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"Corrupt, malevolent and unprofessional - that's the GOsC." Anonymous GOsC registrant

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Using the Concept of Ideomotor-Based Treatment in the Management of Chronic Pain

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Numerous treatment approaches exist within manual and manipulative therapy. In osteopathic medicine, manipulative techniques are broadly defined by the terms 'direct' and 'indirect'. Direct technique refers to the application of external force to engage a restrictive barrier and includes HVLA technique, MET, articulation and soft tissue massage. In contrast, indirect techniques, such as functional technique, strain-counterstrain and facilitated positional release, are generally unconcerned with restrictive tissue barriers and attempt to bring about change via reflexive somatic responses. Direct techniques have received more of the attention in the literature, both in terms of efficacy and therapeutic mechanism, whereas indirect approaches remain relatively unexamined.

A unique explanation for the effect of indirect methods of manual therapy on pain has been proposed, and has led to the development of a treatment approach described as 'Simple Contact'. Although this approach uses similar handling methods to other indirect manipulative techniques, the model does not rely on hypothetical pathophysiology or detailed assessment of the patient for subtle dysfunctions which cannot be substantiated. The premise of the model is that in patients with mechanically induced or maintained pain, active movement designed to reduce the mechanical deformation of painful tissue will emerge from the patient as an instinctive and

effortless movement response. This inherent activity is called ideomotor movement, or ideomotion.

Descriptions of ideomotion have been present in the medical and psychology literature since 1852 when a lecture by Carpenter was reprinted in The Proceedings of the Royal Institution of Great Britain. Carpenter identified ideomotion as a third category of non-conscious, instinctive behaviour, which also includes excitomotor activity (e.g. breathing and swallowing) and sensorimotor activity (e.g. eye blinking and startle reactions). Ideomotion can be described as instinctive, automatic expressions directly coupling dominant mental representations to action without intermediary volition. Ideomotor theory suggests that motor patterns can be automatically and intimately associated with their internal and external sensory effects and will occur in the absence of any other cognitive representation or efferent motor command. Although ideomotion has been commonly associated with involuntary movements, ideomotor theory also provides a compelling explanation for the generation of goal-oriented voluntary actions. Ideomotor movements include the involuntary and unconscious movements that make up our non-verbal communication behaviours, such as facial expressions and changes in posture. It contributes to complex tasks, such as operating a car while we

focus on the road, and to write or speak the beginning of a sentence while we are mentally constructing the end of it. In addition to its expressive functions, ideomotion also has homeostatic or corrective functions, such as shifting in one's chair or changing posture to relieve discomfort, yawning, and forward motor planning to ensure end-point comfort. Ideomotion is also responsible for many illusory perceptions, such as those experienced in dowsing, the ouija board and pendulum diagnosis, the observations of applied kinesiology, and some palpatory experiences in manipulative therapy and 'energy work'. The occurrence of ideomotor movement is well detailed and strongly supported in the scientific literature.

The most frequent reference to the ideomotor effect in relation to common indirect manual therapies is explication of the potential error in associating palpatory confirmation of hypothetical physiology with substantiation of a theory. Some indirect manual treatment methods presuppose unsubstantiated physiological or pathophysiological mechanisms, and suggest that palpatory confirmation can offer sufficient evidence of these mechanisms. However, in accordance with the ideomotor principle, the anticipation of a sensory consequence itself can act as the stimulus which directly and involuntarily prompts the muscular movements that will produce it. Thus, expression of a desire or expectation to perceive hypothetical body functions, such as cerebrospinal fluid rhythms, tissue 'unwinding' or 'energy', can result in the practitioner subconsciously generating internal movements and sensations that match the practitioner's envision. However, in the absence of anticipatory projections from the practitioner, gentle, non-provocative palpation can reveal a great deal of subtle, involuntary movement within the patient. Considering the fact that expressive and corrective ideomotor movements, large and minute, can occur almost continuously in humans unless consciously suppressed, it is possible that ideomotor activity is responsible for a significant proportion of the subtle tissue alterations observed by practitioners using some indirect techniques. Knowledge of the presence and purpose of ideomotor activity should inform our understanding and interpretation of such observations.

