Bowen for patients who have Joint Hypermobility Syndrome

Isobel Knight MSc. Dip. BTAA.

There are very broadly two categories of patients; one where they come for Bowen with a few health problems, but overall they are quite straight forwards and because there is 'less' for the body to work through, they tend to recover and respond quickly. Another group of patients attend with a very long and often complicated history and for whom the 'less is more' adage is particularly apt because the body is working through many more layers of problems. Patients with the Joint Hypermobility Syndrome (JHS) tend to fall in the latter group.

JHS is a poorly diagnosed condition with only one in twenty being correctly diagnosed (Grahame, 2009). JHS is an inherited, multisystemic connective tissue disorder, causing systemic tissue laxity caused by resultant faulty collagen throughout the body (Grahame, 2003). Research shows that JHS is also a gender-dominant condition and is predominant in females (Raff & Byers, 1996 & Simpson, 2006) and more common within African and Asian populations than the Caucasian population (Grahame, 2003; Russek, 1999 & Simpson, 2006). It is also known that hypermobility declines with age, hence it is sometimes necessary to ask adult patients to reflect on their youth, because if they could achieve challenging body postures or exhibit what might be defined as being double-jointed in the past, they might still have JHS (Bird, 2005; Raff & Byers, 1996).

Patients with JHS often look healthy and well and might be dismissed by some health professionals because they have an excessive range of joint movement. Hypermobility can be described as having an excessive range of movement (ROM) in any given joint, above and beyond what would be considered the normal Gaussian range (Grahame, 2003; Grahame, 2009; Nijs, 2005; Simmonds & Keer, 2007). An observed hypermobile joint might look inside out for example, as shown in Figure 1, and a joint that is passively hyper-extended in excess of 10° when measured with a goniometre, - in Figure 2 - would be considered hypermobile (Grahame, 2003).

Figure 1: A Hypermobile elbow joint **Figure 2: Measuring a hypermobile joint**

JHS is ultimately diagnosed by a consultant Rheumatologist, but diagnosis can be determined by use of the Beighton Score (see Table 1). A score of 4+ would give a positive score for generalised hypermobility, but it is the Brighton Criteria that defines whether a patient has Joint Hypermobility Syndrome. It is perfectly possible to be hypermobile and asymptomatic. The syndrome is diagnosed in accordance with the Brighton Criteria which assesses for joint pain, dislocations, subluxations, skin stretchiness, and short-sightedness which are all features of JHS. However it is the symptomatic element and pain which distinguishes a patient with JHS. A crucial aspect of the Brighton Criteria is that an element of joint pain or soft tissue rheumatism forms part of both the major and minor criteria, so injury could therefore be a determining factor in fulfilling the criteria for many JHS patients (Keer, 2003).

Table 1: The Beighton Score

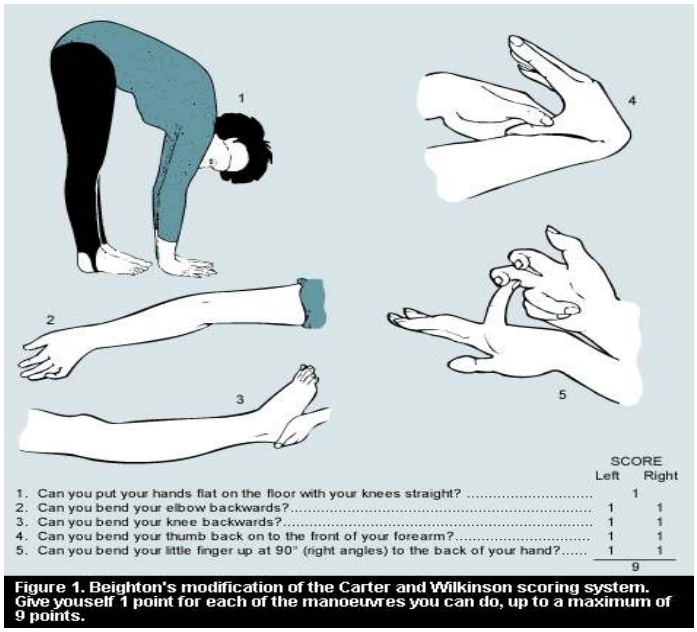

Figure 1. Beighton's modification of the Carter and Wilkinson scoring system. Give youself 1 point for each of the manoeuvres you can do, up to a maximum of 9 points.

The Brighton Criteria looks at the body in a diverse way – including questions on skin-stretchiness because in JHS we are considering widespread faulty collagens and collagens are found throughout the body including the skin, gut wall and lungs (Grahame, 2003; Bird, 2007). Once we begin to understand the holistic nature of collagen (it occurs everywhere in the body) it starts to become apparent that hypermobility is not simply about joints with an extra range of movement, but that it affects the body systemically. Research is increasingly linking the symptoms and syndrome with a whole range of other medical conditions such as IBS, asthma, anxiety and fatigue (Grahame, 2009; Bird, 2007). In addition, there is a further hormonal link for women when there is a natural rise in progesterone during the menstrual cycle which can increase tissue laxity and therefore corresponding symptoms (Bird, 2005, Bird, 2007).

