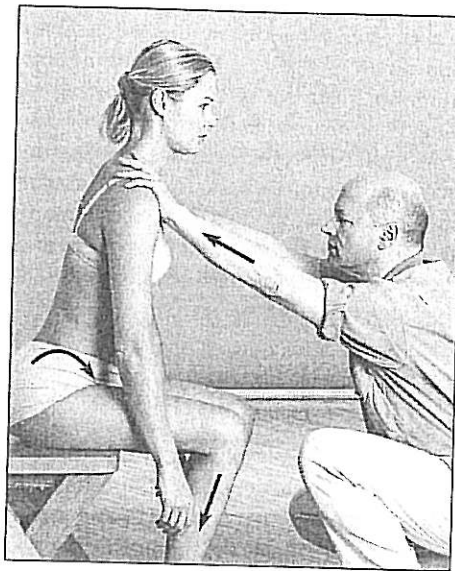


Principles of Treatment in Practice

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Note: The following is an excerpt (text from Chapter 3) from Peter Schwind's book Fascial and Membrane Technique: A manual for comprehensive treatment of the connective tissue system, copyright Churchill Livingstone Elsevier 2006.

In the curricula of most forms of manual therapy training, the discussion of therapeutic setting (or therapeutic environment) is usually regarded as of secondary importance, and this is in marked contrast to training in psychotherapy. This disregard of therapeutic setting does not reflect the challenges that confront manual therapists in their day-to-day practice. From a traditional viewpoint, the therapist is the expert, the active "subject," who treats the (possibly quite uninformed) patient as if he or she were a passive "object." There is certainly a kernel of truth in this viewpoint because the hands of the therapist actually do stimulate the organism of the patient in such a way that preexisting impulses are guided in other directions and, in a certain way, new objective realities are created. These new objective realities may include, for example, verifiable changes in the movement path of a joint, improved gliding behavior of layers of tissue adjacent to one another, and improved fluid exchange between body cavities. Yet this viewpoint does not take into account the fact that manual treatment involves a multilayered communication process that is similar in many respects to psychotherapy. In modern practice, this important fact is increasingly ignored as the use of physical devices has begun to shape the normal course of therapy. We do not wish to discuss here how effective or ineffective these devices are or how specifically or unspecifically they influence the body. This type of critical question may be asked only in the context of empirical studies. However, it is a legitimate and important question for anyone engaged in day-to-day practice to explore the manner in which this "hands-free" treatment differs from treatment in which the hands of the therapist are used.



The use of medical devices that administer mechanical, electrical, or electromagnetic impulses may, for example, locally or globally alter the muscle tone or provide stimuli to the nervous system in a clearly defined manner. However, such devices are unable, or able only to a very limited extent, to register the response of the organism at the same time as they administer the impulses, to process the response as feedback, and to use this feedback to durably modify the impulses being administered. The stimuli of these devices are therefore fundamentally different from the stimuli originating from the human hand. The difference lies in the fact that the human hand is able to vary its stimuli using feedback from the brain in an almost infinite variety of ways, and therefore is able to register the responses of the organism being treated while it administers the impulses. To put it differently, the hand may be used simultaneously to transmit

and receive information; the hand provides a stimulus and, at the same time, registers the effect of this stimulus on the organism of the patient. In order to allow this process to take place, a series of preconditions for the therapeutic setting must be taken into account.

In order to make use of both aspects of touch, transmission and receipt, i.e. administration of the impulse and observation of the response, the therapist must depend on being able to switch freely between an active and a passive use of the hands. We will see that, for certain techniques, it is possible and even necessary for part of the hand to be actively engaged while another part of the same hand behaves passively. This sort of differentiated use of therapeutic contact can succeed only if the therapist is able to guarantee a "neutral" setting.

This "neutral" setting, the therapeutic setting, is characterized by some basic rules of communication.

INTERNAL EQUILIBRIUM OF THE THERAPIST AS A BASIS FOR OBSERVATION

In order to be able to observe the patient with as few outside influences as possible, it is necessary for the therapist to be neither in an overactive state nor in a too-passive one. In this state, both poles of the therapist's autonomous nervous system, the ergotropic and trophotropic sides, are equally activated. As soon as the therapist emphasizes one side, this emphasis will be transferred to the patient through the quality of the contact. In this manner, the internal state of the therapist is intertwined with the overall state of the patient, making an objective diagnosis no longer possible.

PRESENCE OF THE THERAPIST

In order for the spectrum of observation to be as broad as possible, the therapist must be completely present mentally. During the application of diagnostic or therapeutic techniques good coordination is essential.

Efficient therapeutic contact is characterized by the fact that it is sensitive enough to detect the most minuscule differences in surface characteristics while at the same time registering the condition of components that are distant from the immediate point of contact and that may be detected only through the interconnection of the three-dimensional fascial network.¹ Dif-

ferentiated attentiveness lends a sensual quality to the contact. At the same time, however, it is important to maintain an "objective" or neutral quality to the contact. Only in this manner is a specific and precise impulse effect possible.

To a certain extent, therapeutic contact has paradoxical qualities. On the one hand, it adapts very gently to the form of the body and thus automatically attains an expressive character, for example, in the sense of support, friendliness, or a positive prevailing mood. On the other hand, therapeutic contact should also be distanced without producing callousness or giving the impression of emotional detachment.

This paradox can also be seen in the basic communicative role of the therapist. The therapist should simultaneously express closeness through the physical contact with the patient but yet remain at a friendly distance as a person. This can be best described by the following image: the hands of the therapist are very close to the organism while the therapist's self is distant from the personality of the patient. Only in this manner is it possible to produce a therapeutic setting that, to some extent, corresponds to Sigmund Freud's working principles. In the context of this setting, the therapist will hardly be influenced by the patient's own moods and feelings. Only within such a setting is the therapist able to efficiently control the course and efficacy of the therapy.