According to the contemporary neuromatrix theory of pain proposed by Melzack, the sensations of the pain experience and

accompanying motor responses coexist simultaneously as two dimensions of a multi-system output response. The perception and localisation of pain sensations occur concurrently with the generation of motor output responses designed to resolve the perceived threat to tissues. Wall has proposed that the resolution of pain thus requires an appropriate motor response, and that such a response may proceed as the result of inherent mechanisms. If this instinctive process is interrupted then guarding, altered posture and continued pain may ensue. Dorko has noted that ideomotor movements constitute the predominant expression of instinctive movement response to both internal and external stimuli in humans during their daily activities. He suggests that enhancement of the expression of ideomotion should lead to the reduction of mechanical pain in patients whose instinctive responses have been inhibited or suppressed, and are thus experiencing continuing symptoms.

Ideomotor movements are expressed to their maximum degree unless there is an antagonistic motor representation present simultaneously in the mind. James explains that unless conditions are simple, full ideomotor expression is often dependant on a mental consent, or permission. Dorko argues that spontaneous bodily expression may be inhibited in the context of culturally acceptable expressions of movement or suppressed by prescriptive body expression, for example, postural correction training. Such external demands may result in the generation of simultaneous 'antagonistic representations' that distract authentic, spontaneous expressions of movement and thus manifest as isometric muscle contraction. Dorko has suggested that such muscle activity is commonly misinterpreted as a lack of appropriate relaxation, and may then be subjected to various forms of stretching, manipulation or choreographed exercise, rather than being encouraged to complete the motor response for which it was activated. The method described by Dorko endeavours simply to provide a context of 'permission' in order to encourage greater expression of ongoing ideomotor activity.

Most indirect manipulative techniques are based on a common concept that the role of the practitioner is to encourage the activity of inherent corrective or homeostatic physiological mechanisms. A therapeutic construct based on this proposal could include the role of instinctive responses, which exist for the purpose of resolving

somatic tension or excitation. The therapeutic use of ideomotion is also recognised by psychotherapists in a similar approach, called Authentic Movement therapy, used to help patients explore the relationship between the psyche and the soma in psychological pain and conflict. The only major difference between Simple Contact and Authentic Movement is the use of verbal communication rather than manual handling to encourage ideomotion; however, Dorko also acknowledges verbal promotion for the emergence of ideomotion.

The manual technique described by Dorko to encourage the expression of ideomotion is very gentle and is not difficult to master. It is important to note that the technique does not introduce movement. Ideomotion is the somatic expression of mental imagery, attention or thought; therefore, it is always present in conscious patients. The goal of ideomotor therapy is simply to make the patient aware of this spontaneous internal activity and then allow it to proceed unhindered. Thus the patient is not directed to do any particular movement; rather they are encouraged to cease restraint of any ongoing ideomotor activity. Manual contact from the practitioner need only be just enough to be felt and draws the patient's awareness to the slightest indication of ideomotor activity. Following the patient's body with very light contact encourages more pronounced expression of these movements. It is suggested that the attitude of the practitioner toward the ideomotor movement should be one of quiet acceptance and interest, maintaining contact but avoiding inhibition or guiding in any way. During ideomotor movements the sensory effects, such as the kinesthetic sensations that accompany each movement, are directly coupled with the generation of the movement itself. As ideomotor movement is elicited during treatment, complex patterns of movement may be observed. Alterations in motor output during the movement are generated by continuing sensory effect representations and may be influenced by both conscious and non-conscious peripheral sensory feedback. Since varying kinesthetic sensations may be perceived with even minute alterations in motor output in some instances movements may not be visible, though they will often still be palpable.

The expression of ideomotion during treatment may be quite striking, involving very slow, arrhythmic, large-range movements of the trunk,

neck or limbs. This response is particularly common when the patient is standing or seated. In the supine position, movement is restricted in many directions and the response is not consistently perceptible from a visual point of view; however, palpable movements and changes in breathing and muscular tension are frequently observed. One of the dominant characteristics of ideomotion is a sense of disassociation with conscious volition behind the movement. Patients often express surprise that their body has begun to move and will either assume that the practitioner is moving them or express a sensation that some internal mechanism separate to their 'will' is responsible. It is possible that a significant advantage to the use of non-volitional movement in the treatment of pain is that subconsciously generated movement may bypass conscious fear-related cognitions responsible for some functional movement impairments resulting from pain. Since ideomotor therapy involves active movement, rather than passive movements as in most other manual therapies, the patient can consequently learn to allow greater expression of ideomotion independently, which is encouraged as a self-management exercise.

