Wolf Mehling: Hands-on medicine

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For better or worse, this transcript retains the spontaneous, spoken-language quality of the podcast conversation.

Serge Prengel: I'm with Wolf Mehling. Hi Wolf.

Wolf Mehling: Hi Serge.

S P: You're a medical doctor and a lot of your work is about pain and maybe the psychosomatic part of it. What brought you there?

W M: I think the main drive was my own back pain. When I was 27 and on the way to becoming an internist, internal medicine doctor, in Germany, I had so much back pain that everybody wanted to do surgery on me and I just couldn't believe that at age 27 I would have to be crippled in a way by surgery. As a student of medicine, I had to learn Wilhelm Reich and I remembered all this psychological stuff that they had developed in the 30's, some of which was related to muscle tension, for example. I felt like this back pain has something to do with the muscle. And at that time I looked for somebody that could help me other than just surgery. And this was at age 27. Commercial medicine had a lot of issues that at that time, this was in the early 70's, beta-blocker was the big thing for the heart and they made advertisements saying, "We know how heart attacks happen. It's all from stress; therefore, you have to take beta-blockers." I was so upset. No one questions how can you get rid of stress in a different way or don't feel stress? Everybody thought about pills and so I was frustrated with medicine in that respect and had my own back pain. That sort of started me on a search and I looked for some biogenic people and I went for Eutony, that's something that's not very well known here. It's Gerda Alexander from Denmark and it's a system through which I found a person who does breath work and that's where I got into the system the most at that time. As a young doctor, I was kind of blown away by how they could do this with their hands, working on my back and how come I noticed that the therapist is mentally present or is somewhat absent-minded. I felt that through my hand. How does a medically-trained person understand that or explain that? That was sort of a starting point and then I had a crisis in my medical career and I was thinking maybe I should do massage. And then I actually learned in

Germany it's a different system, it's similar to what chiropractors do, so the majority call it "manual medicine" and that is becoming a generic term for this process or "manual therapy." Manual therapists are all totally mechanical. I actually had a title in Germany, you can do a subspecialty, it was in family medicine, it's four year training, and it's a subspecialty in manual medicine so you can teach these people and another subspecialty for psychotherapy. So in Germany I have a title of psychotherapy too. It's such a long training so it's been parallel to your work, so you do courses and you have to pass exams and stuff like that.

S P: Yeah. I find myself touched as I hear the story of how it's coming from a sense of healing the pain and dealing with the pain that is potentially crippling, where essentially society diagnoses it as something that has to make you a sort of cripple and looking for support emotionally in a way physically, practically, but also emotionally in seeing that other people have a different conception of it and looking for a breath of fresh air and finding it in a way, among other things, that is something about breathing.

W M: Yeah, very much so. I don't know if you know this woman named Isla Middendorf she's in some sort of dissonance body-oriented psychotherapy. For example, George Downing, I don't know if you've heard of him, he would not consider Middendorf breath work as psychotherapy because they say we don't actually need to cognitively work up all the emotions that have logical issues, so it's not necessary to verbalize everything that happens. They say that breath therapy is neither psychotherapy nor somatic therapy, actually we have something third. As a psychosomatically-interested physician, I would say this works right as an interface between the two; it's not just either psychotherapy or… no, it doesn't follow this dichotomy.

S P: For your own work, where would you position yourself in the spectrum?

W M: Well, my background is, and I cannot really give that up, as a medical doctor and I see patients coming with suffering symptoms that they look for understanding through the physician's approach. So primarily they want to have a biomechanical explanation, a kind of physical explanation for the pain. But I can best deal with patients who are open-minded enough to also see that there is a relationship in their lifestyle to this story; they have a history that comes before the pain started and that there's some psychological aspect to that pain at least. At least, in the course of the pain and how they perceive it.

S P: Right. In a way, the population, or the way you engage people, is a little different from the way psychotherapists engage people. People don't come to you for a psychological component; they come to you for a pain component.

