Editors' note: A number of PTs have incorporated "alternative therapies," including "mind/body" approaches such as the Feldenkrais Method® (see interview with Ooa Jackson-Wyatt, PhD, PT, page 58) and the Alexander Technique® (page 42), into physical therapy practice. The author discusses the potential for using these types of approaches as tools in bridging what he calls "the gap between the fields of physical therapy and psychology." Some of these ideas are controversial; none has been discussed in the peer-reviewed literature. See commentary, page 74.

Author's note: Early in my undergraduate schooling, it became clear to me that such fields as biology, psychology, recreation, health education, and sociology were related to each other—and yet studied separately. I designed an independent curriculum and major that integrated these fields. This prepared me for my graduate school education in physical therapy; however, as a result both of my studies and what I found lacking in the physical therapy body of knowledge and clinical practice, I sought out information and practices that emphasize "mind/body work"—that is, those that address both mind and body—such as the Feldenkrais Method®, Rosen Method Bodywork®, Being in Movement®, Bioenergetics®, Process-Oriented Psychology, Holotropic Breath Work, Aston-Patterning®, Yoga, and Body-Mind Centering®. I also completed a second master's degree in psychology through a somatics curriculum.

Somatics is a multidisciplinary field of study that has been undertaken by rehabilitation professionals, psychotherapists, educators, researchers, health care providers, philosophers, "body workers" such as Rollers, clergy, dancers, and martial artists. Somatics was described by Hanna1 as

the field which studies the soma; namely, the body as perceived from within by the first-person perception...[and] holds that first-person human experience must be considered of equal scientific and medical importance as outside, third-person observation.3

I believe that first-person experience and first-person observation are crucial elements.
in treatment and that phenomenological experiences and descriptions are valid and important information to use when treating patients. (Shepard et al. discussed phenomenology in the context of physical therapy research.) The cases on the following pages illustrate that a patient's own somatic experience—from a patient-centered, first-person perspective, without a value judgment imposed by the professional—is important in expanding our understanding of physical function and dysfunction.

As a PT working toward licensure in psychotherapy, I ask you to—

- Suspend your concept of “physical function.” Relax the boundaries between what you have been taught is “physical” and what you have been taught is “psychological.”
- Remember that working with patients on psychological issues is beyond the scope of physical therapy practice. It is critical for the PT to know when a patient should be referred to an appropriate mental health professional, such as a counselor, social worker, psychologist, or psychiatrist. (See In Practice, pages 30–31.)
- Recognize that, although it is not within the PT's scope to purposely facilitate a patient's “psychotherapeutic process,” physical therapy and professional touch may unintentionally trigger this process. With appropriate training and consultation, the PT may be able to allow this process to unfold. Consulting with a psychotherapist while treating patients can enhance the PT's understanding—and may enhance the PT's ability to promote the healing process.
- Consider counseling to better understand your own history and emotional and psychological processes.

It can be said that mind/body approaches such as Rosen Method Bodywork® (see page 71) and the Feldenkrais Method® are based on a philosophy of “non-duality” of body and mind. Many PTs have been taught to believe that physical and psychological patterns of behavior are related but separate. “Mind/body practitioners” consider the possibility that physical and psychological patterns of behavior may be one and the same—forming what may be referred to as a “psychophysical” pattern—even though these patterns may be described differently through contemporary reductionistic models of behavior.

Reich referred to one type of psychophysical pattern when he suggested that repression of emotions involves muscular effort on a continual basis. As this muscular effort persists over the years, could physical dysfunction develop in addition to psychological and emotional dysfunction?

A 1985 Los Angeles Times nationwide poll indicated that as many as 27% of American women and 16% of American men were sexually abused as children, and

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Exercises in Attention and Intention

Kinesthetic experience of countertransference and intention

1a Stand with your eyes closed. Imagine that you are at the foot of a set of 10 steps. Intend to step up onto the first step with one foot, but do not actually move. Notice what you have done with your body. Are you aware of shifting your weight, slightly rotating your trunk, slightly moving your shoulders? What are your eyes, head, tongue, and hands doing? Is your entire body oriented in one direction, or were you trying to move in more than one direction simultaneously?

1b Gently rest your hands on a partner's cervical spine as though you are preparing to apply traction while he or she is sitting in a chair in front of you. Imagine you are beginning to apply traction.

What do you and your partner notice and feel? How effective would your handling and manual techniques become if you consciously intended to “orient” your manual techniques, your body, and your attitude prior to and while you were applying traction? Would effectiveness improve, effort decrease, and ability to sense subtle sensations of your own intention and the intentions of others increase?

1c Rest your hands on a partner's shoulders. Remember the last argument you had, visualizing the room, your opponent, and the content of the argument. Hear the tone of voice you used and heard.

Ask your partner what he or she notices. Are your hands clenched and gripping, or are they loosening and becoming limp? What is occurring in your throat, neck, pelvic? Can you identify what may be called your “psychophysical” pattern of intention?