Some patients experience a rapid onset of warmth throughout the skin over the spine, face, upper limbs and/or the feet, accompanied by pronounced sweating during treatment. Adoption of a deep breathing pattern may also be noted. These phenomena often commence within approximately five minutes of the beginning of the treatments and suggest a marked alteration in sympathetic tone. Such observations are considered typical by practitioners using this approach. It has been noted anecdotally that these overt reactions are commonly associated with favourable outcomes.

Motor output as a dimension of pain generally serves to both promote evasion and to limit provocation of the painful area. Evidence from PET studies suggests that cortical and subcortical motor mechanisms become activated in anticipation of movements intended to escape the noxious stimulation. For example, the premotor cortex has been shown to be significantly activated during noxious stimulation, even though the patient is stationary. However, modulation of nociception occurs at all levels of the neuraxis, thus generating the multidimensional experience of pain involving sensory-discriminative, affective-motivational, cognitive, autonomic, and motor

components. While ideomotor responses to pain may primarily serve to decrease or resolve noxious mechanical peripheral input, additional central mechanisms may be involved in producing pain modulation during the therapy. Nociceptive inputs can be modulated in the CNS by other sensory inputs or by descending inhibitory influences. The application of non-threatening and supportive touch, the emergence of novel movement patterns or the unusual sensation of non-volitional movement may facilitate inhibitory modulation via the sensory-discriminative pathways of pain. The patient-oriented approach and non-threatening context of ideomotor therapy, as well as the learning of a new self-management technique might alter affective-motivational and cognitive components. Commonly observed clinical changes, such as pronounced warmth, sweating, muscle relaxation, and deeper breathing, suggest that autonomic modulation is also involved. Placebo mechanisms must also be considered.

Chronic musculoskeletal pain infrequently presents at a single site of the body. Carnes et al have suggested that in the presence of non-specific pain at multiple-sites, assessment and intervention targeted specifically at a single pain site may be inappropriate and may fail to have a significant

effect on overall pain and disability. Patients presenting with multiple-site pain may gain greater benefit from less site-specific interventions. Ideomotor-based treatment typically precludes attempting to isolate treatment to a single area of the body. Although further investigation is necessary there is some evidence – to be published shortly - to suggest that the ideomotor treatment may be beneficial in the management of complex, multiple-site pain presentations.

Increasing evidence suggests that over-reliance on passive coping strategies is a strong predictor of chronicity and risk of disability. Active approaches to the management of neuromusculoskeletal pain are commonly associated with better outcomes than passive treatments, and where manual therapy has shown benefit it is often when used in conjunction with active management. Although the ideomotor-based therapy involves manual contact, the resulting movements are entirely active. Once a patient has become familiar with the process of 'taking the brakes off', as it is described by James, they can allow the expression of ideomotion independently. Thus, it is possible for the patient to achieve similar effects from treatment on their own as they do with the therapist, which may reinforce self-efficacy and active coping.

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The Psychology of Tissue

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Tissues have memory

Let me tell two stories as an introduction. The first is from Bernard Weber. A farmer is trying to push his donkey into a horsebox and his son is observing them. The donkey does not want to go into the box; it does not want to be forced into the box. The harder the farmer pushes, the harder the donkey resists being pushed. The son laughs at the scene. After a while, the father, frustrated and irritated by the obstinate donkey and the laughing son, shouts at him to do it if he thinks he can. The son approaches the donkey and pulls its tail. The effect is immediate. The donkey jumps forward into the box and remains content.

The second story was told to us students by Colum Gregory about when he was a student at the ESO teaching clinic under Gez Lamb and was trying desperately to thrust a patient's restricted T9 with little success. Gez Lamb finally came in the room and told him to unwind T9 using one of the legs as a lever. He did so and after a few moments the patient started crying with a good somato-emotional release. She had remembered a particular incident of her childhood when some boys attached her to a tree and were particularly nasty to her. This restriction could not be forced to shift with a HVT or an LVT technique. Fascial unwinding was THE technique for this patient.

While we could have forced the donkey into the box by pushing it with a tractor or cracked that patient's vertebrae with the help of a professional wrestler, a different approach adapted to the patients' particular needs worked and did the trick. We are constantly confronted in practice with multiple choices of techniques we can use on a patient and on a particular restriction. On some patients, a structural adjustment will have fantastic results, while others will react by tensing up even more. On some patients, deep tissue massage relaxes the contracted muscle whilst with others the muscle will contract even more. On some patients, the cranial approach will have almost miraculous effects whilst others will take you for a quack.

