

Learning About Pain Management Post-Certification Training and Integration in a Rolfing® SI Practice

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Introduction

Over the years, many estimates have been made as to what percentage of clients seeks out Rolfing structural integration (SI) because of issues related directly to pain, and the answers range from 80% to 95%. I believe that there are very few, if any, Rolfers who have not intentionally worked to reduce a client's pain. My problem is that Rolfers are trained in Rolfing SI, and are not specifically trained to address the pain-management cases that will show up in their practices.

Obviously, it is impossible to complete an authentic Rolfing series without proper training. It is also impossible to render effective and reproducible pain-management treatment without proper training as well. If you have not been well trained in this particular domain, there is a significant possibility that you will make mistakes. The Rolf Institute® of Structural Integration (RISI) currently has over thirty teachers of Rolfing SI, yet no one teaches pain management specifically. This is something I have worked to redress, both in my own professional development, and in the work I do mentoring other Rolfers.

In Section I of this article, I will discuss how I came to where I am in my career, and how I have structured my trainings to assist other Rolfers in learning pain-management skills. I hope readers will see the possibility of determining their own paths through the maze of what is available in post-certification trainings. In Section II, I discuss elements to consider in having an integrated practice in Rolfing SI and pain management, and ways to best use these together. I attempt to present the case for how it is possible to help reduce the suffering in the world – a noble cause – from a well-educated, well-trained, and experienced platform. I also attempt to show how it is possible to integrate a traditional Rolfing practice, Basic or Advanced, with a practice in pain management as well. Your clients then will have a choice of the two: of you addressing their pain issues directly, or of getting Rolfing work. In my practice, it is often the case that after the pain issue is under control, the client may be interested in Rolfing sessions. S/he has experienced your touch, is familiar with you and your process, and is comfortable with both. You are in charge of your post-certification training and where it takes you and your client base.

Section I: Learning and Teaching

My Own Journey of Professional Development

Thirty years ago the Rolfing training was simple: you did your basic training, completed three six-day workshops, and then went on for your advanced training, because that was all that was available. The original five teachers that Dr. Rolf, trained passed on her edict that new Rolfers should do nothing but Rolfing SI for the first five years of their practice. Then it was time for your advanced training, and then you were done. Well, some of us were done.

After my advanced training the great split at the RISI occurred and I was disenchanted with both sides and took my studies elsewhere. I did some of Peter Levine's early trainings. John Upledger gave a class in 1981 to the RISI teaching staff and a few others, me included. Off and on during the mid 1980s I studied with Robert Fulford, D.O., training in the use of the percussive hammer/massager. In 1987, I trained with Jean-Pierre Barral at his first U.S. visceral manipulation class. I was certified by Mary Burmiester in Jin Shin Jytsu in 1983.

At the RISI annual meetings of 1985, 1988, and 1989, I presented papers and gave talks on a number of pain-management-related topics including: arthrogyrosis in children, soft-tissue management of acute pain, and chronic-pain management as it relates to Rolfing SI. I presented papers and lectured on sacroiliac dysfunction, treating musculoskeletal disorders, Rolfing SI and structural realignment and functional anatomy. All of these papers were based on work I did in my clinical setting. Over the course of my career I have shared office space with medical physicians, chiropractors, Rolfers, and massage therapists. All have taught me on many levels of being and learning.

I was elected chairman of the Southwest Regional Rolfers Association and traveled between Tucson, Phoenix, and Los Angeles for meetings from 1986 through 1991. These meetings allowed me to meet with other Rolfers, diversify my perspective, have the opportunity to learn new techniques, and enhance what I already had learned.

In the 1990s I studied pain management with a number doctors of medicine, osteopathy, chiropractic, psychology, and psychiatry. I joined and have maintained clinical membership in the American Back Society and the American Academy of Pain Management. I also have maintained membership in the American Board of Forensic Examiners since 1994. I did Gil Hedley's class on human dissection and assisted him teaching the same class at St. Regis College in Denver.

During this decade there were a number of SI practitioners in the Tucson area. Half a dozen of us took advantage of this opportunity and began meeting weekly, once again allowing me to meet with other SI workers, diversify my perspective, have the opportunity to learn new techniques, and improve what I already had.

In the 2000s I trained with the American Academy of Craniofacial Pain for motor vehicle collision-related injury diagnosis and testimony preparation. I took five ten-hour classes in the University of Arizona (UA) Mini-Medical School program covering a variety of health- and pain-related topics that included hands-on clinic work. I completed three eight-hour dissection classes of fresh cadaver knees and shoulders at the Department of Orthopedic Surgery at the UA Medical School.

My Approach to Teaching Pain-Management .

