

# Somatic dissatisfaction - Somatic dysfunction and the role of intention in treatment

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## Current scope of osteopathic practice

Experience through such global organizations as the Osteopathic International Alliance, which now has 62 members,<sup>1</sup> and the interest of the World Health Organization,<sup>2</sup> which recently published Benchmarks for Training in Osteopathy, highlight the diversity in expressions of osteopathic practice globally. Osteopathic principles and methods have diversified principally along three streams. In the United States, the scope of practice was largely self-defined by A.T. Still and his students as they progressively attained full medical practice rights in each state.<sup>3</sup> Probably due to language affinity, Osteopathy spread from America to the British Isles as early as 1898, stimulated by J.M. Littlejohn's speeches before the Society of Science Letters and Arts.

Due to differences in the politics of healthcare systems, British Osteopathy has developed with distinctive differences to the U.S. osteopathic physician model.<sup>4</sup> In the United Kingdom, the Osteopaths Act of 1993 finally regulated, but did not define, Osteopathy or scope of practice.<sup>5</sup> A third stream developed at a later date, as students of William Sutherland introduced Osteopathy in the Cranial Field as the fundamental method of osteopathic practice.<sup>6</sup> Besides this geographic proliferation, diversity has been amplified by particular individuals formulating models and establishing schools in an unregulated environment, as well as variation in scope of practice and definition of what it is that osteopaths or osteopathic physicians do.

## What role is the role of somatic dysfunction? What level of function is primary?

In the founding days of osteopathic medicine, American practitioners conceptualized the osteopathic lesion<sup>7</sup> Since the mid-1960s, Osteopathy and osteopathic medicine have identified correction of somatic dysfunction as the primary intent of treatment. The official U.S. definition is cited in the footnote below.<sup>8</sup> The history and use of this term, a construct developed to describe a broad range of anatomical considerations, were reviewed in a previous article.<sup>9</sup> That article suggested revisiting this aspect of osteopathic terminology to reconcile the

definition with the progressive diversity of how osteopathic practitioners currently describe the focus of their intention in treatment. As more DOs begin to circulate globally in the osteopathic community, these divisions become more apparent, and some legitimate work appears beyond the scope of the glossary definition of somatic dysfunction.

A partial list of models of osteopathic approaches, each emphasizing different parameters defining dysfunction but vying for prominence, would include the following: muscle energy, high velocity, functional methods, visceral, counterstrain, myofascial, cranial Osteopathy, biodynamic approach, bioenergetic approach and the fluidic approach. To this could be added the notable differences in trends between groups of practitioners within different countries and regions. Sometimes the divisions are reduced to the distinction between biomechanical versus functional approaches. Also, I see an emerging common trend in newer models along the dimension of *subtlety*. How does the definition of somatic dysfunction relate to these variations, especially as we move into the subtle domain?

An additional dimension of this complexity involves the often anxious relationship between osteopathic and conventional medicine. The very use of the *somatic dysfunction* reflects the inadvertent influence of medicine and its bond to conventional bioscience. It presents a representational bias toward comprehension and manipulation through categorization—in this case, grouping findings as a diagnosis. Following a scientific revolution in Germany, resulting in the Flexner Report in the U.S., social and intellectual pressures have influenced all branches of health care to incorporate the scientific method without reflecting on its basic premises.

Science, in this sense, has a bias toward only recognizing materially tangible, reproducible and measureable discrete entities (things or categories of things) and processes. The implication is that for scientific and medical purposes, if something cannot be measured by a detached, external observer it does not exist. Osteopathy, through the generational efforts of Denslow, Korr, Patterson and others had attempted to define mechanisms responsible for the experience of dysfunction. In so doing, osteopathic

clinical experience would be scientifically validated. The term “somatic dysfunction” and its implications have been elaborated around this scientific model.

Yet biological science has continued to evolve. Currently, the definition of body function is progressively viewed as a complex, dynamic, interactive system, rather than as an assemblage of component parts providing coordinated localized function. Correspondingly, in cognitive science (the discipline evolving from neuroscience) there has been a successive series of paradigm shifts in addressing its own scope of study.<sup>10,11</sup> Most recently, the relationship between knowing and physiology has been reformulated in terms of what is called the “hard question,” namely, the neurophysiological basis for the mind or consciousness.

