional disorders. Treatment is carried out by trained therapists, with techniques varying according to school and indication. Historically, osteopathy dates back to the US-American physician Andrew Taylor Still, who presented it in 1874 and founded the first school in Kirksville (Missouri) in 1892. Manual therapy developed later, primarily in Europe from **orthopaedics** and **physiotherapy**; **chiropractic** is a separate, likewise US-American school.

For understanding the evidence base it is crucial that **osteopathy** and **manual therapy** are not uniform procedures. The techniques range from gentle mobilisations to high-velocity manipulations, and the duration of application varies from single treatments to multi-week series. In addition, the procedures are often combined with **exercise programmes** or other therapies, which complicates comparability. Most studies measure **pain intensity**, **functional capacity** or **quality of life**, less frequently objective parameters such as range of motion or imaging findings. **Placebo control** is methodologically demanding, as sham treatments are difficult to blind.

2. What the Studies Show in Detail

The key human studies and the most important reviews — by indication, with population, duration, preparation, outcome measure and result as reported in the original papers. Numbers appear only where the work states them.

Distribution of **controlled human studies** by indication — the numbers are not additive, as one paper may be assigned to several areas:

INDICATION	CONTROLLED STUDIES
Musculoskeletal system	180
Bones and joints	102
Safety and tolerability	59

INDICATION	CONTROLLED STUDIES
Fatigue and stress	30
Cognition and psyche	25
Gut and microbiome	12
Oncology	9
Inflammatory processes	9

Bones and Joints – Chronic Non-Specific Low Back Pain

Participants received either OMT (diverse techniques such as high-velocity low-amplitude manipulation, muscle energy techniques), sham manipulation or no intervention – in addition to usual medical care. Primary endpoints were the SF-36 health questionnaire, a visual analogue scale (VAS, 0–10 cm) for pain, the Roland-Morris disability questionnaire, lost work days and satisfaction with treatment. Control, $p < 0.01$ as well as higher satisfaction ($p < 0.001$). The effects remained stable until month 6, albeit with decreasing participant numbers ($n = 66$). Limitations: No blinding of therapists, sham manipulation possibly not inert, high drop-out rate (22 % until month 6) ³.

Primary endpoints were pain intensity and disability (modified Von Korff scales, 0–100 points) after 12 and 24 weeks. Secondary endpoints included pain-free days, medication intake and global improvement. The group with 18 sessions benefited most, yet without significant difference from the 12-session group. Limitations: No blinding of therapists, control group received light massage (no true placebo control), high drop-out rate (20 % until week 24).

A further RCT with 60 patients (mean age 46 years, 60 % women) investigated the effect of maintenance manipulation (every 2 weeks over 9 months) following an initial 4-week therapy phase (12 sessions) in chronic low back pain. The groups received either (1) sham manipulation + usual care, (2) manipulation + usual care without maintenance therapy or (3) manipulation + maintenance therapy. Primary endpoints were pain (VAS) and disability (Oswestry Disability Index, ODI) after 1, 4, 7 and 10 months. Group 3 showed significantly lower pain after 10 months (–2,2 cm VAS vs. group 1, $p < 0,01$). The effects were stable from month 4 onwards. Limitations: small sample size, no blinding of therapists, sham manipulation possibly active ⁷.

The review examined various complementary and alternative procedures in chronic nonspecific low back pain. Long-term (6–12 months) the effects were no longer significant in the controlled studies. The quality of the evidence was rated as low to moderate, as many of the controlled studies had methodological shortcomings (e.g. lack of blinding, heterogeneous interventions). None of the controlled studies directly compared osteopathic with chiropractic techniques ⁴.

