

Unwinding the Pattern of Rheumatism

Andrea Randall



Andrea Randall, structural integration (SI) practitioner, graduated from SI Australia in 2011, and holds a Bachelor of Health Science (Musculoskeletal Therapy) degree from Endeavour College of Natural Health, graduating in 2008. In May 2014 she had the privilege to work with a team coordinated by Bibiana Badenes, Certified Advanced Rolfer™ and Rolf Movement® Practitioner, in a residential program for Swedish clients with rheumatoid conditions where she was able to apply the skills and principles of her structural integration training. The visible changes in the clients' movement and attitude toward life at the completion of the program prompted her to write this article. Andrea lives and practices in Brisbane and can be reached at andrearandall5@gmail.com.

Abstract

The author describes her participation in a residential rehabilitation program in Spain that treated patients with rheumatic disorders, showing how the principles of structural integration were applied to effectively enhance the patients' well-being and health. Her experience illuminates how structural integration can be a component of a multidisciplinary approach to rheumatic disorders within a medical paradigm.

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is considered a clinical syndrome, which involves several inflammatory cascades that lead toward persistent synovial inflammation and associated damage to articular cartilage and underlying bone (Scott, Wolfe, & Hiuzinga, 2010). Scott et al. summarized the condition:

Rheumatoid arthritis is characterized by persistent synovitis, systemic inflammation, and autoantibodies . . . Fifty percent of the risk for development of rheumatoid arthritis is attributable to genetic factors. Smoking is the main environmental risk. In industrialized countries, rheumatoid arthritis affects 0.5 to 1.0% of adults, with 5 to 50 per 100,000 new cases annually. The disorder is most typical in women and elderly people.

(2010, p. 1094)

Symptoms and Etiology

A recent systemic review to promote early diagnosis identified screening tools that increase detection of individuals with inflammatory arthritis. These self-reporting tools, such as the Connective Tissue Disease Screening Questionnaire (CSQ), include questions about symptoms and identify RA and a variety of connective tissue diseases (Kung & Bykerk, 2014). Patients described that predictable symptoms, such as joint swelling, stiffness, pain, and tenderness, as well as fatigue, weakness, and the emotional impact of those symptoms, preceded the onset of RA. Foot and hand joint pain was most commonly described; larger joint involvement was less common. The study identified emotional distress

including anger, fearfulness, and depression. The authors suggested that emotional well-being should be explored in patients at risk for RA.

Patients with arthralgia (joint pain) and early RA report common themes:

- Pain in the joints, muscles, and tendons.
- Intermittent or sudden symptoms such as
 - tingling sensations,
 - weakness and loss of strength,
 - fatigue and sleeping difficulties,
 - swelling, redness, and warmth, and
 - joint stiffness.

The intensity of the symptoms was noted to worsen through the spectrum from arthralgia to early RA. For example, patients with arthralgia only described pain as being bothersome and annoying, whereas the patients with early RA had pain that intensified to excruciating levels before diagnosis. This suggests that pain intensifies as inflammation increases just before diagnosis. Patients with arthralgia commonly reported short episodes of intermittent joint swelling, pain, and fatigue versus more persistent symptoms in patients with RA. Patients with RA reported a significant change in swelling occurring soon before diagnosis (Kung & Bykerk, 2014)

Synovial and cartilage cells are the dominant cells in joints affected by rheumatoid arthritis. Synovial cells include fibroblast-like and macrophage-like synoviocytes. Macrophage-like synoviocytes are believed to be the predominate cause of overproduction of pro-inflammatory proteins, and fibroblast-like synoviocytes display abnormal behavior in rheumatoid arthritis. Implantation of fibroblast-like

synoviocytes with cartilage in experimental models has shown fibroblasts invading cartilage, which resembles joint destruction. Osteoclast activation seems to be a key process leading to bone erosion in joint destruction, and inhibiting osteoclast activation has been proven to reduce joint destruction; however, joint inflammation is not affected. It is unclear whether arthritis starts as a primary problem in the bone and then moves to the joint, or starts in the joint and moves to the bone. Arthritis in five or more joints might develop by fibroblast-like synoviocytes altering their behavior and spreading between joints (Scott, Wolfe, & Hiuzinga, 2010).