W M: When I worked at the University here, I had a clinic, I saw patients at the clinic. And those patients often had seen all their primary care doctors, orthopedist specialists, surgeons, or neurosurgeons, all these kinds of therapists. Then they come and want to hear another opinion from somebody. The center that I am working at is called the Center for Integrative Medicine and they may read on the website, ok this is a guy who's looking psychosomatically at pain and has a hands-on approach. So I have 30-60 minutes with patients. I frame my approach under the subject of manual medicine. So I offer myself as a medical service provider, as a physician, that's why I make a lot of manual medicine, not just manual therapy. They come to me also expecting that I have neurological determination skills and understand the entire language that physicians speak, when they discuss with patients surgical options, for example, or non-surgical options, so I have that

medical background to understand surgeries. I've seen them do it, assisted in those surgeries, as a physician you can do that, though I understand a little broader than most physicians what medical options are. When they don't want to surgery, for example, they come to me.

S P: Right. In a way, that's an alternative to surgery, the idea that manual medicine… Say, people you see, you see them for, the session lasts for 50 or 60 minutes, is there a course of treatment where you seem them for many sessions? And is the course of treatment mostly something that you do with manual medicine or is there also some talk and some cognitive aspect to it?

W M: Yeah, actually, I try to pick the patient up where they are, so it's very different. Some patients are referred by other physicians, who know about our clinic or me, some come out of their own motivation, some are expecting me to do a spinal manipulation and this breaks through their problem and then they're done. And some come to me knowing that nothing works, you know, "What do you have to offer?" And then I say, "Let's examine you first, here's the story. Maybe I can help you, maybe I can try to help you, maybe I cannot help you at all." Some patients come with years of narcotic medications and already had surgery and then I say, "I don't have enough time, certainly not enough hours per week, and I'm already booked pretty much until the summer. In order for you to get any improvement, you should go to a good body worker, a physical therapist, I can give you some names, but that's not what I can do really." And some people I can say, "Ok, let's do three sessions, see where we get, revaluate," and if they are willing to wait, for example, for two months or so, before we can set regular appointments once a week or so. I see some patients, over years once a week and I see some patients just sporadically, every four months once. It varies a lot; it varies depending on their stories. Some patients need to get into their body, just to feel their body and not be manually manipulated, and some people benefit a lot from touch, and some other people need to reframe their thinking. Now, it depends on the person. Talking with you I am aware that I have a whole spectrum of options and people fall in different places in that spectrum.

S P: I think any of us, if we were asked, in a way, would have that same saying of "we behave differently with different people, we have a whole spectrum," and so it feels nice to have that acknowledged and in the case of your practice, yeah. So what would be a good way to get a sense of, a flavor of, how you work? I understand that you work very differently with different people in different situations. Could we just take maybe a case that would give us some sense of one of the ways that you approach things?

W M: Yeah, as an example, there's a guy coming in, he's 84 and has had 40 years of hip pain. He's about to go to another orthopedist or another shot at his hip joint. Nothing has helped so far, he's had a boursectomy, there's a bourse on the side of the hip that could cause lots of pain and he has seen all the best surgeons in town. He himself is a professor of history, runs a big company at one of these learning universities in which you can enroll and get a degree on the Internet. He's a very smart guy, but not that young anymore, he's in his 80's, a totally different generation guy, from the days of my father. I say, "You're funny, you've been in 40 years of pain, what do you think I can do?" I examine him and find what they call, in the physical therapy world, a "trigger point." Within the muscle it's a defined, local section of the muscle, that when you put your finger on it and press on it, it causes a radiating pain, moving away from the site of the pressure to space in your body that's kind of distant to that. It produces the pain experience that he is coming for. In this case, it was the tensor fascia lata, it's the muscle on the side of the leg, that seemed to be, in this case, the main source of pain. Some people call this a muscle that causes a pain that's almost the same as a bourseis, a boursa surgery, which hasn't helped him. This professor comes very casually. I have him

lay down, I have a student with me, who's following me and the kind of medicine we do. I have the leg on the side, and as he's already an older guy, he has had some experience in how to relax. So he knows how, in the face of pain, how he can relax. He's closing his eyes, focusing somewhat on his breathing, not distracting himself with thoughts, feeling what's happening, and quieting his mind down. He's an educated guy, he can relax without me coaching him much. I push in a way that other people would do on the trigger point and have him create a feedback circle with me, where I say, "Where do you feel that pain? Where does it really occur?" asking him questions that he can not really answer by mental activities, he has to focus on the pain itself to answer that question. He has to go to perception, away from thinking, in order to keep the conversation going with me. I have him focus on that pain, to see the pain and get details about the pain. One of the details is that they perceive the pain in an internal space; the body is an internal space. There's the external space, where the five senses are, and then there's the inner sense of the body perceptions, the neurology, proprioception or interception. People can realize this, if you put it in the right words that feeling on the inside is feeling to an inner space, where in this inner space the pain goes. They try to be more specific and more detailed. That's why I'm doing this with him, in this dialogue form. All of a sudden, he starts to do jerky movements. He was laying on his side, with both knees bent forward a little bit, like an embryo laying there. All of a sudden, he jerks his body and I thought, "What's going on here? Is that a seizure or something like that?" He's fully awake and I ask him if it's ok if I keep doing it like that while you're doing those movements. He says it's ok.