A full client load in my private practice has allowed me over the years to implement and practice what I learned in my diversified training and study program in pain management. In the 1990s I started mentoring newer Rolfers in pain management, usually for a week at a time. Some had more time and different commitments and would do an internship for a month to six weeks. Others would rent office space for longer periods of time and we would do case reviews, four-handed work, and assisted assessments when appropriate. Below I will discuss these approaches to professional development and what I seek to impart to mentees.

Preparation

Before starting any study of pain-management, there are some essential self-study components the practitioner should familiarize him/herself with:

1. Language of medical, osteopathic, and chiropractic physicians.
2. Images and their reports.
3. Common syndromes such as neurological entrapments, gait alterations, and postural deficits and anomalies.
4. "Red flags" in patient examinations.
5. Range-of-motion limits.

Formats

One approach I have used is a workshop training for a class of practitioners, a "hands-on approach" laid out in either a four- or six-day format. These are formulated to the needs and wishes of the individuals, but some things are common – elements that are aspects of any practice regardless of the practitioner's intended emphasis or practice focus:

1. Review of case history form with each new client.
2. Review charts of existing clients returning for further treatment prior to appointment.
3. Review changes in status with each existing client.
4. Review of images, image reports, and referral information.
5. Perform basic physical exam.
6. Assess the state of the client and his/her issues.

7. Application of appropriate treatment modalities utilizing algorithms and a self-teaching cycle.

For those doing longer mentoring or interning, I use a four- or six-week format that entails learning how to utilize and benefit from direct client treatment utilizing the following:

1. Diagnostic/treatment algorithms and protocols for common conditions.
2. Techniques specific to pain-management patient care with specific circumstances.
3. Thermal scanning.
4. General pain-management practice tools and techniques.
5. Practice enhancements, including: aspects and benefits of a computerized practice, establishing supply vendor accounts, appropriate exercise protocols, ergonomics and treatment-room equipment.

In this format an individual practitioner (who already has the foundational knowledge taught in workshops) works with me in my daily practice to take clients from initial interview to problem resolution in an onsite pain-management clinic setting. I also give these practitioners direct phone and email access for twelve months for case consultations and pain-management practice support.

Section II: An Integrated Practice in Rolwing SI and Pain Management

Once a Rolfer has learned effective pain-management skills, there is the work of integrating this into an existing practice of Ten-Series work, Post-Ten work, and Advanced work.

Identifying the Pain-Management Client

The majority of pain-management cases will reveal themselves through the basic intake procedure: case history, physical examination, and assessment. In the same way as our postural evaluations prior to a Ten Series guide us, pain-management work requires specific training in history-taking and assessment to enable the practitioner to determine first whether treatment is appropriate, and then the appropriate course of treatment. A number of questions should come to mind early in the relationship with a new or prospective client: Is s/he in the right office given the complaint(s). What are your objective findings? What differences between the objective and subjective come up and how are these differences rectified? All of these questions and considerations are part of the history and exam.

As the practitioner becomes more proficient s/he will ascertain that there are particular findings that lead to asking the client more detailed questions. Perhaps the client initially did not report pain, but upon examination and running through the protocols the practitioner determines that there are probably pain generators

that the client has adapted to. Maybe in running a low-back pain protocol you determine that the client has a pelvic torsion, which leads you to look at the sacroiliac joints, the pubic symphysis, and the lower lumbar vertebral units. Then, upon palpation, the client reports that “yes, in fact, there is pain where you are touching.”

In order for folks to live their lives, they have to adapt to low-back pain, headaches, and large assortment of other maladies. Living in pain is very draining. Living in pain without awareness can be very confusing. "I'm tired but don't know why" is often a complaint in these cases; so is weight gain, sexual dysfunction, and irritability. It builds trust in the process when as a practitioner you can proactively educate clients as to why they are not feeling as good as they could, when you can help them understand their pain, perhaps even before they are fully aware of it. Hope is built and the client is encouraged for, in some cases, the first time in a long time. The underlying belief is that if there is trust and hope then relief might follow. (Somebody say “Hallelujah!”)

Complementary Care

Some pain-management clients will be referred by other practitioners – allopathic or complementary – specifically for pain management. *The focus of a pain-management approach is complementary by design.* "Complementary" is a process where there is more of a “team” approach to client care. (In contrast, an "alternative" approach to care infers the idea “instead of.”) Most pain-management clients seek complementary treatment because traditional allopathic approaches generally addressed the symptoms and not the problems. An important service that the allopaths are able to provide is to rule out pathology. Once pathology has been ruled out, there is a greater probability that the pain generators in questions are biomechanical. These clients may have given up on allopathic care, or they may be seeking your work in addition to allopathic and/or other complementary care. In some cases, interaction with an attending physician (whether medical doctor or chiropractor) may be necessary to work with the client, particularly in third-party insurance cases that may require referral and diagnosis codes from an attending physician (medical doctor or chiropractor), as well as appropriately formatted SOAP notes. (Third-party payments will be the topic of a future article.)