Scientists have identified genes that are associated with ankylosing spondylitis (AS), a form of arthritis that causes inflammation and possible bone growth on the spine. The HLA-B27 gene is found in nearly 90% of people with AS, but is present in only 8% of the general population. Two additional genes (IL23R and ARTS1) have also been identified (Arthritis Australia).

A new classification criterion for early detection of arthritis has been designed by The American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR). These criteria (Sidebar 1) assess joint involvement, autoantibody status, and acute-phase response and symptom duration (American College of Rheumatology, 2010).

It is common that treatment for RA involves some or all of the following professionals in a health care team: a general practitioner physician, rheumatologist, orthopedic surgeon, dietician, exercise physiologist, occupational therapist, nurse, physiotherapist, podiatrist, and pharmacist. Water exercise and strength training are common forms of exercise-based treatment for people with RA.

3H Rehab Program

In 1998, Bibiana Badenes, a physiotherapist and Rolfer®, was invited to run part of the physiotherapy program for Haga Rehab, a Swedish organization, to provide rehabilitation for Swedish patients with rheumatic conditions. This created 3H Rehab, a four-week residential program for adults and three-week residential program for children in Benicassim, Spain, located along the “Great Blue” Mediterranean Sea with white sandy beaches and beautiful, green parks. This had the advantage of being a non-hospital environment. The health care team consisted of Bibiana, three additional physical therapists (trained in myofascial release and postural

Classification Criteria for Rheumatoid Arthritis (RA)

Score-based algorithm: A score of six or more is needed for classification of a patient as having definite RA. (Scores listed in parentheses)

A. Joint involvement (0-5)

- 1 large joint (0)
- 2-10 large joints (1)
- 1-3 small joints, not counting large joints (2)
- 4-10 small joints, not counting large joints (3)
- More than 10 joints, with at least 1 small joint (5)

B. Serology (0-3; at least one test result is needed for classification)

- Negative RF and negative ACPA (0)
- Low-positive RF or low-positive ACPA (2)
- High-positive RF or high-positive ACPA (3)

C. Acute-phase reactants (0-1; at least one test result is needed for classification)

- Normal CRP and normal ESR (0)
- Abnormal CRP or abnormal ESR (1)

D. Duration of symptoms (0-1)

- Less than 6 weeks (0)
- 6 weeks or more (1)

alignment), one massage therapist (trained in aquatic teaching), a Pilates and tai chi instructor, a nurse, an ergonomic therapist, a physician, and myself (trained in structural integration and musculoskeletal therapy).

The physician assessed the health condition of each patient at the beginning of the program and after the program. A pain analogic scale and joint measurements were taken before and after the program, and spinal measurements were recorded for those presenting with ankylosing spondylitis. The patients completed questionnaires at the start of each day and at the end of the program.

Patients received daily treatments including hydrotherapy, movement exercises, body awareness exercises, cinesitherapy (therapeutic active and passive movements), and myofascial release. Some treatments were provided in groups and others were given individually. The activities depended on the needs of each person; there was not a single standard program provided for all participants.

Structural Integration in the 3H Program

Bibiana started the 3H Program with a conventional physiotherapy program, but through the years realized that working only with symptoms was

not enough, and that the residential program gave the opportunity for more education and self-care. Bibiana's Rolfing™ education changed her understanding of a person: Rather than focusing on the patient's symptoms, the goal was to engage the patient in understanding and education of his condition. This goal became the core of her approach to organize the multi-disciplinary team.

