

Clients' experiences of frozen shoulder and its treatment with Bowen technique

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Bowen technique (BT) is a therapy that uses a light, non-invasive pressure applied to specific and prescribed locations throughout the body to trigger the body's own self-healing powers. Frozen shoulder is a painful condition associated with a reduced range of motion in the affected shoulder that is often resistant to conventional treatment. Within this paper, the qualitative findings from a larger study are presented and 20 participants' experiences of BT, their comparisons with other interventions, and their satisfaction with the therapy are explored. Overwhelmingly, BT was experienced as being gentle, relaxing and non-invasive and of help with significantly eliminating and improving the symptoms associated with frozen shoulder. © 2002 Elsevier Science Ltd. All rights reserved.



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practice is based on his original technique and approach. There is much anecdotal evidence, from Bowen teachers, practitioners and clients, that BT is successful, although there is very little peer-reviewed literature. Carter (2001) was the first published research study into BT. Rentsch and Rentsch (1997) describe BT as a:

...dynamic system of muscle and connective tissue therapy..... [which] balances the body to allow it to heal itself. The technique uses positive moves that initiate a positive energy flow and negative moves that isolate this energy to a specific area.

A single treatment for a client consists of a specific sequence of moves, which the therapist applies using their fingers and thumbs. Only a light, non-invasive pressure is utilized and the moves are applied over the client's muscles, tendons, nerves and fascia. The moves are applied to specific and prescribed locations throughout the body, depending on which body system or which body part is to be affected. The therapist feels the level of tissue tension beneath their fingers and thumbs and this guides them in determining the level of pressure to use and when to perform a move to release the build-up of stress. Between the moves the therapist moves away from the client (and often actually leaves the room) to allow the body to respond. BT aims to use the minimum number of moves and procedures to trigger the body's own self-healing powers. BT adopts a 'less is more' approach to

INTRODUCTION

Bowen technique

Tom Bowen developed the therapy known as Bowen technique (BT) in Australia and current

healing. Minnery (2001) a leading practitioner and teacher in the United Kingdom states that despite less pressure being applied and fewer moves being undertaken in sessions with clients with poor or acute health problems, the effects can be profound.

As with other BT treatments, the 'frozen shoulder procedure' has a carefully documented BT protocol for practitioners to follow ensuring that each practitioner, using a pure technique, undertakes the same moves. The treatment for frozen shoulder is repeated 7 days after the initial treatment, and then a period of 28 days must then elapse before repeating the cycle. This regime of 7 and 28 days between treatments is continued as necessary, although anecdotal evidence suggests that ongoing treatment (beyond three sessions) is rarely necessary (Minnery 2001).

Frozen shoulder

The term 'frozen shoulder' is one that is often used as a catch-all label for any type of painful and stiff shoulder. It is sometimes used interchangeably with the term 'acute capsulitis' although this diagnosis can only be achieved after radiological and other diagnostic investigations (Stam 1994). Various categorizations of frozen shoulder appear in the literature with Nash and Hazleman (1989) defining frozen shoulder in two categories:

- primary frozen shoulder (unknown aetiology) and
- secondary frozen shoulder (associated with an injury or another disorder).

Incidence figures range from 1:50 annually (Lundberg 1969) to 7–25 per 1000 GP consultations (van der Heijden et al. 1997) with most clients being cared for in the community (Croft et al. 1996). A precise diagnosis of the cause of shoulder pain is very problematic (Bamji 1998) and even within the conventional literature on assessment and treatment this creates problems in assessing the value of treatments for shoulder pain (Szebenyi & Dieppe 1998). This lack of consensus in relation to diagnosis is an issue that appears to limit many studies and causes post-publication critique (Alvado et al. 2001). Despite this debate, there are well-accepted criteria that can be used in the primary care setting (Pearsall & Speer 1998).

Clients' typical experience of frozen shoulder starts with 'a pattern of pain followed by a loss of motion' (Boyie Walkder et al. 1997). The pain is often vague, generalized and it is often referred down the forearm. The limitation of movement is often accompanied by hyperaesthesia. Some clients will also experience hyperalgesia. The main problem experienced, once the pain has

eased, is functional disability (Stam 1994). Alongside the pain and loss of function, clients often experience problems with sleeping, other physical functioning problems and psychological symptoms (Croft et al. 1996). Some authors describe frozen shoulder as a self-limiting condition (albeit with a protracted recovery period) (Reeves 1975) although others propose that episodes are not isolated and previous history influences new episodes (Croft et al. 1996).