Kinesthetic experience of transference and intention

2a Hold your partner's hand as though you are shaking it formally. Both of you should have relaxed—but not limp—arms and hands. Clearly focus all your attention on intending to move your partner's arm to the left or right, but do not actually move it.

Does your partner sense the direction you are intending? What senses are used to gather this information?

2b Have your partner sit in a chair, in back of which you are standing. Rest your hands gently on his or her neck and throat. Have your partner imagine a and time. As your partner becomes aware of tears or a sense of heaviness, he or she should continue to remember that incident but not allow tears or sadness to show.

What do you feel occurring in your partner's body, in the neck, chest, pelvis? What is occurring in you? Can you feel a change in physical behavior when your partner is told not to cry? How does he or she do this? What is his or her intentional pattern, and how does it manifest physically? Can you identify with this pattern? What do you imagine it would feel like, for example, if he or she had repressed those tears for 35 years?

You may have noticed these types of psychophysical patterns in patients, who, unlike you and your partner, may not be conscious of their psychophysical patterns of intention.

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a 1993 Commonwealth Fund study found that 7% of American women who are married or living with a man—3.9 million—have been physically abused by their partner. The implications of these and other statistics are staggering. Many patients—and many practicing PTs—may consciously or unconsciously be holding in experiences of abuse, resulting in pain or physical dysfunction.

Most PTs have had experience with patients who become emotional during treatment or who have emotional or psychological processes that may exacerbate or even result in physical dysfunction. As one of the health professionals with whom the patient has the most physical contact, the PT should be aware of the possibility that repressed memories of past physical or emotional trauma may emerge during treatment. If the PT is not aware of this possibility or is resistant to allowing a memory to emerge, the PT may unknowingly “collude” with the patient, that is, encourage the patient to maintain the repression and to perpetuate emotional patterns of denial or patterns of movement that predispose the patient to injury, pain, or illness. (For more on this topic, see interview with PT and licensed psychotherapist Carol Manheim, MEd, MS, PT, LAC, pages 55-57.)

A patient may cling to or resist physical therapy because he or she may have an unconscious intention to not feel emotions or to not allow the emergence of repressed memories; the idea of having been traumatized, ill, or abused may be frightening and difficult to believe or accept. In addition, changing old patterns can be threatening; habitual patterns of behavior may be comforting even when they result in pain.

Are all pain and musculoskeletal problems a result of emotional problems? Of course not! But using mind/body approaches may help the PT better recognize some patients’ psychophysical patterns and understand how they interact with the PT’s own patterns. Helping the patient overcome or understand resistance to changes in movement or posture may help the patient discover the origins of the problem, which in turn may assist with physical healing.

Patient-Professional Interaction

When discussing psychophysical patterns and mind/body approaches, it is important to emphasize that the psychophysical makeup of patient and PT—that is, upbringing, emotions, and movement patterns—are interwoven in the professional relationship.

Psychologists have long recognized that the relationship between the professional and the patient is a component of treatment that may be more important than any specific treatment intervention or technique. One of the most important behavior patterns in this relationship involves transference and countertransference.

In the professional relationship, transference occurs when the patient transfers his or her feelings, beliefs, and attitudes about another person (displacement) or about himself or herself (projection) onto the health professional. These emotions may have to do with such issues as authority, gender, age, ability or disability, sexual orientation, power, autonomy, love, and dependence.  

Countertransference involves the therapist’s projection or displacement of his or her own feelings, attitudes, and desires onto a patient. Countertransference may interfere with the patient’s progress and, if left in the unconscious mind of a therapist, may be damaging to the patient. Many examples of countertransference exist in clinical practice: A PT who comes to work angry because his child is failing in school may treat a patient as though he or she were a misbehaving child; a PT who is in need of companionship may be attracted to a patient and act subtly seductive; a PT who is unaware of his or her sexist attitudes may unconsciously harass or be sexually inappropriate with patients or colleagues. Transference and countertransference issues may emerge as a person’s repressed attitudes about, feelings for, and interactions with that person’s primary caregivers when he or she was a child.

The concept of attention and the concept of intention also can help in understanding the professional relationship. Paying attention to one’s beliefs, attitudes, emotions, and behaviors to understand their origins and how they affect both personal and professional behavior may be just as important to practice as paying attention to outcomes to determine treatment effectiveness. Consider the following case example:

A PT is performing a mobilization procedure at the level of C-5, using a well-accepted, commonly practiced technique in an appropriate manner. The PT detects a change in the patient’s tone of voice during the procedure and observes that the patient has become emotionally irritable. The PT begins to “attend” to his technique, to his own “clenched” jaw and shallow breathing, and to the tension in his own neck, arms, and pelvis. He realizes that he is feeling and “doing” anger and that he is transmitting it to the patient. He then is able to adjust his behavior. During another session with the patient, after receiving a salary increase, the PT is using the same technique and finds that it is working far better than he anticipated. He again attends to his attitude and realizes that he is relaxed in his neck and torso, his breathing is full and easy, and he is feeling—and “doing”—joy. The patient, who reported feeling sad at the outset of the session, now reports feeling “happier,” even though no discussion has occurred.