It's like an exploration that we do together. He keeps jerking and I notice that the tension of the muscle, that I've been pushing with my fingers, it's a manual touch, softens under my fingers. I have a perception of muscle release under my fingers. Then I'm doing this, for more than 30 years now, it's a training-acquired skill of perception into muscles. When I started in the beginning, I didn't feel anything. This other guy started to show me, "Feel it now. Is it different?" Now I can notice the muscle tension slowly melt in front of my hands. That's not something that you can do with tools, you have to really use your own hands for that. The guy relaxes and says, "My pain is 50% less." It didn't go away. Then he goes home and it's the first night that he can sleep thoroughly for 1 ½ years. He comes back a few days later, a week or two later, and he reports how he had slept and everything. I say, "Ok, let's keep doing it. I thought that you having this for 40 years, we can't do anything, but it looks like there is an action, there is an approach." We do it again, he jerks again, and what I would ask him, that's the problem, he's 85 and a man of that generation, going through a divorce and everything. I ask him, "Is there any emotion associated with this jerk? Do you feel anything but the mechanicality of that jerking?" He says, "No, I don't feel anything, just the jerks." I inquire a little longer and he says, "Well, the pain started when I became a professor 40 years back at Ohio State University." He didn't know anybody in this town. He was a lonely professor there starting out. After work, he would run everyday. My idea was that he was running to kind of self-medicate his loneliness or whatever. I asked the student what her perception was as an outsider when she saw this guy jerking there, after she overcame the idea that it might be a seizure. I asked her, "What does it look like?" and she said, "It looks like a crying baby." I felt the same, he looked like a little kid in front of me, who's lonely, helpless, and doesn't know what to do. Maybe he was running like crazy to get away from his lonely feelings at that time, but this topic we could not talk about. He was not open to open up the can of worms of his life and his emotional stories. This case I stayed as a mechanical therapist. I had all these ideas that were not just mine, because my students had the same perceptions. I thought it was very intriguing to see how muscle can relapse after 40 years and make a significant change in his pain perception.

S P: Right. That's a very, very beautiful example and maybe we can talk a little bit more about it. No, no, it's beautiful because as you point out it's not that you don't do it ever, but in this case you didn't. And even thought you didn't, the not doing it was informed by your own awareness of psychological factors and keeping the question in your mind very much.

W M: If this guy wouldn't have been so busy, he would have a little more time to come back and do regular visits. We could maybe get closer to reframing this physical understanding of his pain.

S P: In a way, the first thing that strikes me, is that even though you did not talk about emotions, it was very present. I wanted to maybe slow down a little bit and point out some of the things that you said about what happened and the session. I think, one is that you were talking about, in a way, about something that happened in the beginning naturally for him because he had some training in it, which you would have otherwise down, which is a sense of getting him into more of a relaxation mode.

W M: Yeah, one of the main things about people coming with pain is that I'm not able to focus on their own pain. They say, "Doctor, can you look at my pain?" They have a default system that is helpful for acute pain, but dejects them from pain. They don't really focus attention on their pain perception. They have ruminating thoughts about it and have kind of a mental access to their pain, the pain interrupts their daily activities, it's a nuisance that they're somehow forced to focus, against their will, because they don't really want to. They have a hard time relaxing in the face of pain. I'm trying to help them to be present with pain, there's a moment of awareness in their pain perception and relax at the same time. That's the biggest challenge for a patient.

S P: Yes, what struck when you were talking about it was how to make it possible for them to be present with their pain is there is the part of relaxing and then there is the part where you continuously direct your attention to the perception, the interception, the proprioception, the inner space—the sensation of pain as opposed to the story they tell themselves about the pain.