Is it possible that for any patient's restriction there is one specific approach which will be the most effective with fewer side-effects? Which technique needs to be used? GAT, GOT, HVT, LVT, recoil, BLT, direct/indirect cranial approach, MET, PNF, A/P work, unwinding, strain/counter strain, trigger point inhibition, dry needling, functional techniques... Is there a reason why a patient may react better with a certain type of technique or approach? I believe there is and the reason can be explained by the psychology of tissue.

Tissue is living structure and it can hold memory which will influence the psychology and conduct of that tissue. There are 3 major memory mechanisms: the somato-psychological, the psycho-somatic and the somatic-somatic memory.

The somato-psychological memory

When we hurt ourselves, afferent information from the injured area is sent to the brain. A part of this information analyses the type and quality of the pain felt while another part is sent to the limbic system where the brain will attach an emotion to this pain and will compare it to previous similar injuries.

To give an example of two similar injuries that happened to two different individuals. Imagine a soldier on a battlefield who, whilst carrying and saving the life of one of his team mates, twisted his ankle. Now imagine another person who, whilst on live TV, missed a step and twisted his ankle. He embarrassed himself in front of million of viewers. During a treatment the practitioner will certainly notice these injuries. Asking about the cause of this trauma will awaken a sense of pride and self-

confidence in the soldier whilst it will awaken a deep sense of shame in the TV personality. The internal chemical secretions and the immediate reactions of these two patients will be totally different.

Imagine a widower who just lost his wife. His many friends individually came to him and, with a hand on his shoulder asked, "How do you feel?" or "How are you?" This scene is repeated hundreds of times. It creates a deep anchor mixed with a Pavlovian reflex between the sensation of feeling the hand of a friend on his right shoulder, the sentence "How do you feel?" and a deep sadness. Six months later our widower starts recovering slowly. One of his friends innocently puts his hand on his shoulder and asks, "How are you?" Unconsciously, a voice will say, "I was feeling fine until you reminded me that I lost my love 6 months ago by reactivating this anchor..." Internally the chemical reaction will lower his mood for the day. It is interesting to note that this somato-psychological link will have an influence on the soma.

The psycho-somatic memory

This is one of the most well-known links and its effect on the body is important. It is often classified as stress. Stress influences body functions by playing with the cardiovascular system, the respiratory system, the digestive system, the immunity system and with mental health.

Stress is mainly perceived through the musculoskeletal, the digestive and the respiratory systems. Constant, repetitive, stressful situations tend to manifest as a general increase in muscle tone. A victim and barometer of stress is the diaphragm; stress generally holds the diaphragm in expiration, limiting the expansion of the thoracic cage. Other good indicators are the stomach and duodenum, as well as the upper back and neck muscles – the trapezii, levator scapulae, SCMs and scaleni. When the diaphragm is held in expiration, the thoracic spine is forced into a kyphotic posture which induces the posterior muscle chain of the thoracic erector spinae and trapezii to contract constantly in order to maintain a relative balance. The lack of diaphragmatic expansion forces the accessory muscles of respiration - the SCM and the scaleni - to increase their tonus. Their contraction allows breathing to take place in the upper chest by raising the upper ribs. Another effect of

kyphosis is that the shoulders roll inward thus compromising their biomechanical action.

The main physical complaints of a stressed person are upper back pain, neck pain, headache, shoulder pain and thoracic outlet syndrome. Stress increases stomach and duodenum acidity thus resulting in gastritis or ulceration. The fact that these organs suffer can make the patient adopt a kyphotic posture.

An example is a woman involved in a car accident. The first time she gets back into a car, she realises that her whole body is more tense than usual.

In fact this psycho-somatic memory can be more specific. A man who suffered from a relatively serious trauma months beforehand will over-protect the affected area by facilitating the contraction of protective muscles. Muscular tone is increased from a constant neurological firing. After years of over-stimulation the muscles become fibrotic.

The somato-somatic memory

Can a tissue have a memory by itself without involving the brain? Some authorities disagree but I say that it can. It is not the same type of memory as in the brain but is a structural/mechanical memory on a cellular level.