Bibiana incorporated Rolfing / structural integration into the program since many problems she saw were related to the person's structure—the uneven distribution of stress in the body—and not only to the rheumatism itself, and she adapted SI principles to work with rheumatoid arthritis clients. As an example, in manual therapy she positioned the tissue in a way to challenge the joint and tissue restrictions while applying gentle and firm pressure, she listened to the body and waited for the person's nervous system to respond so that motion restrictions diffused as the client's awareness grew.

As part of the myofascial release (MFR) therapy program, Bibiana and I delivered sessions using structural integration strategies to accomplish goals of balance and alignment. Our structural integration work was not based on a 10-session model; rather it was based on structural integration's unique understanding of the human body and structure. The hands-on treatments were delivered to the clients in 25-minute sessions, two to three times each week. Patients rotated among therapists throughout the program without a specific protocol for each patient to receive care from each therapist. Some patients requested to have a specific therapist; sometimes the request could be accommodated and sometimes not, due to the schedule.

For the adult program, I worked 20 days and delivered approximately 90 sessions for 27 patients. I saw each patient at least once. Approximately 80% of the sessions I did used structural integration strategies to accomplish the goals of increased balance and alignment. In the remainder, I applied general myofascial release and massage. Eight patients received consecutive structural integration sessions.

The children presented differently than the adults and fewer knew English, so I was less able to apply structural integration for them. I worked 15 days in the children's program and delivered 45 sessions (only about 30% being structural integration) for 33 children and teenagers.

Delivering care in an environment where SI and MFR were seen as interchangeable created challenges for me as an SI practitioner: how to work, how to apply my knowledge of SI, and how to be part of a team of therapists co-treating patients? At first, I wondered how I could possibly facilitate integration in a client in a 25-minute session, but I soon learned to make a quick decision about structure based on posture, gait, and verbal complaints. I remembered from my SI training to "make the most of each buck" (that is give the most value to the person for whom you are caring), so I worked with few strokes on areas I could see and feel were key zones impacting the person's structure. On reflection, the shorter sessions did give adequate time for clients to integrate spatial relationships of the body. Knowing that I would potentially see the patient two days later helped me to know that I'd be able to work progressively deeper.

I adhered to Rolf's method of working the body from the sleeve to the core with great focus on the feet and hands due to their sensory potency, functional importance in daily activities, and continuity with the core of the body.

The hands and feet are sensory organs, which listen as well as act, receiving stimulation which feeds the entire rest of the body. They feed the core with vital information, not least of which is auditory, for the palms and soles can hear.

(Maupin, 2005, p. V)

The work I delivered to each client was shaped by her physical complaints and the disorganization I could see in her structure. I looked for lack of support, limbs dragging on the upper or lower poles, lack of groundedness through the feet, lack of mobility in the ribs underlying shoulder and neck complaints, pelvic tilts, shifts of weight, plus emotional response to life and herself on that particular day.

For example, I worked with a lady who presented with a painful right shoulder and abduction limited to 70 degrees. On observation I realized that I needed to organize her lateral line. I worked in three sessions to bring her pelvis to a more neutral position, increase the inhalation movement of her ribs, lessen the drag of her arms on the shoulder girdle, and increase the extension of her thoracic spine in accordance with mobility of her shoulder girdle. After the sessions, shoulder abduction increased to 140 degrees.

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Another patient was a woman who rode horses and complained of pain across her low back and pain in her right knee. I observed that the medial line of her thighs and lower legs needed to be integrated; her pelvic floor needed to drop down and her weight needed to ground through the medial line of her legs. I adapted the concepts of Session Two and Session Five from the classical 10-session series. I released the medial line and the ramus of her ischium as she made micro-movements of knee flexion, knee extension, and anterior and posterior pelvic tilts. Afterwards, she reported decrease in pain and a sense of being more grounded when walking.

A man presented generally fatigued, with lack of balance and coordination. I observed a disconnect between his abdominals, pelvis, and feet. I concentrated work on his legs and feet, brought his pelvis toward neutral, and taught him to use his legs and to breathe with his diaphragm, which resembled much the first three sessions in a classic Ten Series. Afterwards, I observed that he had more mobility in the pool exercises and was more coordinated in his gait.