W M: Those stories are coming up of course, it's what body works does when you touch. It reminds of Wilhelm Reich, that's why he did it, that's why he used touch. Touch stimulates memories or to have a traumatic or whatever history emerge in consciousness for these people out of the unconscious. People all of a sudden have memories from years back when they walked down the street and there were other kids from their class making fun of them. They come to me for certain pain problems and every time I work on their pain with them, painful memories come to their minds and they finally tell me about it. "Wow, it's so strange, I never thought about this. It's been 20 years." Or they remember how they walked down the schoolyard stairs and realized, "Oh Jesus, it's not just play, school, and work…" This memory comes up and I work on their subtle neck tension. So stories come up of course. Some people just want to talk about these things. Psychotherapists are also happy showing up this topic and then working through it cognitively. I am not that interested in that. I love their stories and I love their richness that comes up, it colors their experiences tremendously. My focus is more back into staying present within their bodies, rather than in the story. Not the narratives around the symptoms, my goal or direction that I'm going in, is more their capability of staying present in their body at the moment.

S P: What I'm hearing in staying in the present, is not so much avoiding the story of, in a sense of the story created the original pain, but I think when you're talking about the relaxing with the pain, is about being able to go directly to feeling the pain as opposed to mechanisms that are avoiding

dealing with the sensation of pain. You're directing people to go, "Where exactly in the body do you feel the pain? What does it feel like?" and not avoiding it.

W M: Exactly, just the opposite of avoidance.

S P: What you were describing in this story of this patient was that as you held him to feel his pain as opposed to avoiding it or talking about it or feeling around it, then came something that was this jerking movement that was a discharge of some sort and felt like…

W M: I felt somewhat comfortable doing that because of prior experiences with body work. If I wouldn't have had that, I would have shied away from letting that happen; I would try to avoid those kinds of things. Physicians are kind of shocked when they see that going on, "What the heck is going on here?" They don't want to get into those kind of things. And I thought, "Well, if he's comfortable with this happening, let's go for it."

S P: Yes, and it was exemplified by the student who was there who felt there was something terrible happening. But you made room for it because on the whole you felt it's not something to be afraid of, it's something that is organically completing what this person needs to be doing. As it was going on, at some instinctual level, both you and your student had a sense that…it gave you a sense of a crying baby. There was also, something where there was a connection with some kind of a meaning that it had or some kind of a completion of something he needed to do.

W M: And the result was 50% less pain. This is pretty striking.

S P: That's very striking.

W M: You can feel it under your thumb. It's not just perceptual one-sided, on the side of the patient. What I'm emphasizing is the work I'm doing. I use my hands a lot. I don't always push on the pain, sometimes I just have my hands somewhere in order to allow the tension to be located in the body in a certain area, for example, lower back pain. They all have the problem that they approach the back pain from the top, from the head down, and don't feel their legs very well or their buttocks, underneath the back pain. I mean underneath in terms of the standing person, it's lower and closer to the ground. You're not connecting to the ground. So I try to guide their attention to sensations so they feel the pain, the leg only as pain. They don't feel presence- that there's some connection to the ground that they still also have. I try to guide them into their body's areas where they can feel and be present there: a present awareness of immediate realization-like experiences, how they feel it. I then notice, for example, that the feet get warm. They were cold first and they notice that themselves. There are objective changes and it's part of the dialogue that I'm creating. I involve them mentally and I give them questions that hooks them. They're aware of or their attention goes around in circles in their thinking and they get out of it. Psychologists call this rumination. That's a psychological factor for complication of pain or for the persistence or prognosis of pain. That's something that you can change immediately. You can get them, in a clinic session, out of the illumination, and into a present moment of awareness. That's why the hands are extremely helpful. Touch has the additional advantage of finding the tension. If two people focus attention on a certain part and they meet to get it they have contact in that space, inside your body, where the whole thing is screaming, in a way, for attention. You meet that, it's a support for the attention. That's why touch is so powerful. If they only think about this and you guide them then you can feel a certain area into their body and they get into their thoughts and they're out of it. Continuing touch and

really focusing it, it's kind of like a red string, leveling the string to get there. So keep the present moment present.

S P: You had a very striking image. Earlier you talked about the pain, the part of the body that's screaming for attention and that you are helping the patient bring present moment awareness to that part. You're not a tool, you're not a machine, but there's a very strong sense of you being aware, moment-by-moment, of your pressure and the reaction of the muscle.