Interestingly, the treatment of frozen shoulder is diverse (Noël et al. 2000) and there is no single best-evidenced approach. Within the literature clients are reported to respond (to a greater or lesser degree) to NSAIDs and corticosteroid injections (Bulgen et al. 1984, Bonafede et al. 1987), physiotherapy and exercise (Wadsworth 1986), manipulation under anaesthesia (Kivimäki & Pohjolainen 2001), suprascapular nerve block (Wassef 1992), hydraulic distension (Halverson & Maas 2002), operative management (Ozaki 1996), arthroscopic release (Ogilvie-Harris et al. 1995), electroacupuncture (Lin et al. 1994), and education and stretching (O'Kane et al. 1999). Despite the diversity of the interventions, they almost universally require prolonged treatment. Best evidence is difficult to ascertain as the literature is full of conflicting (Anton 1993) or inconclusive (van der Heijden et al. 1997) results or do not suggest any significant differences between differing treatments (Rizk et al. 1991). Slow healing and recovery naturally occurs within about 12–24 months (Rizk et al. 1991).

METHODS

The intention of this study was to evaluate BT in the treatment of frozen shoulder. A mixed method, case study (Stake 1995) approach was adopted. The target population was all clients, who met the inclusion/exclusion criteria (see Table 1) and who presented to the participating therapists during the period of the study. The study was given ethical approval by the Local Research Ethics Committee and the usual safeguards in respect of confidentiality and anonymity were adhered to throughout the study.

Quantitative data were generated in relation to physical functioning, range of motion, levels of pain experienced, past medical history and specific shoulder pain history through specially developed consultation sheets, self-report pain diaries and self-complete questionnaires. Qualitative data were generated in relation to individual clients' experiences of BT and their responsiveness, or otherwise, to the therapy through audio-taped, semi-structured interviews during and after completion of the treatment. Two therapists were involved in the study, their practice was reviewed and any potential

Table 1 Criteria for inclusion in the study

- 1 Client should meet the criteria for frozen shoulder as proposed by Pearsall and Speer (1998):
 - clinical history of worsening painful shoulder
 - motion loss of at least 1 month duration
 - physical examination documenting painful, restricted shoulder motion
- 2 Client should freely consent to participate in the research
- 3 Clients should be aged 18 years or over
- 4 Clients should not be experiencing any major mental health problem
- 5 Clients should not have received any other physical treatment modality such as physiotherapy, cortisone injections, trans-cutaneous electrical nerve stimulation (TENS), heat or cold therapy for 3 months prior to commencement of Bowen therapy

discrepancies discussed and eliminated. The therapists were involved in some aspects of data generation and collection but were primarily delivering the therapy. The outcomes of the quantitative element of the study have been reported elsewhere (Carter 2001). This article focuses primarily on the interview data.

RESULTS

The interviews were fully transcribed, and entered into Atlas.ti© and subjected to thematic analysis. Analysis of each case (participant) was undertaken and then comparison across cases was undertaken.

BACKGROUND DEMOGRAPHIC DATA

Twenty participants were recruited to the study (10 male, 10 female). Seventy five percent of the participants were aged over 50 years. Fifteen participants were right-handed and five were left-handed. Twelve participants were experiencing symptoms in their right shoulder and eight in their left. Overall 15 participants felt that their health was either very good or excellent, with five stating it was either fair or poor. Six participants had a medical condition that contributed to their overall feelings towards their health status. However, during the interviews these participants stated that the frozen shoulder was causing the most significant health impact at the time of presentation for treatment.

Clients' experiences of living with frozen shoulder

Most clients had experienced reduced range of motion in the affected shoulder for as long as they had had the pain, although for some their shoulder gradually froze. Most participants had moderate restriction. The participants' descriptions of how their frozen shoulder presented,

reflected a typical clinical history scenario, for example:

I'm not *even* terribly conscious about when it happened. The only thing I can think of originally is that I did knock my arm one day at work, but it went away and there wasn't much after that. It was only maybe a few weeks after that I began to find my shoulder getting really, really sore and having difficulty in lifting my arm. Well, it gradually just got worse and worse. Eventually it was really extremely painful. I went to the doctors a few times and they said 'Oh, just take painkillers.' And that was basically what I was just doing for quite a long time.