Structural Integration and Myofascial Release

I saw MFR as complimentary to SI, particularly as preparatory work: softening the tissue and creating body awareness. When possible, I worked using SI strategies for the patient to have a better relationship in gravity. I determined whether to provide SI or MFR based predominately on the patient's structural presentation, as Bibiana explained that the effects of RA are felt more in the weak areas of a person's structural pattern. If I saw a chronic postural pattern that any person could have regardless of being diagnosed with rheumatoid arthritis, I worked to balance, align, and integrate structure. I applied MFR when the patients had other medical complications presenting: when their energy was low, when they seemed to need to not participate, and with the young children who couldn't speak English. In the cases where I applied massage, I used Swedish

massage, lymphatic drainage, and remedial massage techniques.

Additional Therapies in the 3H Program

Structural integration complements the other therapies offered in the 3H Program.

- Hydrotherapy and land exercises were included, starting with mobility exercises and progressing slowly into cardiovascular and resistance exercises.
- Integral Aquatic Therapy, which works with the fascial and joint restrictions of the client within the lower-gravity environment of a heated swimming pool, was offered. In this method, the client is supported by the water and therapist while being moved in ways that are not easily accessible on a table to achieve fascial release and activation of the parasympathetic nervous system.
- Short sessions following the concepts of Gabrielle Roth's *Five Rhythms* were also adapted for the RA clients, giving them the opportunity to explore movement in a raw sense without effort, force, or perfectionism.
- Tai chi was also offered to provide structural support as well as spatial, emotional, and mental adaptability.

Each soft tissue therapy session and activity was modified to benefit the whole client by recognizing the structural, functional, and energetic dysfunctions, conflicted worldviews, as well as emotional and physical trauma impacting the body as it organized itself in gravity. Clients were able to continue most exercises and activities in their home environments.

Movement education and body awareness were important aspects of the exercise therapy so patients could adequately adapt and maintain new movement and alignment patterns. "Awareness" was the word often repeated, so patients could change the way they perceived and understood their bodies. Thus the movement programs supported one of the tenets of SI as explained by Ed Maupin in *A Dynamic Relation to Gravity: Volume 1*:

Structural integration uses the experiencing subject as a partner in the process. It assumes a fundamental wisdom in the body, which can participate, seeking to find its optimal pattern. Awareness, the body's own experiential awareness, is what makes the change. (2005, p. 3)

Education also included how to release and use the feet, and how to walk and sit with the support

of gravity. Many exercises were also done on the floor and adapted to the patient's needs. Repetition of exercises was not forced; the exercises were encouraged to be felt to create a new movement experience. This education was included in the hydrotherapy sessions, benefiting from the resistance and buoyancy of the water; in land-based mat, step, and gym ball exercises to create adaptability to gravity; when walking with the aid of Nordic walking sticks to increase awareness of the two major gravity centres of the body and enhance fluidity of movement; and during personal coaching of the developmental stages of movement.

Structural integration can be used effectively within a team of other health professionals to provide life-giving opportunities for clients of different ages with rheumatism.

Structural Integration as Part of a Health Care Team

Sharing patients with other therapists was challenging for me as I didn't know how other treatments affected the level of integration in the patient or what other processing may have been occurring. Furthermore, the specifics of how an area was worked by other therapists were unknown. Also, I desired to follow up with patients, to know how they responded from treatment I had given them, when they were not scheduled to see me again. However, I equally saw the benefit of patients receiving treatment from different eyes and hands, being given new perspectives, and being able to experience similar, yet different, approaches.

In this environment I felt spontaneous, creative, and very much in the present moment. This was due mostly to the time schedule and working with how the patient presented on the day—not necessarily following up on what they received two days previously. Treating the patients consecutively with SI goals was much more rewarding for me: to see and to know that a change occurred and a new way of being in the world had emerged.