The evolution has progressed from the cognitivist (emphasis on representational conceptual objects) to a connectivist (emphasis on synchronous, rhythmic, interrelated processes) perspective, now trending toward appreciating the mind and body as a sensate/locomotory system to be understood as a complex dynamically interactive system.<sup>10,12</sup> In this context, the relationship of mind and brain has provided a contested, yet illustrative discussion.<sup>13</sup> Yet, the mind is recognized as an active component of the functional biology of the person. Intention and action are linked.

Certainly this development is highly pertinent to the osteopathic principle of the importance of the reciprocal relationship between structure and function, and the parallel emphasis on “seeing the whole person.”<sup>14</sup> If we, as practitioners, are such a system, what is the new understanding of the relationship between our observation, perception, analysis, intention and manipulation?

Also, following these developments, does the mind or experiential perspective of the patient play a legitimate part in defining our work? If so, these trends would suggest expanding the definition of somatic dysfunction beyond identification of discrete, localized structures to consideration of dysfunction as a multi-component, dynamic process, including the mind, even a relational encounter between two such mind-body systems. Who observes, who judges? Does this influence which actual criteria constitute clinically relevant dysfunction? Is there a subjective element to the “dys” aspect of dysfunction based on expectations?

### **Psychological component of dysfunction- Refining mind**

This concept—that psychological or mental factors play a role in osteopathic practice—should not be new. Dr. Still himself defined Osteopathy as the science of mind, matter, and motion.<sup>15</sup> But how does this translate

operationally in contemporary osteopathic practice? Following a longstanding trend in medicine, osteopathic literature recognizes certain psychosomatic influences on health.<sup>16</sup> Additionally, experienced practitioners recognize the importance of the patient’s psychological orientation in weighing the complaint and assessing the significance of physical findings. If the patient is perceived as a complex, dynamically interactive system, what role does the mind play, and how do we integrate this component into diagnosis and treatment? Currently, this discussion and the component of mind have no recognition in the current definition of dysfunction. It is treated as an outlier, or the concern of atypical practitioners, such as the late Robert Fulford.<sup>17</sup> Yet, pain itself is a subjective experience.

Neurocognitive developments such as those cited above, would suggest expanding our response, especially to complaints of pain, beyond the identification of discrete, localized somatic dysfunction to a consideration of dysfunction as multi-component process, including the patient’s cognitive and affective state. This would expand the parameters included in history taking and goal setting, and validate some of the subtle methods that already factor in these considerations intuitively.

The current article introduces a reflection on the cognitive or experiential aspect of the patient-oriented dimension in this discussion of the scope of osteopathic practice and its potential relevance to the term *somatic dysfunction*. Should elements from the patient’s perspective be included in a definition of the problems we treat? To continue this inquiry, let us reflect on why patients, in the contemporary healthcare environment, seek our help for specific osteopathic care.

### **It all starts with the complaint**

Although not so commonly stressed, osteopathic treatment is directed toward functional improvement reflected in symptomatic relief. Otherwise, patients would not present themselves for treatment initially. Ultimately, the patient, in light of their expectations, is the judge.

Ascertaining the complaint or symptoms constitutes the beginning of a medical inquiry. “I hurt”, or its equivalent, is a common starting point. Descriptions of symptoms can be startlingly creative and varied. Other times, they can be mundanely the same, as is the example of back pain. The task of discerning a cause is referred to as developing a differential diagnosis, then determining a primary cause. However, this paradigm presumes a standard use of terminology and the correspondence of this terminology to a consistent physical or physiological standard.

The field of medical anthropology proposes the biopsychosocial model of patient care, recognizing the need to view a patient's presentation within an appropriate understanding of cultural context.<sup>18</sup> Although most obvious when the practitioner and patient come from diverse cultural backgrounds, this theme represents an essential dimension of interpersonal communication. Certainly language and customs vary between cultures, and this heavily colors the meaning of a complaint, as well as acceptance of the suggested treatment. The more divergent or distant the cultures, the more apparent the issue. In the exchange, the physician's role is termed *cultural competence*. B.L. Worff,<sup>19</sup> in his classical comparisons between Anglo-American language and culture and that of Native American cultures, reveals startling differences, not only in terms of vocabulary, but more strikingly, in terms of how a person can vary their definition of time or space in structuring a whole world. In less extreme cases, individuals from the same locale can have drastically different childhood experiences, educational opportunities, as well as current economic circumstances. Expectations of normal versus abnormal, as well as conceptual appreciation and semantic expression of the same physical process, can vary greatly and influence the occasion and manner of expressing a symptom. These dynamics are not usually verbal, and are therefore usually not addressed by a conventional, rational and analytic diagnostic approach.