A working understanding of appropriate health-care vernacular will help in these situations, and in reviewing the client's history and records to make treatment decisions. Given that the focus is on the care of the client, it is important to utilize all relevant information in assessing the client's needs, including allopathic diagnostic findings. We stand on the shoulders of those who have been trained to know different things than we know for the betterment of those in pain who seek our services.

If before the client presents at your office s/he has had an image taken – say a CAT scan or MRI – you can use that report and the client's case history to determine with a greater margin of safety whether it is or isn't appropriate to treat. For example, if the client's image report indicates an abdominal aortic aneurism, obviously the practitioner will decide not to relieve the client's abdominal discomfort with a traditional fifth-hour psoas approach, but with consideration still treat the client.

Treatment Considerations

One of the important aspects of addressing pain management in a Rolfing practice is *not to forget about Rolfing*. However, without specific training, a considerable amount of case and pain management is rendered through “incidental consequences” of doing something else. I call this “shot gunning,” where the practitioner attempts lots of things that s/he hopes might help, such as a random Fourth Hour of the Ten Series, without a specific plan; often these attempts include a collection of things that have worked in the past with other clients but may not be appropriate for the current clinical presentation.

In learning to work with pain management in a Rolfing SI context, consider these factors: The absence of pain will often lead to reduced postural aberrations. The absence of pain will often lead to a higher level of cognitive function. Higher cognitive function can lead to increased self-awareness, which can lead to better posture. Antalgic posture or gait is a function of seeking to reduce pain. Many clients have adapted their conscious awareness of their pain issues and unconsciously altered their posture and consequently their gait. Some of the pain is historical and adapted to somehow. Sometimes pain is very current and present but simply placed out of conscious awareness for a variety of reasons.

Given all of this, it is easy to understand the *importance of addressing both pain and posture* in working with these clients.

As for how to work, while the client is in the acute phase of suffering, sessions two to three times a week for the first two weeks with no specific Ten-Series work will often serve best. When s/he reports that suffering is noticeably reduced, and your objective findings corroborate, introducing early Ten-Series work seems to be in order. Interjecting Ten-Series sessions in sequence during a course of pain-management work is always prudent (see discussion below, and also "Four Chronic Pain Syndromes and the Basic Rolfing Series"1).

There is the potential for an ethical issue here commonly referred to as “bait and switch.” It is imperative that the practitioner not use pain treatment to lure the client in any way – into perhaps a more expensive treatment regime involving ten sessions of Rolfing – when all s/he came for was a nagging headache. The practitioner is the responsible party in the treatment room to make sure that there is no possibility whatsoever that this ruse could happen. Be careful to make it

very, very clear that these two components of your practice are separate and independent. You are in charge of how the aspects of your practice integrate and benefit your client base.

There are a number of treatment strategies that are appropriate for various stages of the reduction of suffering. Here are some examples of factors that affect the setting of a particular treatment strategy: the level of suffering that the client is experiencing, the objective projection of the progression of the client's given condition, finances, upcoming holidays and vacation schedules, etc.

The nature of the issue or issues addressed in pain management will determine the duration of your work with any given client. In some cases only a session or two of additional work may be needed to successfully achieve the goals of Roling and address the pain issue/s. Sometimes with chronic and intractable pain conditions, the ten-session series provides a framework on which to organize and format your pain-management work. I have clients whom I have treated for years and continue to treat to this day for intractable pain. They can't be fixed. I assist them through reducing their need for medication. I assist them by keeping them functional by helping them reformat gait and stance weekly as they deteriorate in their pathology. My hands-on work with active AIDS clients helped them when everyone else was afraid to touch them in their suffering.

The client and the practitioner will always be in dialogue as to the efficacy of the treatment strategy. You will adjust and adapt minute by minute, session by session, and week by week. It is a living working process. It is a relationship.

Ten-Series Work

I discuss different strategies for integrating pain-management work and the Ten Series in my publication "Four Chronic Pain Syndromes and the Basic Roling Series."¹ Above I discussed how I interject Roling Ten-Series sessions into a pain-management series. Here I will discuss how I interject pain-management sessions into a Ten Series. Knowing when each strategy is appropriate depends on a multiplicity of factors, some of which I have already mentioned. It is a subject beyond the scope of this paper, best covered in a training setting.

