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PSYCHODYNAMICS IN MANUAL THERAPY

# Understanding and working with the psychodynamics of practitioner–patient relationships in the manual therapies

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**Summary** In this paper, we argue that practitioner–patient relationships in the manual therapies would be strengthened by a deeper understanding of the psychodynamics and emotions of those relationships. We suggest that in many cases, a purely bio-mechanical approach may neglect underlying psychological and emotional reasons of the patient's presenting condition, and consequently, lead to a less than adequate outcome for the patient. We offer easily adopted suggestions that could enhance the practice of practitioners of manual therapies as well as other professions that rely on the application of physical methods of diagnosis and treatment. These suggestions could lead to improved prognosis and increased professional satisfaction for practitioners. This paper describes five key dynamics that characterize practitioner–patient relationships: (i) pain as a form of communication; (ii) the 'heart-sink' patient; (iii) dependency; (iv) the erotic transference; (v) endings and loss.


## Introduction

This paper is the result of joint work by the authors who conducted two post-professional programmes for osteopaths in 2006 and 2007 entitled: *What is the patient really telling me?* The programmes were provided under the auspices of the Tavistock Institute of Human Relations' Professional Development Programme and aimed to improve understanding of the relationship between patients' symptomatology and their mental states and the application of psychodynamics in the work of manual therapists. This paper also challenges the training institutions of manual therapists to consider the relevance of *'psychodynamics'* in their education and training programmes.

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## Background

Psychodynamics, in its broadest sense, is an approach to the study of human behaviour that emphasises the study and use of the psychological forces that underlie human behaviour, feelings and emotions; how they relate to early childhood experiences, and for the purposes of this paper, how they re-emerge in the relationship between patient and practitioner, often to the puzzlement of the practitioner. Pincus (2006) outlines the mind-sets of patients in osteopathic consultation — processing what the osteopath says and does, identifying patterns, evoking emotions, thoughts and even physiological responses. She rightly claims that the psychology of the patient and the osteopath, and importantly, *the interaction between the two*, i.e. the psychodynamics, will affect not only how the patient behaves (e.g. adherence to treatment and advice), but how they feel emotionally and physically and even in their clinical response. Pincus' comments can be said to apply to all manual therapies. Williams' (2007) found that patients obtain psychological benefits, such as reduced fear, from improved understanding and a positive approach, but we challenge his proposition that the benefits could be due to the *placebo effect* of increased clinical contact, treatment preference, or the caring attitude of the practitioner. Rather, it is asserted here that an integrated (or holistic) approach of manual treatments with empathic understanding and therapeutic relationship between practitioner and patient, *is* the major contributor to clinical improvement and psychological wholeness (Jackson et al., 2005; Lamm et al., 2007). The 'therapist effect' cannot be discounted; it lies at the core of the recovery process (Horvath, 2001). This paper evaluates, through the description of selected cases, the psychodynamic approach to effecting change in the patient's physical and mental states as a function of *both* the method of treatment *and* the patient—practitioner relationship. While other models of understanding have been used to explain patient recovery rates, few offer interpretations of the importance of the patient—practitioner relationship. We describe, using our understanding of patient—practitioner interactions, how practitioners establish themselves as providers of *both* pain relief *and* changes in physical and emotional health.

Practitioners often claim to be frustrated because of the gaps in their understanding of feelings, emotions and relationships. Patients may appear at consultation with fear and worry about their conditions. Patient and practitioner 'dance' around each other, juggling their individual perspectives on the 'condition', its causes and treatment. Practitioners may concentrate on technical methods and techniques and ignore the emotional states of their patients. Practitioners understand pathology, physiology and diagnosis, but in many instances, presenting cases have strong psychological elements which require more than the application of techniques (Pincus et al., 2002), such as providing opportunities for patients to talk about their worries, face fears and gain confidence in their capacities for self-recovery. Poor outcomes, increased dissatisfaction, ethical problems and burnout are more likely to occur through ignoring patients' emotions and attending only to the technical aspects of their problems.

The awareness of potentially troublesome emotions between patient and practitioner — sometimes referred to as the transference and counter-transference — is vital to a holistic approach to healthcare (Field, 1989; Wiener and Sher, 1998). Transference and counter-transference are terms that describe feelings and behaviour that are present in most patient—practitioner relationships and have their origins with important people from the patient's past. Transference feelings towards the practitioner may include hope (that the practitioner will provide relief), distrust (that the practitioner will not provide relief), dependency (feelings of not being able to cope alone), fear (that the practitioner will reject the patient), eroticism (that the treatment will satisfy sexual needs). Counter-transference feelings are feelings aroused in the practitioner by the patient which are the counter-point of transference feelings — the practitioner experiencing feelings of hope, distrust, dependency, fear and eroticism that stem from the patient (Hinshelwood, 1997). The presence of counter-transference feelings in the practitioner can be used to identify what is troubling the patient.

Many psychological therapists understand that the body speaks in a language of its own. Joyce McDougall (1989) describes how patients who are accustomed to "*speaking through their bodies*" present enormous challenges to physicians, psychoanalysts and practitioners of physical therapies. Patients' physical distress is often disconnected from its emotional component; and they have no words to reconnect the two, even in the context of talking therapies. McDougall writes about patients who seem trapped in a primitive psychological merger with their mothers, which she calls '*one body for two*' — an useful concept in cases of certain alarming psychosomatic maladies that seem to serve mainly as confirming their owner's existence. Through the use of insight and gentle guidance, words are given to the body's messages and the pre-verbal trauma is addressed. Wiener (1994) writes that all patients '*talk with their bodies*' when they come to see practitioners in a 'language' that patients are 'asking' to be decoded and understood.

## Pain as a form of communication

*Pain as a form of communication* originates from the universal human condition of birth and infancy and their states of near-total dependency and vulnerability (Rayner, 1978, Pg. 33). Being in pain and being in the care of a therapist practitioner may elicit primitive fears. Childhood struggles against parental control can be a source of aggression, shame and scorn that come from self-consciousness of repeated failures of motor mastery. Failing to manage to do things in front of others often leads to feelings of shame, a wish to run away or getting cross (Rayner, 1978, Pg. 56). If laughed at over failure, deep hurt results that bears no physical damage, but is felt inwardly. This happens most with those we love most and the sense of a loving bond, with all its tender physical feelings, is savagely cut; we are dismissed or disowned and our self-esteem broken. It is as painful, often more so, than a physical wound. But