### **A phenomenological perspective on perception**

Phenomenologist Maurice Merleau-Ponty (MMP), in approaching knowing as a product of perception, recognized that these same potential differences exist between individuals, even in the same culture.<sup>20</sup> He attributed this to being part of the human condition and the nature of seeing and knowing. Perception of an object is an interactive process in which our mind encounters an external stimulus through the medium of our physical senses. But it is our mind, directed by our expectation to action, which configures these sensations as we interpret the experience as an object. This way of understanding perception is not the common or natural attitude toward knowledge.

The value of MMP's contribution to this discussion is that, although his thoughts are dated at fifty plus years, he initiated a dialogue between physiology, psychology/psychoanalysis and experiential philosophy that has continued into the present in the mind/brain/body debate in cognitive science. Mind/brain/body–body/mind/spirit; I hope the reader can see the significance to osteopathic thought.

We commonly presume that we are accurate external observers in an intact pre-existing world and our knowledge is purely representational, with a clear correspondence to external "reality." We see things. Although physiologically complex, our sight, for example, then acts as a biological camera focused on external objects. MMP challenges the representational model with the riddle of the classical printed illusions, in which perceived interpretation may be confused or distorted compared to physical measurement.

MMP proposes that our primary and reliable orientation to the world is from our experiential vantage point, our being in the world. Perception is interactive, and our "world" is defined largely by our experience with manipulating it; perception is colored by our intentions or expectations in relation to our actions. He extends this discussion to our relationships to our bodies, which are never purely an external object that we observe and from which we can step away.

Our experience of our bodies, both as a patient and as a palpating practitioner, are always a mix of what has classically been called objective or representational and subjective or experiential data. The fact that we develop a steady state of function and expectation that we perceive as normal is the development of what MMP calls the "habit-body" reflecting a consistency in perception of the body, presuming a consistency in function. In MMP's approach, this challenge to objectivity is not catastrophic, but only an explicitation of the process of perception essential in human experience. All perception is experiential, not representational. The representational model of the world is a socially contractual construct mediated by language. It is necessary, but also limited. Phenomenological knowledge is simply raw experience, not put through this secondary analytic filter.

Both ways of knowing are functional, each with its own limitations. Let me use an analogy. We travel. Looking at the weather forecast and the thermometer—conceptualized data—allows us to plan, to choose clothing. Our felt sense, in the moment, of temperature, humidity, sunny/cloudy allows us to adjust, to button up or take off a jacket. The analytic and phenomenological ways of knowing complement each other.

The process of perception is similar if we are patients, practitioners, or even research bioscientists. This mix of objective and subjective ways in which the patient, in our current focus, perceives and presents their body state is much more fluid than is generally acknowledged in medical or osteopathic history taking and diagnosis. And so, if included, this would temper, in an osteopathic context, the

full scope of what we deal with in the patient who presents with a desire for change in function due to frustrated expectations. In this case, we may summarize the clinical problem, without trivializing it, as one of somatic dissatisfaction.

One of the confounders of osteopathic research is the issue of inter-rater reliability in assessing physical finding.<sup>21,22</sup> The osteopathic community is not alone. It becomes progressively evident that the problem is not simply standardization; variation in assessment is intrinsic to human perception.

### **Specific examples of relevance**

MMP presents several classic clinical examples in which there is a mismatch between physiology of a patient and their self-perceived state, or habit-body. The examples given include cases of anosognosia, male sexual frigidity and of phantom limb pain. In each of these situations, there is a lack of correspondence between the patient's perceived/expressed state of their well being and that considered to be the desired, both experientially *and* representationally (compared to medical texts). Based on a review of the diversity of osteopathic approaches, especially the contrast between biomechanical approaches and more subtle models, it is probable that diversity stems from a lack of distinction between these two starting points in the osteopathic encounter—the experiential and the representational. They are presumed, sometimes erroneously, to correspond.