It might be commonly assumed that good places to bring in pain-management work in the Ten Series are after the third and after the seventh sessions, because these are points where the designed intention changes. However, I more commonly break to interject pain-management work after the second and sixth sessions of the series because of a different take on the same reasoning, as follows. We are changing intention and the course of focus after sessions three and seven of the series: after "three" the focus becomes more one of the intrinsic musculature and the muscles of balance and organ support; after seven, the focus becomes more integrative. Accordingly, before closing down one aspect of the work, I want to have completed what is necessary at that stage.

Thus, I would want to complete more superficial issues *before* closing that first phase with session three of the series. If the pain-management work needed is going to take more than the time allowed in a given session, I find it often works well to interject additional sessions between the traditional second and third sessions of the Ten Series. Likewise I will add pain-management sessions after the traditional sixth session, so that the seventh session closes that phase of work. With sessions three and seven having some integrative aspects/findings, the Rolfing series work and the aspects of the pain-management work fit together with more ease.

Post-Ten and Advanced Work

Work in pain management after the Ten Series needs to have two primary characteristics other than pain reduction:

- The work needs to be able to stand by itself. That is, the clock should not have to be taken apart to find out the time. (I remember one of the early Rolfing instructors had the reputation of taking Rolfers apart in their sessions with him to the point that it would take days if not weeks before they could function well again.)
- The work must not take away from the integrity that has been established in the Ten Series.

In an Advanced Series, specifically tailored sequences of sessions for individual issues such as whiplash, post-surgical recovery and complications, and post-partum issues set up for the most efficacious treatment plan.

Rolfers trained in pain management can treat patients outside the Ten Series with the specific intention of reducing patients' pain and/or need for pain medications. When following the basic protocol training that I teach, you will have formats for evaluation, screening for appropriateness to treatment, and for appropriate treatment itself. In those cases where pain management is the primary issue, you may work solely in pain management until pain management is no longer the primary issue and structural integrity moves to the forefront. There is often a period or periods where you will have to go back and forth between these two approaches to achieve your case goals. Sometimes the case falls into a special category such as third-party payments, which will be discussed in a future article.

Conclusion

It is my wish that those addressing pain issues in their clients do so from a very educated and, eventually, a very experienced position. You have been well trained to bring your clients and their structures up to a higher level of

functioning. You have helped them get out of the way of their own evolution. I want Rolfers who so choose, to be equally well trained in pain management, to give clients hope that something significant can be done to reduce their pain and suffering and to enhance the quality of their daily lives. Toward this end, I would like the RISI to offer two types of advanced training: one in SI, like it offers currently, and another a certification in pain management. I believe that Dr. Rolf's dictum is appropriate – Rolfers should first learn how to practice Rolfing SI. Her idea, I understand, was for newly certified practitioner to do nothing but Rolfing SI for five years. (Jan Sultan told me this many times.) After that, practitioners would have a better idea of what Rolfing SI was and the potential for change that was inherent in the process. And after five years, enough questions have come up in your practice to make you very curious.

In satisfying that curiosity, some practitioners may lean toward finding a higher level of order in structure and learning how to establish that in their clients, while others may lean toward focusing on intentionally reducing pain in suffering in a way that no other discipline can possibly approach, for what sets us apart from the rest is our understanding of order and function and – singularly – our ability to establish that order out of chaos as only Rolfers can do.

Endnotes

1. **Cox, Clay**, "Four Chronic Pain Syndromes and the Basic Rolfing Series." Private publication, 1989.

Clay Cox Bibliography

- 2010** "Common Peripheral Nerve Entrapments and Syndromes." Boulder, CO: *Structural Integration: The Journal of the Rolf Institute*, Vol.38, No. 1.
- 2009** "Temporomandibular Joint Dysfunction: Overview, Diagnosis & Treatment," Third Revision. Missoula, MT: *IASI 2009 Yearbook of Structural Integration*.
- 2008** "Temporomandibular Joint Dysfunction: Overview, Diagnosis & Treatment," revised edition. Boulder, CO: *Structural Integration: The Journal of the Rolf Institute*, Vol.36, No. 4.
- 2002** "Low Back Pain and Dysfunction." Boulder, CO: *Structural Integration: The Journal of the Rolf Institute*, Vol. 30, No.3.
- 2001** "Temporomandibular Joint Dysfunction: Overveiw, Diagnosis & Treatment." Boulder, CO: *Structural Integration: The Journal of the Rolf Institute*, Vol. 29, No. 3.

2000 "Contra-indicacao do Rolfing para Pacientes com Cancer." *Rolfing Brasil*, ano 1 numero 4, Novembro 2000.

1989 "Four Chronic Pain Syndromes and the Basic Rolfing Series." Private publication.

1988 "Soft Tissue Management of Acute Physical Trauma." Boulder, CO: Rolf Institute. Private publication.