THERAPEUTICALLY EFFICIENT CONTACT

It is extraordinarily difficult to document scientifically what occurs during the manual treatment of the human organism. Part of the difficulty lies in the fact that human contact always manifests itself in the organism on completely different levels at the same time. And whenever we observe one level in isolation, there is the danger that we will take into account only a partial aspect of the investigation or even "measure" a pseudoresult. In addition, contact always has an individual quality. The quality of contact may be similar in different people but ultimately is always individual, like the handwriting of two different people. However, it is still possible to formulate a kind of basic technical orientation that may be valid for the most varied types of contact.

I have already referred to the fact that every human contact unites in itself two aspects.

One aspect may be characterized as passive and non-directive—this means to observe, to diagnose—and the second may be characterized as active, directive, and providing a stimulus—this means to actually treat. Many forms of treatment attempt to separate these two aspects from one another to the greatest extent possible. They use the non-directive, passive side of contact for diagnosis and the active, directive side for precisely defined manipulations. I think that this kind of separation is not entirely realistic and, moreover, carries with it increased risks in treatment. Every form of human contact in the therapeutic realm should unite directive and non-directive qualities. In other words, one of the aspects can move more into the forefront while the other aspect retreats into the background and vice versa. This means that the passive/non-directive aspect is present throughout the entire treatment and not only during the diagnostic process. In this manner, it is possible for the directive impulses originating from the therapist's hand to be modified in such a way that they utilize forces already at work in the organism of the patient and therefore are more effective and gentler at the same time.

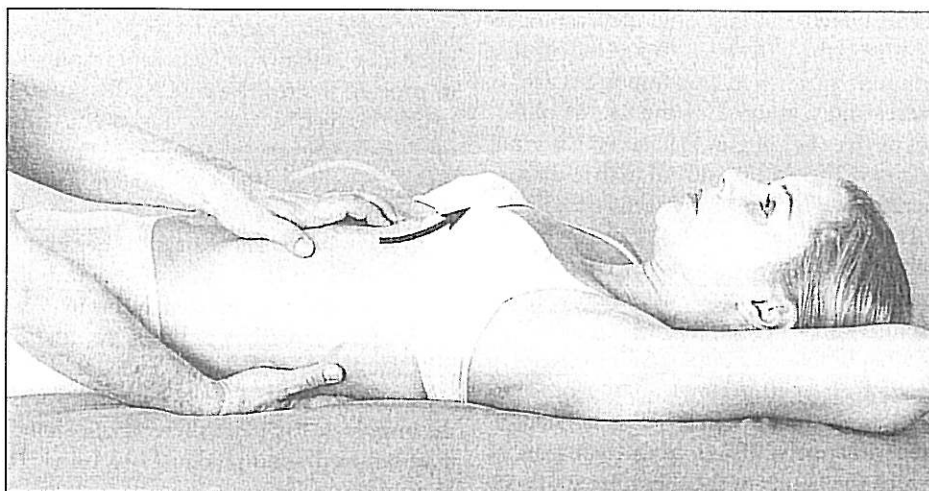
THE USE OF THE HAND-CONTACT TECHNIQUE

The first and generally applicable distinction for the practical use of the hand is the distinction between weight and active pressure. As soon as the therapist's hand is placed on the surface of the patient's body, the weight of the therapist's hand, forearm or upper arm, and shoulder is transferred onto the body of the patient. The therapist can intensify this weight, for example, by leaning forward over the axis of the hip

and adding the weight of the torso. In this case, the coordination of the therapist plays a large role in the quality of the contact. Finally, the contact becomes more effective as soon as the therapist uses active, directive pressure in addition to the applied, passive weight.

In the treatment of fascial and membrane layers, it is essential that we train our own perception so that we can clearly differentiate between the various forms of contact. When the patient is lying on his or her back and the therapist's hand is placed on the surface of the patient's body, the weight of the therapist's hand and forearm is transferred onto the body of the patient no matter how carefully the therapist is making the contact. The therapist's hand being placed supportively under the patient's back however is a completely different process. In this case, the weight of the therapist's hand and forearm is transferred onto the treatment couch and the patient's weight is transferred to the therapist's hand and forearm. Both forms of contact have a different quality, reach different levels, and are perceived by the patient as two fundamentally different ways of being touched.

The most efficient treatment techniques for the fascial and membrane system use both forms of touch at once. The therapist can thus use one hand dorsally to support the patient lying on his or her back, i.e. to accept the weight, while using the other hand ventrally to work with weight and/or active pressure. The therapist is therefore literally taking the organism in his or her hands. This allows the therapist to give consideration to the entire three-dimensional network from the outset instead of receiving just a selective, linear, or superficial impression.



Another important distinction is the difference between stationary, local contact and sliding contact. In sliding contact, the speed must be adapted to the tension of the tissues; the denser the fibers, the slower the contact must be.

The next step toward technical differentiation of contact is the differentiation between the use of the palm and the individual fingers or the thumb. A large number of possible combinations are available in practice. Despite a widespread misunderstanding, the palm is much more sensitive than the fingertips in differentiating fine distinctions. For this reason, the combined use of the palm and the fingers is particularly efficient when the palm is used in a supportive and observational capacity while the fingers provide an active stretching impulse.

Another differentiation of contact is made possible by the fact that each of the fingers can be used to apply a different amount of force and can apply stretching impulses in different directions independently from one another.

The most important technical condition for being able to treat the fascial and membrane system efficiently in its spatial structure is the independence of one hand from the other, the independence of the palm from the fingers and thumb, and finally the independence of the individual fingers and thumb from one another.

NOTES:

1 This ability is widely referred to as "end-feel."