Paul Gordon, M.A. | *Advanced Rolfer*®

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875 Massachusetts Avenue, Cambridge, Massachusetts 02139 617.628.6661
43 Mast Cove Road, Eliot, Maine 03903 207.439.8522
www.PaulGordonRolfer.com

A Paper Presented at the American Back Society Conference
in Los Angeles, California on December 3, 1994

Interdisciplinary Relationships in the Treatment of Chronic Back Pain: Helping People Get Better

At the August 1994 Meeting of the International Society for the Study of The Lumbar Spine, a presentation was given by Drs. Tom and Ane Bendix of Denmark's Copenhagen Back Center. They reported that "higher low back pain impact is achieved by an intensive multidisciplinary program that included physical training, psychological pain management, work hardening, stretching, education and leisure time activities." This observation has been made in a number of papers in recent years and it is shared by many clinicians in the field.

The intention of this paper is to present a model for understanding multidisciplinary programs and to suggest a reason why they are often more effective in the treatment of chronic back pain than single disciplinary interventions.

First, we must clarify some definitions. Healing is a process whereby damage is repaired so that the structure is able to respond appropriately to both normal and abnormal demands. When healed, a normal demand (such as leaning over to pick a paper off the floor) will not result in damage. An abnormal demand (such as inefficient lifting of a heavy object) may result in damage to the healed back but the damage will not be out of proportion to the stress which has been placed on the involved structures.

Healing is achieved by two methods. The first, curing, is practitioner directed. The patient is essentially passive and needs only "the will to live." If the correct remedy is administered, improvement will occur. In curing the number of interventions as well as the time needed for the process to be completed is predictable. When cured, the patient is usually "good as new." Many diseases and most infections respond to cure.

Mending, the second method, is a process which is patient active with the practitioner often (but not always) part of a team. The number of interventions and the time necessary to complete the process is much less predictable. When mended the patient is restored to sound functioning, he or she may not be "perfect."

There is a fundamental misunderstanding on the part of most of the public and, unfortunately, many of the practitioners about chronic back pain and the methods needed to fully heal it. This

misunderstanding has created enormous frustrations for both the sufferer and the practitioner. Many clinicians are unwilling to treat back patients - whom they find difficult, noncompliant, incurable. At the same time, many back patients feel disappointed - more, deceived - by those they believed would end their pain.

The chronically dysfunctional back is rarely responsive to cure. There are two reasons why this is so. Much of the tissue involved in back pain has a relatively limited blood supply. Because of the physiology of these soft tissues, they do not heal easily. The structural material at risk, the ligaments, discs, joint capsules, do not heal well and once injured tend to stay injured.

The second reason has to do with adaptation. Chronic pain can create musculoskeletal, neurological and emotional changes which can perpetuate a dysfunction. Unless these adaptations are dealt with, the pain will likely recur.

While a cure is usually not possible, mending often is. Painful backs may never be the same as they were but they have the potential to be better than they are. As long as the tissue is viable, if it is not diseased or compromised by age to the point that the body no longer has the energy to repair itself, that structure has the potential to be mended.

There are six components in the process of mending. In an appropriate evaluation we understand the location, tissues involved and mechanism of an injury. We understand the predisposing factors - physical, emotional and spiritual - which led to or exacerbated the injury and are aware of any compensatory responses.

Communication and Commitment refers to the necessity of explaining to our patient our diagnosis and suggested treatment in terms that they can understand. It is essential that we explain what is happening and what must happen next in ways that are meaningful to that particular patient. Once explained (it may take more than once), the patient must commit to doing whatever is necessary for repair to occur. The patient who is unwilling to do any part of the prescribed treatment is a cause for concern.

The third component in the process is the Correction of Mechanical Issues. In chronic back pain, it is the author's contention that there is almost always a mechanical dysfunction. Whether by surgery, manipulation, pharmaceutical or other reduction, any mechanical inhibitions to healing must be removed.

The fourth components are Strengthening what has Weakened and Expanding what has Contracted. Through physical training, work hardening and other programs, stabilization of weakened structures is accomplished. With stretching expansion of contracted structures is achieved. (While stretching is the most commonly prescribed expansion technique for back pain, any intervention which creates expansion in the structure - relaxation techniques, biofeedback, psychotherapy, among others - are included in this component.)

The fifth component in mending is Learning Appropriate Movement. This component concerns how to use the body appropriately and is accomplished through "back schools" and various movement re-education techniques such as the Feldenkrais Method, the Alexander Technique, yoga or Rolfing. The sixth component has to do with a certain amount of good fortune. No matter how hard patients strive to heal damaged structures, if they are reinjured by another fall, car accident or mis-step off a curb, they must begin the process again. The final component is therefore labeled Avoiding Re-Injury.

The healing process is often non linear. One does not go from Totally Dysfunctional to Complete Resolution. There are many intermediate stages along the path. But as long as the patient continues to make progress, he is healing. The job of the patient and practitioner is to remove any barriers which are preventing that process from moving forward.

The components involved in mending will not be the same for every patient. Some will need emphasis on component one or three, others two, three, five and six. Whether a practice is single practitioner or multi-disciplinary, if a patient is not improving, an examination of the various components may help us understand what is needed.

The theme of this conference has been the new health care environment. Multidisciplinary centers are becoming the norm in a time of managed care. One of the intentions of this paper was to present a model for understanding how the various disciplines fit together into a comprehensible totality. Every treatment currently prescribed fits into these components. It is suggested that the reason multidisciplinary practices (as opposed to practices which have a number of practitioners sharing space but who are not interacting in patient care) may be more effective than single discipline interventions is that different practitioners will emphasize and supply different components to the overall process. By working together we may significantly increase the chance for success.