It can be said that in the above example, countertransference, which usually is unconscious, had a physical component that could be attended to consciously. The PT’s unconscious intention (consisting of attitude, emotions, and motor activity) formed a psychophysical pattern that may have affected treatment outcomes. This intention may be compared to anticipatory movement. Prior to the execution of an actual movement is thought, then intention, to move. With thought, there is measurable electromyographic activity; with intention, movement may be initiated, as shown by electromyographic activity.

When the PT understands his or her own unconscious intention, the PT may be able to consciously control it. (See “Exercises in Attention and Intention,” opposite page.)
Environment and Behavior

The way people interact with their environment influences, and is influenced by, their physical and emotional well-being. Events and traumas may affect interactions and the ability to function efficiently and effectively. How a person deals with the circumstances may help determine his or her behavioral patterns—and vice versa. Because movement is one component of behavioral patterns, it is useful for the PT to understand how physical function corresponds with psychological and emotional patterns of behavior.

Socialization may affect how an individual achieves externally required outcomes or learns to disregard internally driven instincts or how he or she behaves to obtain love and attention and succeed in society. It therefore may have an effect on how the individual uses the body and movement. Socialization may be planned (eg, toilet training) or unplanned and traumatic (eg, controlling the impulse to cry; the death of a loved one; physical, sexual, or emotional abuse). Do environment and socialization directly affect neuromusculoskeletal functioning? Consider the following case examples based on the author’s clinical experience. In each case, remember that the PT has been trained in a variety of mind/body approaches and has received formal education in psychological counseling.

“ Stuffing Emotions”

Ms A, a woman in her early 30s, sustained a cervical sprain in an accident at work and is referred for physical therapy. During the course of physical therapy, she reports that she is upset about not being able to work but that she is determined to get better and, as she states during one session, “to not cry about it.” In her family, she explains, “We were taught that crying about our problems would get us nowhere. We were told that we should just ‘grit our teeth and bear it.’”

Ms A also says, “I stuff my emotions.” She complains of a persistent “sucking-in type of headache.”

The PT observes that, to avoid crying, Ms A collapses and tightens the chest; tightens the throat by “elevating” the larynx; contracts the cervical extensors, which increases cervical lordosis; and “clenches” the temporomandibular joint, all as though she were physically “stuffing her emotions”—an unconscious intention that also may be an example of a “psychophysical” pattern.

After observing Ms A literally gritting her teeth and determining that she is unaware she is doing so, the PT decides to use the technique of amplification/relaxation (see box, above). He asks her to exaggerate the tension of the involved muscles and then relax those muscles. As she does this, Ms A begins to consciously feel her sadness related to the situation, and she cries. As her tears end, she says she realizes that another unconscious intention has been to “swallow” her anger. As she expresses this anger, she reports that her cervical pain is beginning to diminish. The PT notes that cervical hyperlordosis is reduced, and that the chest is no longer “collapsed.” As Ms A describes it, her breathing has become “more full,” her movement “more expansive.”

Amplification/relaxation exercises are combined with conventional treatment that includes cervical stabilization exercis-

Opinion: A New Framework for Understanding?

I propose the establishment of a bridge between physical therapy and psychology. This bridge would be a philosophical and theoretical framework for a more complete understanding of function and dysfunction, the patient, and the relationship between the patient and the therapist. This framework would have the potential to expand the boundaries of current treatment approaches, emphasizing the “non-duality” of body and mind and the possibility that physical and psychological behavioral patterns are identical—“psychophysical” patterns. It would foster an empathic, compassionate approach that stimulates personal growth and allows and encourages emotional responses in patients during the treatment of physical dysfunction.

Research in this area is needed. Controlled studies investigating the effects of the use of the Feldenkrais Method®, Rolfing®, and the Alexander Technique® on well-being, pain level, functional level, and employment status of people with chronic low back pain recently were proposed by the somatics faculty at the California Institute of Integral Studies, San Francisco, Calif. Protocols have been developed, and funding is being sought.

—David Berger, MA, PT
es, manual therapy, and a review of body mechanics. Ms A is able to return to work and reports feeling both physically stronger and more conscious of how her upbringing may have influenced her biomechanics.

"Holding In"
A 40-year-old woman, Ms B, is referred to physical therapy with a diagnosis of low back pain. She has no neurological signs, and her strength is normal. She complains of "deep aching," with occasional sharp pains in the areas of her right sacroiliac joint and gluteal muscles. She also has a history of gastrointestinal problems. She has a left-on-right sacral torsion and right iliolumbar ligament sprain. The PT notes that Ms B’s pelvic-floor musculature, gluteal muscles, and respiratory diaphragm are contracted.