Bones and Joints – Neck Pain

The MT comprised mobilisations of the cervical and thoracic spine as well as soft-tissue techniques. Primary endpoints were the Neck Disability Index (NDI), pain (VAS) and pressure pain threshold (algometry). After 4 weeks the MT group showed significantly greater improvements in the NDI (–2,2 points vs. control group). The changes in pressure pain threshold (algometry) were not significant and do not permit conclusions about clinical effects. Limitations: no blinding of therapists, short follow-up (no long-term data).

The review examined MT, ET and MT + ET in neck pain (grade I–II). The quality of the evidence was rated as moderate. Limitations: heterogeneous MT interventions (e.g. manipulation vs. mobilisation), lack of blinding in most controlled studies ⁸.

A further systematic review (23 RCTs) differentiated between acute/subacute and chronic neck pain as well as different MT techniques (e.g. manipulation vs. mobilisation). For acute/subacute pain the evidence was inconsistent. Limitations: high heterogeneity of the studies, lack of standardisation of MT techniques ²⁰.

Bones and Joints – Migraine and Headache

The primary endpoint was the change in the Headache Impact Test (HIT-6) after 6 months. Secondary endpoints included medication consumption, migraine days, pain intensity and functional disability. The OMT group showed greater improvements in the HIT-6 (–8,74 points vs. medication alone, $p < 0,001$; –6,62 points vs. sham, $p < 0,001$), reduced medication consumption (RR 0,20 vs. medication alone, $p < 0,001$) and fewer migraine days (–21,06 days vs. medication alone, $p < 0,001$). The effects remained stable over 6 months. Whether osteopathic manipulation produces long-term structural changes in humans has not been investigated.

HYPOTHESIS Some controlled studies suggest that OMT may be effective as an adjunctive therapy in chronic migraine, particularly in patients with high medication burden. However, comparisons with established non-pharmacological procedures such as biofeedback or relaxation techniques are lacking to determine the place of OMT.

Bones and Joints – Pregnancy-Related Back Pain

Adjunctive manual therapies (including osteopathic techniques, often combined with massage or exercises) were compared with usual care or relaxation. The effects were detectable in the short term (up to 6 weeks after birth); long-term data were absent. Limitations were heterogeneous interventions and lack of blinding in all studies ²².

An older systematic review (7 RCTs) found strong evidence for the efficacy of acupuncture and pelvic belts in pregnancy-related pain. The evidence for manual procedures in general – including osteopathic techniques as a subgroup – was rated as “very limited”.

Bones and Joints – Infant Colic

Controlled studies compared MT with sham therapy or no intervention. The quality of the evidence was rated as “very low” owing to methodological shortcomings (e.g. lack of blinding, small samples). None of the studies reported serious adverse effects.

HYPOTHESIS The heterogeneous results could be attributable to different techniques (e.g. craniosacral therapy vs. spinal manipulation) or populations (e.g. age of the infants). Owing to the very low quality of evidence of the available studies, no recommendation for practice can be derived.

Neurological Effects – Central Nervous Processing

Participants received 4 weekly OMT or sham sessions. fMRI measurements were performed before the first session (T0), immediately afterwards (T1) and after 1 month (T2). The primary endpoint was the change in BOLD response in the insula, the anterior cingulate cortex (ACC) and other interoceptive areas. After 1 month the OMT group showed a significant reduction in BOLD response in the bilateral insula (−0,5 % signal change vs. sham). The effects were not yet detectable immediately after the first session. Limitations: small sample size, lack of clinical endpoints (e.g. pain reduction), sham intervention possibly active ⁵.

HYPOTHESIS The results suggest that OMT may modulate activity in interoceptive brain areas. However, comparisons with other non-pharmacological procedures (e.g. cognitive behavioural therapy) are lacking to assess the specificity of the effects.

Safety and Tolerability

A systematic review (147 RCTs, including 5 on MT) examined the safety of various manual and complementary therapies in neck and low back pain. The meta-analysis found that MT (manipulation, mobilisation) was not associated with increased serious adverse effects compared with no treatment or physiotherapy. Mild to moderate adverse effects (e.g. transient increase in pain) occurred. The quality of the evidence was rated as low, as many studies did not systematically record adverse effects and the review covered several therapy forms ²¹.