When we are faced with a patient who has a particularly long history which in the case of a JHS patient is likely to include widespread injury and soft-tissue trauma, we absolutely have to rely on the brilliance of Bowen and the body to truly prioritise the most urgent healing need. This is an absolute case in check of thinking outside the box and critically a case of 'less is more'. The JHS patient often suffers from chronic fatigue and fibromyalgic tender points. They are often working twice as hard as non-hypermobile patients just to attempt to stabilise their very wide range of movement and chaotic joint patterns which regularly include dislocation-related injuries (Grahame, 2003). They are very often highly sensitive to touch and can be highly responsive, if not hyper-reactive to tiny amounts of Bowen. This group of patients fits in with those with autoimmune disorders e.g. chronic fatigue, ME, MS (Armstrong, 2004; Wilks, 2007).

As Bowen Therapists we don't diagnose, but if observed, a patient who (after reading this article) you suspect is hypermobile or has a complicated medical history – just look at the way they move and stand. Hypermobile people often 'hang' into their joints, particularly those with 'swayback knees.' They often gesture a lot with their hands and arms and some may appear more anxious than other client groups, and research is beginning to show a genetic link with JHS and anxiety (Martin-Santos, Bulbena, Porta, Gago, Molina & Duro, 1998). When observed standing, hypermobile people will often show a systemic instability, and they will find it hard to stand for too long. This group of patients are often poor sleepers and are likely to be fatigued, regularly in pain and have low energy scores. This group of patients are also more likely to be uncomfortable on the couch, fidget when they are lying

down and seem to be more easily startled. Their sympathetic nervous system seems more heightened or hyper-stimulated. They might need greater reassurance about the need for the breaks in Bowen, and regularly check their comfort throughout a treatment as they are also more likely to suffer from changes to autonomic function. For example, fluctuations in pulse rate and body temperature (Armstrong, 2004; Wilks, 2007). These patients are also more likely to experience dizziness and feeling light-headed as they are 'sat up' at the end of treatment (Armstrong, 2004, Wilks, 2007).

Bowen will be highly beneficial for this patient-group, providing they do not get overloaded and suffer a detrimental post-Bowen over-reaction. In my experience of working with this particularly group of patients, they find that Bowen helps with:

- Improved energy levels and sleep
- Feeling calmer
- 'My IBS improved'
- Less pain overall
- An improved ability to function and cope overall

There is a high prevalence of hypermobility in the dance and performing arts sector, probably because of the desirability of flexibility and an ability to produce interesting body postures. (Desfor, 2003; Mc Cormack, Briggs, Hakim & Grahame, 2004). One JHS dancer said that her hips feel much more secure after Bowen and this improves her control in classical ballet classes. The same dancer says that Bowen has helped with shin-splints, another common problem in dancers and patients with JHS.

One of the difficulties for therapists working with JHS patients are that one is often 'chasing' injuries throughout the body. To clarify this further, one injury/problem area might improve, and the next session something else will have become a problem, and by the third session you might be back to the original pain/problem area again. It is difficult to rationalise other than the condition is so complex and the chaos and joint laxity is so widespread that the body is going to only manage to work on bits at a time, coupled with the fact this group of patients is highly injurious, and re-injury is a very common problem. As a therapist it is important to

accept this and keep looking at the positive outcome of treatment and reassure the patient accordingly.

Palpably the tissues in the JHS patient are likely to be soft and boggy, even in the well-toned. They are the ones with very 'boggy' lats, but equally they are also likely to have some incredibly stiff areas in the body – very often the neck and upper back are very tight in this group. It often works that a stiff segment of the spine will follow a very hypermobile area (Bird, 2007). When doing the pelvic procedure, or knee procedure, be very careful and gentle and support the knee joints of those with swayback knees. As a patient it can feel really unnerving if they knees are not held and supported well when the legs are lowered in the 'Pelvic and Knee Procedures'. Equally be aware overall that the joints will often click and pop in this group – e.g. 'TMJ'.

Another problem encountered with this group is muscle spasms. This group are likely to regularly endure muscle spasms and cramp, and it seems to be associated with the condition. They are the ones that just very occasionally require the 'Back Cramp procedure' or may say they feel sharp and sudden pain when you return in the room following the two-minute break. Reassure them that this will pass and this seems to be sufficient, and the pain often passes. If in any doubt, and the body is still processing something, leave longer breaks!

The article will conclude with reflection upon my experience of learning Bowen and finding learning and memorising the sequences of the Bowen moves particularly challenging. Further research about JHS revealed it was indeed related to conditions such as dyspraxia and general coordination and memory sequencing problems (Adib and colleagues, 2005; Jaffe and colleagues, 1988; Kirby, Davies & Bryant, 2005; Kirby & Davies, 2007). Sensing moves was more difficult, and this all ties in with joint proprioception which is very often impaired in patients with JHS. In other words, it is difficult for them to sense end range of movement and be aware of where their bodies and joints are in space (Ferrell, 2009; Hall, Ferrell, Sturrock, Hamblen & Baxendale, 1995). This is particularly important for instructors to be aware of for those who have hypermobile fingers and thumbs as it will be much more difficult for them to sense the pressure and tissue tension required to perform a good and effective Bowen move. The best way to support the student is to try and avoid them going into their end range of movement in their fingers. They might need to do specific remedial and rehabilitation

exercises as many hypermobile people have to do in order to strengthen and support their large range of movement (Simmonds & Keer, 2007).