Part of the treatment plan involves patient education. To help Ms B feel the way she unconsciously "tightens" her muscles, a variety of techniques are used, including myofascial release (see pages 55-57), autogenic relaxation (self-induced relaxation), movement awareness, and "sensory tracing." As used by this PT, "sensory tracing" involves asking patients—particularly those with conditions such as chronic pain—to describe their subjective experience of the body, including kinesthetic, proprioceptive, olfactory, gustatory, auditory, and visual sensations, with the goal of improved body awareness. The PT chooses this technique rather than amplification relaxation because the patient is unable to contract or relax the pelvic-floor musculature voluntarily. During the sensory tracing exercise, Ms B notes that she "feels tight in my stomach." When the PT asks her to describe the feeling more specifically, she responds, "It feels like clenching."

During the session, as Ms B becomes aware of how she "clenches" her jaw, throat, and pelvic-floor musculature simultaneously, she remembers an elementary school incident when she had to go to the bathroom but the teacher would not allow her to leave the room. She casually describes being angry at the teacher and doing "everything I could to hold my anger in and not get yelled at and not pee." Ms B also related that she had not been allowed to wear diapers as a toddler when she was sent to the babysitter and that she had been forced to learn to "hold it in." This was not a new or dramatic revelation for her, but rather a realization that her socialization may have had a musculoskeletal impact.

With the emergence of the elementary school memory and the increased kinesthetic awareness of her unconscious intentions, Ms B can practice relaxing her pelvic floor musculature. She now is able to consciously choose either to 1) "clench" her pelvic floor musculature and "do" anger and fear, thereby increasing the strain and pressure on her lumbar spine, or 2) relax these areas, thereby allowing a more "fluid" movement of the pelvis. Unconventional techniques are combined with conventional treatment to help diminish Ms B's pain and correct structural deviations and to help her realize that she can be in control of her own pelvis.

"Rearing Up"
A 54-year-old man, Mr C, is referred to physical therapy for low back pain. At one point during the course of physical therapy, he reports that as a child he received parental attention only when he was ill, in pain, or in debate with his father.

Mr C is resistant to learning new postural patterns. He demonstrates this resistance by assuming a rigid posture that can be described as "defensive". He "rears up" (his words) by locking his knees, increasing his lumbar lordosis, and thrusting his chest forward.

Mr C remains in chronic pain despite standard medical intervention (medication) and conventional physical therapy (strengthening exercises, heat modalities, and stretching exercises). Because he is in pain, does he unconsciously perceive that he is receiving "parental" attention from the PT, displacing onto the PT his anger and need for interaction with his father through pain and debate? Is he maintaining a familiar "psychophysical" pattern? Until the PT understands the possibility that this pattern exists in Mr C, the PT feels frustrated and, on occasion, angry at the patient for not following the program (emotions of countertransference that the PT recognizes but does not express to the patient). Until the patient understands the pattern, he continues to be in pain and maintains his psychophysical pattern of defensive resistance to intervention. To him, the PT may represent an authority figure—most likely Mr C's father (transference).

In addition to abdominal muscle strengthening exercises, body mechanics education, manual therapy, and stretching exercises, sensory awareness and pattern identification through amplification and relaxation are used. Just as the PT would help patients explore the circumstances in which they might be using poor body mechanics in lifting, the PT helps Mr C explore the circumstances in which he engages in a "rearing up" pattern. Mr C realizes he "rears up" when trying to "prove" himself at work and in social situations. The PT also asks Mr C to experiment with less painful postural alignment. By the end of the treatment period, Mr C's pain is reduced, and he has a more flexible, better aligned posture. He reports that he is "allowing" his previous repressed vulnerability as a human to surface.

Although Mr C worked in the past with a psychotherapist on issues related to his relationship with his parents, and with PTs
on his back problem, no one had ever worked with him on his “psychophysical” pattern as a whole.

For more detail on evaluation, treatment planning, treatment course, and discharge planning for a patient whose childhood abuse may have contributed to physical dysfunction, see “Startled,” below.

“Startled”

To provide healing therapy, physical therapists must attend to patients as human beings, with all the complexities involved in human processes and behaviors. We may or may not “fix” a dysfunction. We may serve a patient simply by providing an environment (physical, physiological, office design, psychological) in which healing can occur. When integrated with physical therapy evaluation and treatment and appropriate consultation, mind/body work such as that described in this article may be one tool that PTs can use to help create that environment.

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References

Ms L is a 35-year-old woman referred to physical therapy by her chiropractor. During the initial telephone call and visit, she speaks a great deal about her symptoms and about how she no longer trusts the chiropractor who referred her for treatment of a neck problem. She reports that although the chiropractor’s treatment initially was beneficial, she has been treated by him for a long time without lasting results, making it difficult for her to trust the referrals he makes.

The evaluation. “I’ve had neck pain for years,” says Ms L. “A couple of years ago, I slipped and fell down some steps at work and landed on my arms and right hip.” She complains of pain in the central region of her neck, radiating into her left wrist. “My chiropractor suggested I come see you after I told him how much worse I feel when I am stressed out at work or when my boyfriend and I have a fight.” She complains of difficulty finding time to relax, even when she sleeps. “Due to my distress of the world...”