After a repetitive trauma, the structure of a tissue will be affected and that is a form of memory. A broken radius in childhood becomes an extra calcification on an X-ray 40 years later; this is a structural memory of a trauma. After a complete tear of a ligament, the memory is there even though the ligament has gone.

In fact, mechanical and chemical changes take place around an injury which in the long run may affect the local vascularisation, the tone of the muscles and ligaments. Generally a sensation of density can be felt by the practitioner over an old injury. Upledger calls it *the cyst of residual energy*.

To sum up:

- An emotion is attached to a physical trauma and a memory of that trauma
- A memory of a mental trauma or stress can affect the physical body
- A memory of a previous trauma can make us overprotective of the injured area

- A physical trauma will affect the structure and therefore the function of the affected area. This is a structural/functional memory of an injury.

Each traumatised or injured area will be unique because of the unique psychological/structural/functional memory associated with it. As each traumatised or injured area is unique, they will each behave and react differently to the same external stimulus of an osteopathic technique. Each osteopathic lesion has its own psychology.

Different body type, different psychology

Sheldon (2,3) distinguished three main body types coming from the three types of embryological tissues: ectoblasts, mesoblasts and endoblasts. Each of these groups is associated with specific physical and psychological attributes.

The ectomorph

...is roughly a predominance of the element of restraint, inhibition, and of desire of concealment. Cerebrotonic people shrink away from sociability as from too strong a light. They "repress" somatic and visceral expression, are hyper-attentional, and sedulously avoid attracting attention to themselves. Their behaviour seems dominated by the inhibitory and attentional functions of the cerebrum, and their motivational hierarchy appears to define an antithesis to both the other extremes.

Ectomorphs are not physically strong individuals. They use their intellect not their physical bodies to survive in the world and tend to intellectual over-stimulation. They tend to be tall, long, thin, introverted, inhibited, quiet and serious.

The mesomorph

...is roughly a predominance of muscular activity and of vigorous bodily assertiveness. The motivational organisation seems dominated by the soma. These people have vigour and push. The executive department of their internal economy is strongly invested in their somatic muscular system. Action and power define life's primary purpose.

Mesomorphs rely on their physical bodies and action. They tend to be competitive, dominating and power seeking. They enjoy physical team sport. They tend to be muscular with large bones

and strong ligaments. They are assertive, risk-taking and adventurous.

The endomorph

...in its extreme manifestation is characterised by a general relaxation, love of comfort, sociability, conviviability, gluttony for food, for people and for affection. The viscerotonic extreme are for people who 'suck hard at the breast of mother earth' and love physical proximity with others. The motivational organisation is dominated by the gut and by the function of anabolism. The personality seems to centre around the viscera. The digestive tract is king and its welfare appears to define the primary purpose of life.

Endomorphs rely on their digestive systems. Life is not only about hunting and thinking but is also about eating and enjoying it. They are *bon vivants*, as we say in French. Endomorphs are social, loving, friendly, lively persons with a tendency to put weight on.

An osteopathic approach to the body types

Tom Dummer expressed this in structural/functional terms. Structural techniques work best on mesomorphs and functional techniques work best on ectomorphs and endomorphs. Of course it is occasionally better to use a functional approach on a restriction of a mesomorphic patient and vice-versa.

HVT/LVT, GAT, deep soft tissue work and general osteopathic treatments are the techniques of choice with mesomorphic patients while ectomorphic and endomorphic patients respond to indirect functional techniques, balance ligament tension techniques, gentle inhibition, fascial techniques and craniosacral treatments.

It also means that ectomorphs can over-react to structural techniques while the mesomorphs are wondering what you are trying to achieve by touching their heads so lightly!

Psychological profile and osteopathic technique

For mesomorphs, use GAT, HVT, LVT and deep STW. For ectomorphs, use gentle inhibition, functional techniques, BLT, cranial and fascial unwinding.

There is a correlation between the psychological profile and the technique used. The technique used for each profile is the best psychological way to communicate manually with the tissue of the patient. The structural approach imposes a certain state to the tissues while the functional one listens and discusses with the body of the patient.

Let's take a typical mesomorphic patient, a rugby player or a marine soldier. How will you convince them? How will you convince them to win a game or to fulfil a mission? Will you use authoritative or diplomatic speech? You will use authority; you will give orders; you will shout at them and you will have to be more dominating than they are. The structural techniques are authoritative, strong, aggressive and dominating.