W M: I like to be myself in the present moment awareness. Actually, my issue is that I'm a thinker myself, I'm not easily present with my body. Right now, I'm talking to you and not present in my body. But using my hands has helped me to become present myself. I'm actually using patients, in a way, for my own limitations. It happens together then, it's very wonderful.

S P: That's also a very nice touch, in a way, a very nice point to make. It's not that mindfulness or present moment awareness is something that is an essential quality that defines people that they have it or don't have it, but it's a practice.

W M: Oh yeah, it's something that happens. The term "practice" suggests somehow that you can make it or do it. In some ways, yes, you've got to do it, but you also have to let it happen. It's more emergence and arising than doing. But you've got to approach it and you've got to focus a little differently than just thinking and talking on the phone.

S P: Yeah, so as we're coming toward the end of this conversation, maybe one way I could think of concluding it would be to talk a little bit about body awareness.

W M: Yes my research. I got an NIH grant for developing a self-report measure on body awareness. I'm applying for another grant now, to get an objective measure, a performance measure, of breath awareness, which is totally something. Well, it has been used in some way for asthma research, but people never applied that for body awareness type of stuff. My interest is, I think that the common denominator of many of these approaches, a common mediator in the beneficial effects of these types of these techniques is training or increasing the facilitation of people being in certain modes of body awareness. Body awareness is a term that has been around in medicine only under the association of hypervigilence, hypochondriacs, and fear and anxiety disorders, panic disorders. People are aware of body symptoms, they see the doctor, and are an annoyance to the doctor because the doctor says, "Well, they are crazy. They're anxious," and they give them sedative drugs or something. That's how body awareness has commonly been used, if it was used at all.

S P: Yeah, it's a problem. It's a problem that has to be cured.

W M: It's a problem, exactly. It's close to anxiety; it's a proxy for anxiety. They use scales for how many of those symptoms and how often do you feel them. They go through a list of 80 symptoms or something. The more symptoms you feel, the more anxious you are. Then you get to this cutoff, and after this cutoff, you've got to do therapy or medication. It's used as a proxy for anxiety. But the people who do body works or body psychotherapy, they, in their own lingo, use that term "body awareness" among themselves and use self-awareness to try to distinguish the body from the self. They have some problems with the nomenclature there. But in general, if you would say the body is not separate from the mind or soul, you frame it, focusing on body sensations. You can talk about body awareness with these people and yoga or tai-chi, focusing, for example, as a psychotherapy

form, sensory awareness, all these therapies; they all use more or less a common denominator: they talk about body awareness. It's different how they incorporate that into cognitive work or psychology. I think there is a common denominator with the body awareness, that's why I try to emphasize that. I try to create a bridge, also in terminology and in language, between the medical world and the world that uses body awareness, even massage. There are qualitative studies that show that one of the benefits after massage, it's not only educational, but the moment after the massage, you feel more in your body as well as people who go running, as in workout. In my philosophical understanding is that in our culture today, we go into computers and virtual reality, movies, lots of mental thinking, and therefore lose touch with our body. The trend for getting a massage once a month or going to yoga classes or having yoga as the biggest practice these days or tai-chi, that there's an unconscious trend for emerging. People say, "There's something missing if I just sit at the computer all day." That's what the body demands in a way. I think that's a wonderful trend. I'm trying to support research into these methods, for example, what kind of benefits come about. The medical community needs to know what the mechanism of action is. They don't understand why yoga is helpful. The mechanisms of action are scientific terms: "How does it work?" I'm proposing increased body awareness. "What is body awareness and how do you measure that?" Nobody can measure that, so medical science, if you want to make a point there, it's not sufficient just to do medical studies, yoga, it helps, but you also have to help physicians in getting their mind around it. "Why does it happen? What are they really doing?" The neuroscientists come along with the term "interoception" and meditation research. They talk about interoception and part of what is going on when you meditate. Putting these things together, trying to use the language from neuroscience and applying that to stuff that happens in yoga, for example, or body psychotherapy; I'm just doing studies on breath work. I think the perception of breathing is one of the most beautiful and fascinating aspects within body awareness. That's my goal: to help move this along. I'm dedicated to my group there.

S P: Thanks Wolf.

W M: You're welcome.

This conversation was transcribed by Vanessa Watorek.