Ms L reports that despite her 10-year history of neck and back pain, she has never taken medications, not even over-the-counter. Her medical history includes stomach aches and loose, irregular bowel movements.

During the initial evaluation, the therapist observes a number of physical behavior patterns. Ms L arranges her hair in such a way that it covers the right half of her face. She elevates her shoulder slightly and depresses her chest, protracting her head forward slightly. Her back is “flattened,” her diaphragm slightly “sucked in.” This pattern appears to be exaggerated when she starts talking about the stress she feels at work. In addition, when talking about situations that she finds threatening (eg, being confronted by an angry client), she begins to draw her right arm inward and toward her face, as though she is trying to both hide and protect her right side as she turns her head slightly to the right. When asked about whether she is aware that she is doing this, she replies, “No.” This psychophysical pattern, or unconscious intention, may correspond with the PT’s finding of structural deviations, which are palpable in her cervical and upper thoracic spine and the right side of her pelvis. These deviations include rotational dysfunctions at C2 (flexion, rotation right), C3-4 (hypermobility), C6-7 (variable and unstable), T4 (variable and unstable), spasms of the right latissimus dorsi and quadratus lumborum muscles, trigger points in the rectus muscles, posterior positioning of the right fourth and sixth ribs, and upright and posterior rotation of the right side of the pelvis.

When asked how her body feels, she responds, “It’s like I walk around afraid all the time. It’s like I’m in a ‘startled’ state.” The PT observes that Ms L’s experience of this “hyperstartle” state is similar to the way an infant reflexively reacts to a loud noise, except that Ms L tightly shuts her eyes. On palpation, the superficial musculature feels “soft,” despite the spasm of the deeper musculature surrounding Ms L’s cervical spine. The PT notes that the deeper levels of soft tissue seem to be “dense” and “tense,” as though Ms L’s core were “knotched.” Ms L holds her head and neck stiffly when in pain. When she begins to feel more comfortable with the PT, her pain diminishes, and she appears to move with ease, although she is not relaxed. (Her diaphragmatic and pelvic floor musculature remain tense.) The PT also observes that Ms L’s movements are neither slow nor fast but seem “cautious,” as though she does not want to be seen; however, she makes regular, direct eye contact.

Other findings include: cervical flexion—90%, with patient reports of a pulling sensation and pain extent—50%, with reports of pain radiating into the left thumb and wrist; rotation left and right—70%, with reports of local pain; right sidebending—75%, with reports of pain radiating into the left thumb; left sidebending—75%, with reports of a pulling sensation in the left side. Sensation and strength are within normal limits in manual muscle testing positions. Diminished endurance is demonstrated by Ms L’s report of fatigue after walking only a half mile. Her ability to work initially was limited after her injury, but this time she comes for treatment, she is working full time, but her pain and fatigue increase by mid-afternoon and she often goes home early, particularly if she spends a great deal of time at her desk writing reports. Radiographic reports indicate a bulge of the C5-6 disc, posterior and left.

Ms L’s affect is almost “apologetic,” and the PT subjectively notes that she speaks with a whine in her voice. She seems appropriately concerned about her symptoms and atrocity. She also seems generally depressed, with a low level of energy, and she acknowledges that a psychiatrist she had seen in the past thought she had low-level depression.

Treatment goals. Goals for Ms L include: 1) to alleviate or reduce pain; 2) to restore a normal range of motion, function, strength, and endurance for work and leisure activities; 3) to return to a 40-hour work week pain-free; 4) to gain an understanding of ergonomic considerations and body mechanics for home and work; and 5) to use stress reduction and relaxation techniques independently.

Treatment plan. To address structural dysfunctions based on the evaluation findings, Ms L’s treatment program includes soft-tissue mobilization, craniosacral therapy, myofascial release, Maitland mobilization, cervical and lumbar stabilization exercises and general body strengthening, a walking program, stretching exercises posture and alignment education, ergonomic education, and body mechanics. Because the PT has noted that Ms L contracts her right side when lying on the treatment table, he chooses Rosen Method Bodywork®, muscle energy techniques, which is an osteopathic approach, and body and sensory awareness exercises. She performs a great deal of her
program at home. Manual therapy is progressed to more aggressive and intensive techniques as Ms L becomes stronger and her body mechanics improve.

Treatment course. The PT treats Ms L twice weekly for 16 weeks, once weekly for 8 weeks, once every other week for four visits, and once monthly for 2 months. She has one follow-up appointment 8 weeks later before discharge. The original plan is for a shorter duration of therapy, but Ms L has two severe exacerbations and a 3-week vacation 2 months into therapy. A treatment plan of this nature may take longer than other times of plans because of the emotional complexity involved.