What about a typical ectomorphic patient, a chess player or a computer geek. How will you convince them to change their tactics or their programs? Will you use authoritative or a diplomatic speech? Diplomatic speech will be the best approach to convince them step-by-step of the need to change their point of view! Functional technique listens to the tissues, follows their logic and gently influences them.

Osteopathic techniques are psychological manual techniques. Each technique is a specific psychological manual tool to communicate with the traumatised tissue of the patient. One technique is more suitable than another according to the psychological profile of the injured tissue.

Psychological explanation of osteopathic techniques

In osteopathy, we often treat the hypomobilities, the restrictions. Traumatized tissue - somatic dysfunction - is stuck in a certain behaviour pattern because of previous stimuli and trauma and it "thinks" in the wrong way.

Structural techniques

HVT: The practitioner gives an order to the joint by imposing a point of view exactly opposite to its. You think A and I order you to think B. I impose B on you and there is no discussion.

GAT: There is a notion of repetition and progression in this technique while being in safe hands with a firm grip. This is like a coach encouraging, stimulating, brain-washing and

overcoming a negative thought A to bring it to a point of achievement B.

The Recoil *: This is questioning the patient in a few words about a deep rooted psychological conflict and bringing this thought from the

unconscious to the conscious. For example, "Did you accept the death of your father?" Because your hands are not in contact anymore means that you as a catalyst do not want to listen to the reply; you let the patient deal with his issues on his own. If the tissue thinks A, the recoil could tell it about B.

Functional techniques

Indirect cranial/fascial and balance ligament techniques: In these types of technique, the aim is certainly not to go against the will of the thought but to encourage it. The tissue thinks A is OK and the practitioner does not confront it or judge it, he merely asks why the tissue thinks A. Sometimes, even though we don't really believe in an idea (A), we follow it just to be in confrontation with others. The fact that others try to confront us on this idea makes us react even more. This is the example of the donkey. The donkey does not really mind getting into the box but it does not want to be forced. Another example is you need to leave and you ask your child to come but she refuses to let go of her toy. You could force her to let go of her toy and come with you causing a tantrum or you can say, "OK. You want to stay here? Stay here but me, I'm going." By leaving the child to do what she thinks she wants, you avoid the confrontation. As she sees you leaving, she quickly realises that she needs to follow you.

Dr Spock might use a different analogy. If someone has a short sighted point of view on a particular subject A, instead of contradicting it or the person, you ask the reason why. Try to get to the bottom of his A point of view. There is a moment when the root of the idea A has no logical value. As soon as you get to this illogical root of the problem, the patient will logically analyse that it is illogical. This realisation will start unwinding the whole misconception about this A idea leading the tissue toward a more balance B way of thinking.

Functional technique: The tissue thinks A and by using a step-by-step agreement, the practitioner brings the point of view of the tissue to B.

MET isometric: The practitioner asks the traumatised tissue to express its A thought while he remains still. After the A thought is expressed, he then counter-attacks with a gentle opposite B view by stretching. The fact that the practitioner's resistance remains still may express his non-acceptance of the A argument given by the tissue.

MET concentric: This could encourage the tissue to strengthen.

MET eccentric: This could challenge the A thought of the tissue.

Fascial unwinding: This is encouragement to the expression of a trauma by "mirroring" the information received.

Conclusion

As two different osteopathic lesions have a different cause and a different memory, there is little chance that they will react in the same way to the same technique. It is possible, though, to have more than a single psychological blockage in traumatized tissue and why there is a need sometimes to use different techniques to relax tension e.g. deep STW, functional inhibition and HVT.

This could explain why studies to check the effectiveness of spinal manipulations in acute low back pain so often fail. Facet joints should not always be manipulated because it is not the correct psychological way to convince them to relax. Remember the patient who benefited from fascial unwinding. It was the technique needed to express his tension.

The art of osteopathy is knowing which technique to use on each individual patient. This comes from a practitioner's experience, skill and an open mind. If a somatic dysfunction does not release with one technique, do not persist but communicate with it in a different way.

<http://pierreosteopath.blogspot.com>

* The Recoil: After 300 to 400 tests, the practitioner finds THE primary lesion of the body, exerts a precise flick against the barrier of the restriction and then quickly removes his fingers from any contact with the body – Chaffour (4)

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