Limitations: retrospective design, confounding by indication (e.g. pain severity) not excluded.

Overall Picture

A proportion of the controlled studies among the evaluated works shows that manual therapies (MT) – particularly osteopathic and chiropractic techniques – are effective in the short term for musculoskeletal pain (low back pain, neck pain, migraine). For chronic pain the combination of MT and exercise therapy appears superior to MT alone, although the differences are often not clinically relevant. The evidence for long-term effects (> 6 months) is limited, as most controlled studies lack adequate follow-up.

Clear gaps exist in the differentiation between different MT techniques (e.g. manipulation vs. mobilisation) and their specific indications. In addition, direct comparisons with established procedures such as physiotherapy or psychological interventions are lacking. The safety of MT is supported by observational data; however, serious adverse effects (e.g. cervical artery dissection) are extremely rare and are often not systematically recorded in studies. For non-musculoskeletal indications (e.g. infant colic, oncological pain) robust evidence is still outstanding.

Methodology of the Evidence Base

The controlled studies considered here (n = 25) and systematic reviews (n = 10) show strongly varying methodological quality. Typical study designs are 2–3-arm RCTs with active control groups (e.g. sham manipulation, exercise therapy) or waiting-list controls. Treatment duration ranges from 1 session (acute effects) to 12 months (maintenance therapy), with most studies covering 4–8 weeks. Primary endpoints are usually pain intensity (VAS/NRS) and functional disability (e.g. Roland-Morris, ODI), less frequently neurophysiological parameters (fMRI) or patient-reported outcomes (e.g. satisfaction). Systematic shortcomings include the lack of blinding of therapists. In addition, dose-response analyses and comparisons with non-manual procedures (e.g. psychotherapy) are frequently missing.

The assumption that manual therapies are equally effective for all pain syndromes

The widespread notion that

OSTEOPATHY

and **manual therapy** are universally applicable for pain is **not supported** by the study situation. The majority of controlled studies examine **chronic non-specific low back pain** or **neck pain**. For other pain syndromes – such as **migraine**, **visceral pain** or **neuropathic pain** – the evidence is **still under development** or **contradictory**. Even within back pain research, meta-analyses show that the effects are **moderate** and **short-term**. Moreover, not all patients benefit equally: **psychosocial factors** such as expectation or fear-avoidance behaviour influence treatment success more strongly than the technique itself. Studies comparing **manual therapy with exercise therapy** often find **no superiority** of the manual approaches.

Another problem is the

LACK OF STANDARDISATION

. Even with similar indications, the techniques, application duration and qualification of the therapists vary greatly. This leads to **heterogeneous results** that are difficult to generalise. In addition, **long-term data** are frequently missing: most studies measure effects after **weeks**, not after **months** or **years**. For **acute pain** the data situation is particularly weak; here there are hardly any controlled studies showing superiority over **standard therapies**. **Safety** is also often overestimated: although serious adverse effects are rare, **transient exacerbations** or **neurological symptoms** after manipulations of the cervical spine are documented. Research focuses on **harmless courses**, while **risks** are rarely recorded systematically.

3. How Reliable the Research Is

Research on **osteopathy** and **manual therapy** is broadly based. A considerable proportion of the works are controlled studies. The focus lies on **chronic musculoskeletal pain**, particularly **back and neck pain**, which have been examined in numerous controlled studies. Other frequent areas of application are **bone diseases** (e.g. osteoporosis), **fatigue syndromes** and **cognitive functions**. In contrast, **oncological**, **cardiovascular** or **dermatological** indications are rarely investigated. Most works originate from the last 20 years, with **systematic reviews** and **meta-analyses** increasingly summarising the evidence. Noticeable is the high number of **observational studies** that describe associations but do not permit causal conclusions.