Two sessions stand out. In the first session, Ms L and the PT are working on sitting posture and stress-reduction techniques designed to help her feel safe, relaxed, and comfortable in situations she describes as "threatening," such as at work with some of her clients—situations she also describes as causing exacerbations of pain. When sitting properly and feeling relaxed, Ms L is asked to imagine exhaling blowing up a balloon around herself. She is instructed to make this balloon as large as she can feel safe and to continue to be relaxed. Ms L succeeds in improving her posture; she moves to the edge of her chair. She releases her pelvic floor muscles and allows her chest to expand while keeping her back muscles relaxed. The PT notes that Ms L's facial expression seems brighter and her eyes seem to sparkle. At this time, Ms L begins to slump, collapsing her upper body toward her legs. Her facial expression becomes solemn, and she is quiet for several minutes. She says she feels small spaces. "As a child, I would always choose the smallest bedroom in a house, even playing in a closet at times, and would sit in corners and sleep in drawers. This was my way of forming boundaries and putting some kind of protection around myself." She then describes feeling fear and doom when in the presence of her family, particularly her father.

Ms L reports, however, that she is able to use the stress-reduction techniques in work and family situations successfully. By "successfully," she says she means that she could return to this relaxed state and make it through the visit without losing her emotional self to a state of confusion or feeling invalidated or small, and her pain did not get worse.

Not unlike many patients with chronic pain, Ms L has two severe exacerbations during the course of treatment. They both occur after she has been feeling better. These exacerbations come after physical strength increases and pain diminishes and can be attributed to some physical activity, such as the horseback riding Ms L does during vacation despite her knowledge that she should not jar her spine. The PT suspects that it may be an example of rapprochement, that is, the stage of development described by Mahler during which a child becomes greatly independent in locomotion and has the ability to walk away from its mother but returns for support, love, and nurturance. Ms L also makes the assumption that Ms L trusts him. Is it possible that just as infants go through stages of development, so do patients? Does Ms L's exacerbation of her pain during her time away from treatment indicate she is not yet ready to face the world she distracts, even though she is more physically independent?

Three weeks after treatment is decreased to once weekly and a month before she is slated for discharge, Ms L has another severe exacerbation, with symptoms worse than her original symptoms. The PT remarks, "It is interesting that as you approach the end of working with me you have such a severe exacerbation." Ms L does not respond to this immediately, but later, as the end of treatment nears, she says she hopes she will "do it on her own" this time.

After the exacerbation, while she is supine on the treatment table and the PT is performing soft-tissue manipulation of the neck using the Rosen Method, Ms L talks about a scenario that recently occurred during a family visit and that made her feel extremely tense. The PT and Ms L both note that she is shifting from a relaxed position to contracting into her usual pattern of self-protection. The PT asks her to exaggerate "amplify" this pattern and hold it for several seconds, then to relax and take a deep breath. She is asked to do this twice more. During the third repetition, she seems to "freeze." The PT continues to hold her neck gently. She begins to tremble slightly, then cry quietly. This continues for several minutes until the PT asks her if she wants to tell him what she was experiencing. She speaks slowly, gradually relaxing her body as she speaks. "I saw myself sitting at the dinner table. No, in the TV room, I was little. My father was sitting on my right. He was yelling. I never knew how he was going to act—I never knew what was safe around him. I was scared. He hit me. He stopped me on my face. It happened so many times. I would always cry when he came home from work. Sometimes he would hit me a lot. Sometimes he punched me. I would hide but he would find me or my sisters. Just now, while I was remembering this, my stomach started to hurt just like it did when I was a kid."

After several more minutes Ms L's breathing becomes more relaxed, and she is able to get up from the table and walk around slowly, which the PT encourages her to continue until she feels comfortable enough to leave the office. He discusses the possibility of referring her to a mental health professional.

After this session, Ms L returns to her psychotherapist to discuss these memories in more depth. Many other memories of childhood abuse surface, both in psychotherapy and during physical therapy, and recognition of these experiences helps her to further understand her psychophysical pattern in response to threatening situations may have contributed to her musculoskeletal problems. Ms L had repressed these memories of experiences that she believes may have accounted for the feelings of doom and fear she experiences when she is with her family. Her psychophysical pattern of hiding and protecting herself also may have served to maintain this repression.

Discharge. The combination of treatment approaches has helped Ms L: 1) improve her strength; 2) improve her awareness of the psychophysical pattern that contributed to musculoskeletal pain and vulnerabilities that may have placed her at risk for injury; and 3) improve her ability to relax or change these patterns. All treatment goals had been accomplished.

References

Suggested Readings
Some themes are evident in "A Mind/Body Approach": An unsound mind is an unsound body. PTs are likely to encounter psychophysical patterns of behavior in their patients, and the therapy of choice for patients who show these patterns is one or more of the mind/body approaches. PTs need to recognize that their professional education has not prepared them to deal with the psychological problems of their patients, and, consequently, referral to and consultation with a mental health professional is necessary.