Bowen has helped me enormously as a patient with JHS, but it has turned me into an even better therapist, very much helped by having an instructor (Nicola Hok) who works gently, makes the practitioner think outside the box and constantly reinforces the importance of 'less is more'. My advice to newer therapists when they are faced with patients with a complicated history and multiple problems, as is common in the JHS patient, and patient with autoimmune disorders in general (Wilks, 2007) is to do very little work because the patient will benefit enormously and remember that the body always prioritises, and adapts. The healing flexibility of the body could never be truer than in the hypermobile patient!

Isobel Knight
May 2010 ©

References:

Adib, N., Davies, R., Grahame, R., Woo, P. & Murray, K. (2005). Joint hypermobility syndrome in childhood – a not so benign disorder? *Rheumatology, 44*, 744-750.

Armstrong, D. (2004). Non-musculoskeletal symptoms in joint hypermobility syndrome. Indirect evidence of autonomic dysfunction. *Rheumatology, 43,* 1194-1195.

Bird. H. (2007). Joint Hypermobility. *Musculoskeletal Care, 5(1)*, 4-19.

Bird, H. (2005). Joint hypermobility in children. *Rheumatology, 44,* 703-704.

Desfor, F. (2003). Assessing hypermobility in dancers. *Journal of Dance Science & Medicine, 7(1),* 17-22.

Grahame, R. (2009). Hypermobility: an important but often neglected area within rheumatology. *Hypermobility Syndrome Association News, Spring*, 4-5.

Grahame, R. & Hakim, A. (2008). Hypermobility. *Current Opinion in Rheumatology, 20,* 106-110.

Grahame, R. (2003) hypermobility and hypermobility syndrome. In: Keer R, Grahame G. *Hypermobility Syndrome – recognition and management for physiotherapists*. Philadelphia, PA: Elsevier; 2003, pp.1-15.
Hakim, A. & Grahame, R. (2004). Non-musculoskeletal symptoms in joint hypermobility syndrome. Indirect evidence of autonomic dysfunction. *Rheumatology, 43*, 1194-5.

Hagan, A. & Hausenblas, H. (2003). The relationship between exercise dependence symptoms and perfectionism. *American Journal of Health Studies, 18(2/3)*, 133-137.

Hall, M., Ferrell, W., Sturrock, R., Hamblen, D. & Baxendale, R. (1995). The effect of the hypermobility syndrome on knee joint proprioception. British *Journal of Rheumatology, 34*, 121-125.

Jaffe, M., Tirosh, E., Cohen, A. & Taub, Y. (1988). Joint mobility and motor development. *Archives of Disease in Childhood, 63*, 158-161.

Keer, R. physiotherapy assessment of the hypermobile adult. In: Keer R, Grahame G. *Hypermobility Syndrome – recognition and management for physiotherapists*. Philadelphia, PA: Elsevier. pp.67-86.

Kirby, A., Davies, R. (2007). Developmental coordination disorder and joint hypermobility syndrome – overlapping disorders? Implications for research and clinical practice. *Child Care Health Development, 33(5)*, 513-519.

Kirby, A., Davies, R., Bryant, A. (2005). Hypermobility syndrome and developmental coordination disorder: similarities and features. *International Journal of Therapy and Rehabilitation, 12(10*), 431-437.

Martin-Santos, R., Bulbena, A., Porta, M., Gago, J., Molina, L. & Duro, J. (1998). Association between joint hypermobility syndrome and panic disorder. *American Journal of Psychiatry, 155(11*), 1578-1583.

McCormack, M., Briggs, J., Hakim, A., Grahame, R. (2004). Joint laxity and the benign joint hypermobility syndrome in student and professional ballet dancers. *Journal of Rheumatology, 31(1),* 173-178.

Nijs, J. (2005). Generalized joint hypermobility: An issue in fibromyalgia and chronic fatigue. *Journal of Bodywork & Movement Therapies, 9*, 310-317.

Raff, M. & Byers, P. (1996). Joint hypermobility syndromes. *Current Opinion in Rheumatology, 8,* 459-466.

Russek, L. (1999). Hypermobility syndrome. *Physical Therapy, 79(6).* 591-599.

Simmonds, J. & Keer, R. (2007). Hypermobility and the hypermobility syndrome. *Manual Therapy, 12(4),* 298-309.

Simpson, M. (2006). Benign joint hypermobility syndrome: evaluation, diagnosis and management. *Journal of American Osteopath Association, 106(9)*, 531-536.

Wilks, J. (2007). *The Bowen technique – the inside story*. Dorset UK: CYMA Ltd.