The methodological quality of the studies is **heterogeneous**. While some **randomised controlled trials (RCTs)** meet high standards, others suffer from small sample sizes, lack of blinding or unclear comparison groups. Particularly in **chronic pain**, controlled studies often show **short-term effects**, while long-term data are rare. The **dose-response relationship** is scarcely investigated: how many treatments are necessary or how long effects last usually remains unclear. In addition, **objective measurement methods** are frequently missing; instead, **subjective pain scales** dominate. The **most-cited works** (e.g. the *UK evidence report 2010*) did show efficacy for certain indications, but also pointed to **methodological gaps**. For areas of application outside the musculoskeletal system, further research is still outstanding.

4. What Is Frequently Claimed — and What the Data Provide

STATEMENT	STUDY SITUATION
Osteopathy helps with migraine	The evidence base is still developing . Controlled studies show no consistent effects ; some studies find short-term improvements , others no superiority over placebo.
Manual therapy is more effective than exercise therapy for acute low back pain	There are few controlled studies on acute pain. The few existing studies show no clear advantage over exercise therapy or placebo.
Osteopathic techniques act via specific physiological mechanisms	Most studies measure clinical effects , not mechanisms . Imaging studies (e.g. fMRI) do show changes in brain activity , but whether these are causally linked to the treatment remains unclear.
Manual therapy is safer than pharmacological pain therapy	Severe side effects are rare , but cervical spine manipulations can in isolated cases lead to strokes . Systematic surveys on risks are lacking. A direct comparison with pharmacological pain therapy is missing.

5. The Most Robust Works

Ordered by strength of evidence, not by familiarity. The complete evaluation comprises considerably more works; the most robust ones are listed here.

Controlled Studies in Humans

- ¹ Effectiveness of manual therapies: the UK evidence report (2010)
- ² Manual therapy and exercise for neck pain: a systematic review (2010)
- ³ Osteopathic manipulative treatment for chronic low back pain: a randomized controlled trial (2003)
- ⁴ A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain (2010)
- Dose-response and efficacy of spinal manipulation for care of chronic low back pain: a randomized controlled trial (2014)
- ⁵ Effect of manual approaches with osteopathic modality on brain correlates of interoception: an fMRI study (2020)
- A Comparison of the Effects of Stabilization Exercises Plus Manual Therapy to Those of Stabilization Exercises Alone in Patients With Nonspecific Mechanical Neck Pain (2016)
- American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients With Low Back Pain (2016)
- ⁶ Clinical effectiveness of osteopathic treatment in chronic migraine: 3-Armed randomized controlled trial (2015)
- ⁷ Does maintained spinal manipulation therapy for chronic nonspecific low back pain result in better long-term outcome? (2011)
- ⁸ Manual therapy, exercise therapy or combined treatment in the management of adult neck pain - A systematic review and meta-analysis (2017)
- ⁹ Dose-response for chiropractic care of chronic low back pain (2004)
- ¹⁰ A randomized controlled trial comparing 2 types of spinal manipulation and minimal conservative medical care for adults 55 years and older with subacute low back pain (2009)
- ¹¹ Immediate changes after manual therapy in resting-state functional connectivity as measured by functional magnetic resonance imaging in participants with chronic low back pain (2014)

- Massage therapy for low back pain: a systematic review (1999)
- ¹² Efficacy and safety of osteopathic manipulative treatment: an overview of systematic reviews (2022)
- ¹³ Immediate effects of region-specific and non-region-specific spinal manipulative therapy in patients with chronic low back pain: a randomized controlled trial (2013)
- ¹⁴ Manual therapy followed by specific active exercises versus a placebo followed by specific active exercises on the improvement of functional disability in patients with chronic low back pain: a randomized controlled trial (2012)
- ¹⁵ Does targeting manual therapy and/or exercise improve patient outcomes in nonspecific low back pain? A systematic review (2010)
- ¹⁶ Immediate effects of a high-velocity spine manipulation in paraspinal muscles activity of nonspecific chronic low-back pain subjects (2010)
- ¹⁷ Additional Effects of a Physical Therapy Protocol on Headache Frequency, Pressure Pain Threshold, and Improvement Perception in Patients With Migraine (2016)
- ¹⁸ Osteopathic manipulative treatment for pediatric conditions: a systematic review (2013)
- ¹⁹ Muscle energy technique for non-specific low-back pain (2015)
- Cost-effectiveness of conservative treatments for neck pain: a systematic review on economic evaluations (2012)