An intriguing question arises. If the mind and body are intertwined inextricably, can both be treated using one approach, or will treating the body "cure" the mind, and vice versa? The author emphasizes the "non-duality" of the body and mind; however, the treatments he describes are a combination of conventional physical therapy and mind/body approaches. Does that mean different treatment is needed for the psychological and physical dimensions? If so, the non-duality of body and mind is called into question, as is the efficacy of the mind/body approaches. Unconventional therapies may be necessary; however, they may not be sufficient to take care of the patient's whole problem. All case examples had successful outcomes, but who can say which treatments were responsible for those outcomes? The author would have us believe that mind/body approaches are responsible for those successes.

A variety of mind/body approaches were used in the case examples, but minimal explanation is offered for their use. Some selectivity evidently is involved; however, the bases for the choices were not given in detail. If these approaches are to be integrated into physical therapy, PTs need to conduct research to answer several key questions: Are all mind/body approaches appropriate for all patients? Do all psychophysical patterns respond to all mind/body approaches? Are the various mind/body approaches specific for certain psychophysical patterns, or are different results obtained depending on the type of approach used?

The author maintains that "working with patients' psychological issues is beyond the scope of physical therapy practice." However, in apparent contradiction, he advocates that PTs use mind/body approaches that "may help the patient discover the origins of the [psychophysical] problem." He also makes assumptions about what PTs have been taught. Not all physical therapy programs set rigid boundaries between what is physical and what is psychological. Physical therapy students learn about physical/psychological issues such as psychosomatic illnesses, mulching; secondary gains; and emotional responses to illness, disability, death, dying, and physical interventions. Some physical therapy curricula cover, at least to some extent, a mind/body method, such as Trager Psychophysical Integration® or the Feldenkrais Method®.

I do not believe PTs are as ill-prepared in the physical/psychological realm as the author indicates. Perhaps the key to his assertions is the magnitude or severity of psychological problems, but no such distinction is made. He also alludes to appropriate training, but he does not elaborate on the type of training. Training in a mind/body approach would mean spending time and money on postgraduate study to become proficient in a given approach; however, if psychological problems are not within the legal scope of physical therapy practice, this expenditure of time and money would be a wasted effort. The author does not identify when the consultation of a psychotherapist should be sought, how to use that consultation, or when a referral is indicated—which could be interpreted to mean that he does think PTs have some knowledge of psychological dysfunction and furthermore that they are aware that physical and psychological dysfunction may be related.

The author wears several "hats"—PT, Rosen Method Bodywork® practitioner, and psychotherapy intern—which may account for some of his apparently contradictory statements. His view of physical therapy and what PTs are capable of doing is shaped by his growing expertise in the psychophysical dimensions of patient care. With his developing expertise in psychotherapy, he sees deficiencies; as a PT with advanced training, he sees possibilities for improving patient outcomes by expanding the care they receive.

According to the author, the treatment of psychophysical patterns by PTs is important because physical, emotional, and sexual abuse is widespread and PTs may be the health professionals with whom patients have the most physical contact. The abuse statistics are impressive, but there is no way of knowing how many abused persons will be or have been receiving physical therapy. He does raise consciousness regarding the possibility that a patient's reaction to a PT's touch may be the result of past or present abuse experiences. Physical touching is a part of the essential nature of our service, and of necessity our treatment may cause pain; it is in the best interest of our patients and ourselves, then, to be cognizant of the fact that our "hands-on" therapy can have negative as well as positive consequences, emotionally and physically.

Are the mind/body approaches panaceas? No more so than any other treatment in physical therapy, medicine, or nursing. Are they effective? For some patients, probably. Little, if any, research has been done on these techniques. Again, how and why each method works on what types of patients and under what conditions need to be established in the literature. Should all PTs be schooled in one or more mind/body approaches? That is doubtful at this point in time, when efficacy, accountability, and cost-effectiveness are at the forefront of our professional concerns. The various approaches are subjective and specific to the personalities involved. In addition, therapy may be prolonged rather than shortened, which has implications for reimbursement or fee for service and ethical practice; the frequency and duration of time spent with one patient has to be weighed against the cost of that patient's care and the needs of other patients.

The author has done us a favor by applying the concepts of countertransference and transference to PTs and reminds us that a PT's makeup—beliefs, attitudes, emotions—is related to behavior and does influence relationships with patients. He provides exercises in attention and intention, which he claims will facilitate understanding of one's unconscious intention and psychophysical pattern. How often they should be done, and, most important, whether they do what they are supposed to do is not documented or justified.

The overall tenor of this article, with its emphasis on environment and interaction with patients, is reminiscent of the concept of "therapeutic milieu," or "milieu therapy" and "milieu therapist," which comes from the tradition of psychiatry. Structuring of specific environmental factors and social interactions occurs in psychiatric settings for the provision of total treatment. Some differences do prevail, however. The therapeutic milieu has a social orientation and involves the family and community, and the milieu therapist traditionally is a physician, nurse, occupational therapist, or other professional with a psychiatry background. The author concentrates on the individual, psychophysical processes and on the PT's collaboration with a mental health professional. Whether PTs could or should function as milieu therapists is questionable because our background and preparation in psychiatry gener-
ally is minimal, unlike that of nurses or some occupational therapists.