### **A solution - an inclusive refocusing of treatment goals**

Biomechanical osteopathy presents an effective model in many instances. Application of the principles of using manual intervention to engage the anatomy to facilitate function is the common approach. Certainly the transition from patient dissatisfaction to satisfaction often does correspond to a parallel process of our assessing dysfunction (asymmetry, restriction of motion, tenderness) and facilitating return to normal function. On the experiential side, in the cultural context of Europe and the U.S., a verbal description of a representational model of dysfunction would have an additional effect on patient satisfaction. For a patient with cognitive orientation to science and scientifically derived medicine, such a description would be culturally correct in conveying attention, professional competence, containment of the problem and therefore freedom from further worry. Home exercise engenders a sense of control or empowerment.

However, there are many instances in which there is an apparent mismatch between our objective findings and the patient's initial complaint, or consistent complaint once

anatomic symmetry and free motion are restored. There is the chronic patient, as well as the patient with a major psychological component of the original stressor or residual strain. I am thinking of cases of post-traumatic stress, concomitant anxiety and depression, and chronic pain.

Additionally, the patient's sense of things not being right may not have reached the conscious, cognitive level in the patient. And so, other parameters of the osteopathic encounter, if included, could meet a patient's experiential needs of dys-ease or dissatisfaction. As appropriate, these might include competently engendering trust and evidencing competency, attention and consideration in handling the body.

Variety subcultures within Osteopathy recognize and confront these cases. The bioenergetic, subtle cranial and biodynamic models of osteopathic approach recognize and accommodate these circumstances. They demonstrate that resolution of issues related to the unity of body, mind and spirit is not a peripheral issue; it is an essential element of the osteopathic patient encounter. Sometimes listening on the verbal, as well as non-verbal level as suggested by Upledger, Fulford or Tricot completes the history.<sup>23, 24</sup> Conscious, verbal reinterpretation of a patient's way of viewing their dissatisfaction may sometimes be appropriate, but there are also indirect methods of "going there." Nuancing application of force, expressing compassionate touch or operational kindness are also treatment options requiring intentional, sensitive attention to subtle relationships.

However, the psychology and physiology of this experiential side is yet to be well articulated in the mainstream of osteopathic practice, let alone bioscience. The field of cognitive science may be taking us further in that direction. If addressed, this phenomenological lens may broaden the foundation of understanding within the profession and help re-establish common ground between divergent models and groups. Additionally, it may direct us regarding where to put our effort in advancing our individual expertise.

### **Summary**

The diversity of osteopathic practice is due in large part to the accumulation, over time, of the experiences of advanced practitioners who then teach their approach. In order to validate itself, the osteopathic profession continually tries to reconcile itself with conventional bioscience. This article suggests that there is much value in this, but unless the profession recognizes the limits of the scientific approach in engaging the complex, interactive, dynamic system which describes our patients and ourselves

we will not recognize the full nature of osteopathic contact. In light of this, the definition and scope of what we treat—currently embodied in the definition of somatic dysfunction—should best be revisited.

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**Footnote:** Somatic dysfunction: Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodiagonal and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: 1) the position of a body part as determined by palpation and referenced to its adjacent defined structure; 2) the directions in which motion is freer; and 3) the directions in which motion is restricted.

See also T.A.R.T. See also S.T.A.R. (Tissue texture abnormality, asymmetry of motion, restriction of motion, tenderness).

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## CME QUIZ

The purpose of the quiz found on page 48 is to provide a convenient means of self-assessment for your reading of the scientific content in “Somatic dissatisfaction - Somatic dysfunction and the role of intention in treatment” by Zachary J. Comeaux, DO, FAAO.

Please answer each question listed. The correct answers will be published in the December 2012 issue of the *The AAO Journal*.

To apply for Category 2-B CME credit, record your answers to the *AAOJ* CME quiz application form answer sheet on page 48. The AAO will note that you submitted the form, and will forward your results to the AOA Division of CME for documentation. You must score a 70 percent or higher on the quiz in order to receive CME credit.