



# The Force of Gentle Therapy

Therapists should abandon the 'no pain-no gain' philosophy, which can often unnecessarily hurt patients

By Richard Fowler, PT

"GENTLE" IS NOT A WORD USUALLY associated with physical therapy, yet it is the first word in my private outpatient therapy practice, the Gentle Pain Release Center (GPRC), which specializes in treating patients with chronic pain.

Most of my patients have been treated by many other types of therapy including traditional PT, chiropractic, acupuncture, massage therapy and, of course, medications. Some have had surgery or injections. They come to the GPRC because they have not gotten satisfactory help for their pain.

Unfortunately, a high percentage of these patients report having been hurt and some even harmed by PT. "Hurt" means that their pain was made worse by PT. Often these patients were told, "It has to hurt to do well" or "It is going to get worse (hurt more) before it gets better." "Harmed" means that good surgeries were ruined by overly aggressive therapy or the patient's overall condition became worse as a result of therapy.

## Perceiving Pain Levels

While there often is pain during treatment at my clinic, it is "therapeutic pain" as opposed to "harmful" pain. It is not the pain itself that is therapeutic or harmful, but a certain quality of pain perceived that indicates to the patient something either therapeutic or harmful is occurring. We don't seem to have words in our language that adequately describe what I am trying to teach patients, so I use "therapeutic pain/harmful pain" or "good hurt/bad hurt."

A "good hurt/therapeutic pain" is quite tolerable, no more than discomfort, and sometimes the patient will say, "it hurts, but please don't stop." Patients should also sense that with the "good hurt" they will feel better or have less pain after treatment.

The patient knows that a "bad hurt/harmful sensation" will result in more pain after treatment. It is perceived as "real pain" and can be intense.

Further, this quality/quantity of pain can trigger a reflex defensive posture in the body that elicits a tightening rather than a relaxation of tissues. It just feeds into the vicious pain cycle with which we are so familiar.

Too often in PT we seem to ignore the harmful pain, pushing through it to increase motion, strength and function. Yet

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... patients' perspectives, if their pain is not improved, then they are not satisfied with the outcome. We need to be able to determine what degree of aggressiveness or gentleness is best for any given patient. This can be different for each patient each visit and for different areas of the body. In all cases we should do no harm.

### Consider Physiology

We need to consider tissue physiology and healing before we progress patients to vigorous and aggressive treatment. For example, with a shoulder sprain/strain in which tendons are involved as well as an inflamed capsule and bursa, there is heat, swelling and loss of motion. Aggressive stretching produces a quality and quantity of pain that increases after treatment as

well as exacerbating already injured and inflamed tissues. A gentler technique will help to preserve ROM, increase circulation and mobilize fluid, while allowing injured tissues to heal.

As therapists, we need to listen to tissue physiology instead of insurance companies in regard to healing time. There are many treatment techniques that achieve great results but do not inflict unnecessary pain.

I speak from experience as both a PT and a patient: I am healing quickly and relatively painlessly from shoulder surgery (rotator cuff repair and calcific deposition excision) six months ago using the gentle approaches of my clinic.

The patients with chronic pain used to be the ones who I did not know how to help. They are often labeled "bad patients" who don't do their home programs (because it makes their pain worse) or complain that therapy is hurting or just quit coming to therapy.

With these patients, I kept asking myself "What am I missing?" The first step is to stop hurting/harming our patients with overly aggressive treatment.

### GPRC Improvements

The Gentle Pain Release Center is achieving an average of 75 percent improvement

by the patients' determination in an average of 12 visits. This phenomenal outcome is with a population of patients who have been in chronic pain for many years and have been to a variety of clinicians prior to coming to us.

Our approach includes gentle hands-on therapy and lots of patient education. The overall philosophy of the GPRC is to: 1) get pain under control (under 5/10 using a 0-10 numeric pain scale); 2) increase movement and activities with pain under control; and 3) achieve maximum level of functioning with pain under control.

**We need to be able to determine what degree of aggressiveness or gentleness is best for any given patient. This can be different for each patient, each visit and for different areas of the body.**

The emphasis here is pain control. It is pain that usually brings the patient to us. From the patients' perspective, the pain is their first priority, then strength, motion and function. Keep in mind that we are in a customer-service business and need to tend to our patient's goals.

Applying the old philosophy of "it's got to hurt to do any good" won't work. These patients have almost all been through that approach with poor results.

### Primary Modalities

Myofascial Release (MFR) and craniosacral therapy (CST) are our primary treatment modalities along with a strong dose of patient education.

A lot of the patient education, especially in the early stages of treatment, is teaching patients how to control and treat their own pain. I also use Milligan techniques that require pain not be increased during treatment.

I especially like mobilization with movement (MWM) techniques that go through a previously painful ROM without pain. Strain-counterstrain/positional release eliminates tightness and tender points without being painful. These techniques are fast, effective and can often be taught to the patient.

With manual therapy, a certain pres-

sure will fit into the "good hurt/therapeutic sensation" while deeper pressure will create a "bad hurt/harmful sensation." Even with deep soft-tissue work, the pressure may be deep or light and different in different areas of the body in order to maintain "good hurt/therapeutic pain" sensation. This kind of discrimination makes the skilled professionals that we promote ourselves to be.

Admittedly, MFR and CST are very controversial treatments in the field of PT because they aren't scientifically based. Our results, an average of 75 percent

improvement in an average of 12 visits, are proof of the clinical efficacy of these treatments in actual practice. What makes MFR and CST especially controversial is that in them we

are taught to use intuition as well as knowledge of anatomy, physiology and good technique.

### Art of the Profession

The use of intuition is part of the "art" of our profession. We all use intuition whether we are conscious of it or not. We look into our patients' eyes and we know a lot about them and their present state. We hear the tone of their voice and read their body language. These tell us a lot and are not all considered scientific.

In a future article, I will address putting science into perspective in relation to therapy. Even though the modalities that we use at the GPRC are admittedly controversial in the atmosphere of evidence-based practice, our results are evidence of the efficacy of our methods.

I came to rely on these methods when more traditional methods did not work for this population of patients who are in chronic pain. ■

*Richard Fowler graduated from the University of Texas Medical Branch in 1970. He has worked in a variety of settings with the past 20 years in outpatient PT. In 1999, Fowler created the Gentle Pain Release Center and has expanded to three clinics that offer physical and occupational therapies in western North Carolina. Contact Fowler at [brpt@bellsouth.net](mailto:brpt@bellsouth.net).*