6. Summary

The present controlled studies suggest that osteopathy and manual therapy (MT) may be effective in the short term for musculoskeletal pain, particularly chronic nonspecific low back pain, neck pain and migraine. They provide indications of significant improvements in pain intensity, functional capacity and quality of life, with effects often lasting up to 6 months. The combination of MT with exercise therapy appears to be superior to MT alone, although the differences are often not clinically relevant. The safety of MT is well documented, with rare serious adverse effects and frequent mild to moderate accompanying reactions.

In addition, OMT could be effective as an adjuvant therapy for chronic migraine, particularly in patients with high medication load. However, direct comparisons with established non-pharmacological procedures such as biofeedback, relaxation techniques or cognitive behavioural therapy are lacking to classify the specific value of MT. The heterogeneous results in infantile colic could be due to different techniques or populations, but due to the low quality of evidence, no practical recommendations can be derived.

Future studies would need to clarify several key questions: 1) **Long-term effects:** Are the observed short-term effects sustainable, and how can relapses be prevented? 2) **Differentiation of techniques:** Which specific MT techniques (e.g. manipulation vs. mobilisation) are most effective for which indications? 3) **Comparisons with other procedures:** How does MT compare in direct comparison with established non-pharmacological therapies (e.g. physiotherapy, psychotherapy)? 4) **Objective measurement methods:** Can neurophysiological parameters (e.g. fMRI) or imaging findings supplement subjective pain scales? 5) **Standardisation:** How can interventions and therapist qualifications be standardised to improve the comparability of studies? 6) **Non-musculoskeletal indications:** Are there specific patient groups (e.g. with visceral pain or neurological diseases) that could benefit from MT?

7. What Remains Open

- **Long-term effects:** Whether manual therapies **permanently** relieve pain or improve functional disorders has hardly been investigated.
- **Dose-response relationship:** How many treatments are necessary or how long effects last remains unclear.
- **Patient selection:** Which patients **benefit the most** and which factors predict therapy success has not been sufficiently researched.

Frequently Asked Questions

Should patients with chronic back pain receive manual therapy or exercise therapy first?

The evidence shows **no clear advantage** for either therapy. Some meta-analyses find a **slight superiority** of the combination of manual therapy and exercise therapy over exercise therapy alone. Other studies show **similar effects** of both approaches. The key factor is **individual fit**: patients with **fear-avoidance behaviour** may benefit more from **exercise therapy**, while patients with **muscular imbalances** may benefit from manual techniques.

Are there differences in effectiveness between osteopathy and classical manual therapy?

Direct comparative studies are **rare**. Most works examine either **osteopathy** or **manual therapy**, not both in comparison. The available data suggest that **both approaches show similar effects** in back pain. Whether **visceral or craniosacral techniques** provide additional benefits remains **unclear** and is discussed controversially. The choice often depends on the **therapist's training** and **patient preference**.

What is the risk of serious adverse effects with cervical spine manipulations?

Serious adverse effects such as **strokes** are **very rare** but documented. The exact frequency is unclear because systematic surveys are lacking. Most studies report **transient complaints** such as headaches or neck pain. Patients with **vascular risk factors** or **pre-existing cervical spine conditions** should receive particularly thorough information. Alternative techniques (e.g. **mobilisations**) may carry a lower risk.

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