Discussion

When designing the program to include structural integration principles, Bibiana asked herself "How

[can you] discover, even with your limitations, that you can be healthy?" She seeks to educate each person to live in his or her own body and said

This is something that is missing many times in rheumatism. They only live when they have pain. And when they are fine, they are not really enjoying their bod[ies]. To live in their body is what I want for them. Come back to your body. Come back to your own perception. Come back and feel you are alive.

(personal Communication, September 2014)

The 3H program offered the RA clients time to recognize and learn to respect the potential of their ability on a given day, neither forcing an unrealistic expectation of performance nor being hindered by the physical limitations of the previous day. In my opinion this acknowledgment and acceptance of being in the present is very important for fascial release.

A number of the patients attended the program several times. One woman reported that the first time she participated in the program seven years ago, she could not do up her bra and had minimal movement of both her shoulders. Over the years she eventually regained full range of motion of her shoulders.

A Swedish patient, Else, who had attended the program a number of times, describes the program well.

I love my treatments in Haga / 3 H Rehab. It's not just for my pain; I got help. It's for my whole body. When you [are] always in pain, it will be problem with your soul, too.

We do exercise for the whole body every day, we have exercise in the garden, train in the pool, we learn how to breathe, how to walk in the right position.

The individual treatments [I received] I have never felt anywhere else. It's not painful, but the therapists work in our body in a way that really helps people.

Bibiana and her staff are all very well educated, and I always learn something new about my body, and we learn a lot that we can use in our home.

(personal communication, December 2014)

Through my experience in this program, I learned that the principles of structural integration can be developed, modified, and continue to evolve for different structural dysfunctions including rheumatic disorders. Structural integration can

be used effectively within a team of other health professionals to provide life-giving opportunities for clients of different ages with rheumatism. Structural integration is a powerful method to be implemented in more holistic programs, and as Bibiana has demonstrated, a structural integrator can be a coordinator for these programs, because she has the ability to see, work holistically, create a better structure and a more functional body, but also to prevent future problems, engaging the person to take care of herself, to be educated, to have a higher quality of life. I believe that this kind of understanding can be applied not only in programs for rheumatic patients, but within any program for well-being: for back pain disorders, personal growth, and preventative programs for children at school.

Bibiana summarized the effectiveness of the 3H Program:

We want people who are willing to get involved with the process of recuperation and therefore enable a team to be formed between patient and therapist. Through the years I have realized that although we must deal with the presenting symptoms, what is most important is to emphasize education when the person is not in an acute crisis. Our patients improve vastly when we integrate a more mindful approach. We achieve our best results working with prevention, noting where the compensations occur and where we anticipate the next problem area. Taking care of oneself is not just taking medicine or doing exercises. Self-care with RA is about understanding yourself as a person.

Discover[ing] the potential in people and find[ing] a way to create vitality, equilibrium, and well-being is our goal. I have no doubt that prevention carried out in a way that we enjoy it is the best medicine there is. Our thoughts, our emotions, our postures, and movements are the history of our lives and they have taken toll during the years. 3H Rehab is not just any holiday, it is the beginning of a new outlook towards health, well-being, and mindfulness.”

(personal communication, September 2014)

From my experience and what I gather from the design of the program, a traditional SI program would be effective for the rheumatic patients delivered in shorter sessions more frequently. For example, I think working with one goal in a 30-minute session and having three sessions each week could be integrative in a progressive and gentle manner for those experiencing RA.

Two clients I treat in my clinic who have lupus, a subset of rheumatism, have responded very positively

to the traditional series with full length sessions. From this experience, I think the goals and strategies are very applicable to patients with rheumatism and a more structured delivery of treatment would further enhance their health. At the same time, I believe it is extremely important that all therapy is delivered to the individual needs of each patient. Often these patients have other health complications that need to be addressed or taken into consideration with a complimentary health professional.

For more information please contact Bibiana Badenes at 3H Rehab, www.bibianabadenes.com or info@bibianabadenes.com.

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