Should the author and other practitioners of mind/body approaches be dismissed outright or ignored? No! We can learn and relearn from them, even if we do not embrace their philosophies or methods. They serve to remind us that each of us, and patient alike, is a complex human being who influences and responds to the dynamics of others and of circumstances with variability—and, often, unpredictability. But neither should a mind/body approach be accepted or adopted by PTs as a part of physical therapy without careful, critical thought and study before, during, and after training in a given method.

The bottom line is: Will this method, in whole or in part, help my patients—and how do I know it will?

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References


Each Patient is a Miniature Research Project
by David Berger, MA, PT

The opportunity to have a dialogue about using mind/body approaches in physical therapy is exciting. It provides me with feedback I can use to clarify and refine my ideas and practices while my colleagues “listen in” and consider their own. Dr Mitchell raises some interesting points.

Because I strongly believe that conscious awareness and intention during treatment is not only imperative but ethically respectful of the patient, I strive to bring my full attention to my intention during evaluations and while using soft-tissue mobilization, muscle energy techniques, and other methods. I also teach patients how to consciously attend to their own movement during therapy the way an athlete might use visualization or imagery to enhance performance. I have observed PTs trying to treat three patients simultaneously while thinking about a telephone call to a physician. This precludes the ability to consciously attend to intention, to the patient’s complexity as a human being, or to the therapeutic relationship. I combine contemporary techniques using my mind/body approaches that address the patient’s mind/body. I also try to understand my countertransference and a patient’s transference, both of which permeate therapy on psychophysical levels.

As much as I would like to claim that mind/body approaches are responsible for the successful outcomes I described, I will not do so. I believe that the broader focus of mind/body approaches interface well with such techniques as strengthening, stretching, and gait training (when consciously intended) to facilitate a patient’s understanding of self, function, and dysfunction. I have found no physical therapy literature that describes a patient leaving therapy with an expanded knowledge of how upbringing, trauma, socialization, and environment influence and are influenced by neuromuscular functioning in this way.

For the purpose of illustration, I cited case examples that were both clear and successful. Many cases are not so clear, and some are not successful; in those cases, I reassess and modify the program, as would most clinicians. It would take many pages describing techniques and theories to explain why I chose one technique over another. Understanding of theory and practice and clinical experience all enter into the decision-making process. How do I know a given method will help a given patient? I like this question. It should be asked by every PT and PTA during every treatment! Although I agree that controlled research in the mind/body area may be useful, let us realize that each patient is a “miniature research project” and that only a trial of a method or technique can yield a genuine answer to that question. I urge us to use this information and to value phenomenological research because somatic experience is essential to understanding. I can only hypothesize, from my clinical experience, that a particular approach or technique will work; then, by assessing the results, I can determine effectiveness.

I agree that some PTs may be prepared to work with the physical/psychological realm. However, the complexity of many problems—which I prefer to think of as formerly useful strategies that are no longer effective, such as malingering, secondary gains, and psychosomatic illness—may require a deeper understanding of countertransference and transference processes and the therapeutic relationship. Even more complex may be personality disorders such as narcissistic, borderline, and multiple personality. Although PTs do not treat patients for psychological diagnoses, they do treat patients who have them. I therefore believe it is in the best interest of patient and PT and that PTs obtain further training regardless of the legal scope of physical therapy practice.

I am excited to learn that there are curricula that introduce Trager Psychophysical Integration, Feldenkrais® and other “bodywork.” However, these schools of “bodywork” do not address transference and countertransference. I would encourage education programs to expand further, integrating somatics concepts, philosophies, and techniques to help students understand their own psychosomatic processes.

Dr Mitchell mentions the “therapeutic milieu,” which also may be called “the therapeutic container” or “frame.” The frame in which physical therapy takes place may include a gym, a private treatment booth, a soundproof room, a pool, or individual or group therapy. Is it the same each time? Is the PT the same each time? Is the family involved? Do changes in frame affect a patient’s level of anxiety psychophysically? PTs already practice in a therapeutic frame but do not usually give much credence to its importance.

As Dr Mitchell says, I wear several hats. But then many of us wear several hats—those of race, ethnicity, gender, sexual orientation, socioeconomic level, profession, and marital and parental status, for example. My apparently contradictory statements are the result of my attempts to bridge several fields that traditionally have been considered different and separate. I believe the physical therapy profession has been skeptical of new approaches, so I try to use language accepted by the profession at large. This attempt has both advantages and drawbacks. Dr Mitchell points out one of its drawbacks.

My attempt to bridge the gap of language and profession started as a narrow walkway and is expanding into a four-lane highway including physical therapy, psychology, “bodywork,” and Eastern disciplines. With this expansion comes knowledge of other possible routes—and traffic and obstacles. The intention of my article is to introduce this material, inspire some meaningful dialogue without the “head-on” collisions that can only injure, and help move our profession in its forward journey.