Seeing the wood and the trees

It is very easy to lose sight of the larger context in which the health problems we are called on to help with, exist. People become unwell for many reasons. Sometimes because of inherited characteristics, amplified by the events and patterns of their life; and sometimes because of life events and demands which eventually overwhelm their adaptive resources, even if there exist reasonably sound inherited features. As practitioners and therapists we are regularly confronted with the results of the interaction between people's historical, as well as their current, interaction with their environment. In order to understand anyone's problems it is therefore important to explore the relationship between the presenting symptoms and complaints, and the individual's work, habits, relationships, social situation as well as history.

This is true even in what appear to be simple biomechanical events. A strain often emerges out of a background in which physical forces have been applied to tissues that fail to adapt to the demands placed on them. Had the tissues been more supple, and the joints to which they attach more mobile, the strain may well have been absorbed by the elasticity of the mechanism. Failure to absorb strain leads to collapse of tissues and breakdown at one level or another.

Therapeutic protocols exist to deal with such events, which take account of the normal progression of healing, involving rest and rehabilitation. But even such a simple example of how to handle dysfunction may be less successful if no account is taken of the individual's nutritional status; or the quality of their emotional life; or their current social and work demands which could influence compliance with rehabilitation demands. If simple strains often occur against a background of already compromised tissues, in an overworked, emotionally compromised and nutritionally unbalanced body, and if therapy and rehabilitation procedures fail to take account of this, therapeutic results will be less than optimal. This is as true in the unfit masses of sedentary individuals who underuse themselves, as it is in highly trained specialist athletes and performers, who overuse aspects of their physiology, often to an extreme.

And what of other apparently uncomplicated health problems? Can a person who presents with chronic headache/migraine symptoms, for example, be helped without awareness of, and attention to, possible causes which lie beyond the biomechanical status of their neck, or the tensions and trigger points in their upper trapezius muscles? What of possible emotional turmoil? Or of dietary indiscretions, nutritional imbalances or possible food sensitivities? Or of liver dysfunction? Or of work or domestic pressures? Or of visual imbalance leading to holding the head askance? Or ... of many other possibilities? What would be the value of manipulation of the neck, or stretching of upper trapezius, if these background causes were ignored?

Journal of Bodywork and Movement Therapies (2000)
4(3), 153–154

And what then of the individual presenting with widespread body pain or dysfunction, where adaptive mechanisms and systems have become overwhelmed by a combination of inherited and acquired features, often too complex to unravel with anything other than a superficial degree of accuracy. Where symptoms are so complex that many of the secondary symptoms have themselves become the causes of new problems. Where a chain reaction of adaptive events involving psychosocial, biochemical and/or biomechanical factors result in a picture of fatigue, pain, depression and/or anxiety, together with a catalogue of symptoms which in total are daunting. It could be argued that any manual or movement practitioner, or therapist, who believes that dealing with the obvious complaints of such a person (pain, fatigue etc), without reference to the larger context out of which these emerged, is doomed to add to the patient's problems rather than solving them.

We can most adequately treat a person with such problems by bringing to bear our fullest possible focus on the circumstances and events which surround the individual as well as their unique characteristics.

Treating effectively, in a complex setting (and even in the apparently 'simple' headache setting), may sometimes mean offering a containing presence, without any attempt to 'fix' or cure the problem(s). Getting better, in many instances, may not be an option. And the best anyone could do for some patients would be to assist towards a better way of handling their burdens, physically as well as psychologically, rather than trying to eliminate the evidence of their failure to cope.

Even in the simple biomechanical strain example, recovery, should ideally involve assessment of less obvious influences than the biomechanical ones that would normally receive attention — including habits (sleep, leisure activities, dietary patterns) as well as psychosocial factors, such as long held emotional states such as anger, which might be producing significant somatic effects.

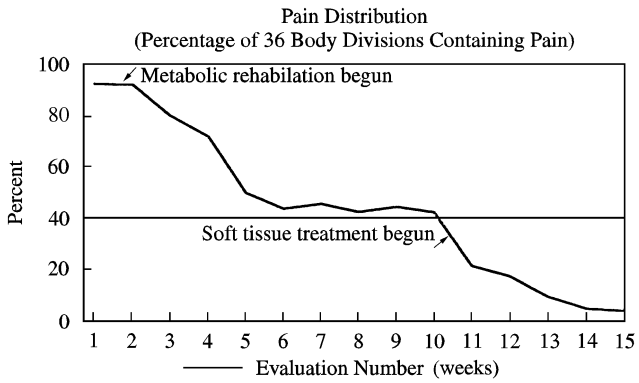

Fig. 1 A fibromyalgic patient's progress.

This simplistic plea for attention to the larger context out of which a patient and his problems emerge, leads naturally enough to a plea for recognition of the relatively narrow perspective which most forms of therapeutic endeavour may bring to such problems. The reflexologist, cranial therapist, chiropractor, osteopath, massage therapist, physical or movement therapist (whether based on yoga, Pilates, Alexander or other principles) may believe that what they do offers a comprehensive approach. Or they may recognize that what they offer is really only able to effectively deal with aspects of some of the problems outlined above, and that they need to either broaden their approaches, or they need to work cooperatively with others, psychotherapists, nutritional counsellors, naturopaths, etc as well as with mainstream therapists and physicians.

Examples of the successful integration of differing approaches in treatment of complex conditions are not common, but they do exist. In the October 1998 issue of JBMT, for instance, Lowe and Honeyman-Lowe discussed the metabolic rehabilitation of fibromyalgia patients in whom a thyroid dysfunction had been identified. In a case cited (one of a series), improvement was noted soon after the start of metabolic rehabilitation, but this improvement plateaued after 6 weeks until soft tissue manipulation approaches were commenced after week 10, when symptomatic improvement escalated again (Fig. 1).

In this issue of JBMT (and the next) as Phil Latey explores the care of patients with migraine, themes emerge in which it is clear that a quick fix is not an option but that progress is often possible if the wider needs of the patient are understood and met. The needs of many of our patient's requires a global, rather than a specialised, approach and in many instances combinations of therapeutic tactics will be called for. Hopefully we can learn to see the trees, and the wood, as we struggle with the problems our patient's present to us.

Leon Chaitow
Editor

REFERENCE

Lowe J, Honeyman-Lowe G 1998 Facilitating the decrease in fibromyalgia pain during metabolic rehabilitation JBMT 2:208–217