Participants were experiencing a range of symptoms on presentation to the therapists; many were experiencing a constellation of pain-related symptoms. The worse the reported pain, the more symptoms reported by the participants. Many participants reported the problems of night-time pain, for example: '...the pain is really quite excruciating when I go to bed...' and

At night particularly, if I lay on it and turned over it would wake me up and I'd give a little yelp of pain, annoy the wife, roll over again I spent the night spinning round.

The median 'worse' pre-therapy pain intensity score reported was 7 and the mean intensity was 7 (on a 0–10 pain intensity scale). The intensity scores reflect one objective measure of the participants' pain. However, the interviews revealed their pain experiences in more detail and demonstrated the suffering and depth of pain experienced, for example.

In my particular case it gave really violent pain to the point of not being able to concentrate on anything else. You could see blue mists and feel as if though you needed to flake out with it.

Many of the participants had reached a point of desperation in relation to their pain and reduced mobility, for example:

Sometimes it was really almost unbearable.

Especially when it was going down into my arm and right into my hand.

With the pain I had I would'a done anything! If he [therapist] had a jumped on ma back and that had cured it, I'd a been quite happy....

Despite the severity of their pain, most clients were very reluctant to take medication despite the toll that pain took on them, 'I don't like to take painkillers unless it gets beyond what I can suffer for the whole day.' Six participants also had associated symptoms of headache and/or dizziness and/or nausea. These symptoms were associated with the most severe episodes of pain and were not experienced as a matter of routine.

Pain and reduced mobility in their shoulder impacted on participants' activities such as bowling, gardening, playing with their grandchildren and shopping. Many had modified their activities to accommodate the disabling effect of their frozen shoulder, for example:

I could'na work at all well, I could'na work with my tools the way I usually did... I had to know my limits... It was hard to work but I had to... It was there all the time through the day... and through the night too... I could'na do the things I wanted to do, it was very frustrating... I could'na lift anything above waist level at all...

Others noted the emotional impact for example, 'It made me more moody and lose my temper with people.. my family definitely noticed a difference, I was more snappy ..'

Previous experience and initial attitudes to BT

None of the participants had received BT prior to their recruitment to the study. Their initial feelings about BT were wide ranging. Some felt neutral about the therapy and some welcomed the therapy as they had been reassured that it was 'gentle and non-invasive'. Other participants felt a high degree of scepticism about its likely efficacy.

I was quite surprised because I was quite sceptical when I started, especially when he [therapist] hardly did anything... The treatment was practically nothing and I thought, 'Oh, I don't know about this!' I couldn't believe it.. It helped me quite a lot I'm reasonably open minded, but extremely sceptical. I suppose it's the same sort of scepticism that might apply to acupuncture or something like that... You can't really see how the hell it's suppose to achieve anything – but give it a try because anything would be better than the status quo. I suppose it was fairly substantial scepticism [at the start of therapy].

Those who had experienced a long history of frozen shoulder had all had previous experience of physiotherapy treatment and some had received cortisone injections. Participants expressed their dissatisfaction with physiotherapy as their experiences, generally, had been characterized by a lack of improvement in their symptoms, increased pain during the treatment episodes, and a lack of support and advice in relation to the accompanying exercises. Gener-

ally, they were reluctant to consider cortisone injections as a possibility for future treatment as the effects were short-lived, as one participant stated:

So they [doctors] said 'We can give you, rather than you taking painkillers all the time. ... We'll try a steroid injection'. So they did – a steroid injection into the joint. That gave me a bit of relief for a while, but not for any sustained length of time – maybe about three to five weeks perhaps... And it just gradually got worse and worse. And then it was much the same again. So then they put me onto physio and I had 6 months of physiotherapy which really didn't have a great lot of effect either. Sometimes I think it made it worse.

Another participant felt somewhat let down by her experience of physiotherapy:

I had one [frozen shoulder] in my left shoulder about 3 or 4 years ago. The doctors sent me to the physiotherapist at the hospital at [name of town] and she said 'Do these exercises!'. I was expecting that she would maybe manipulate it a little bit. But it was just a case of 'Do these exercises and see what happens and tell me next time you come back'. I did try the exercises but it didn't seem to do terribly much for the shoulder. Eventually, I gave up doing them because all it was doing was making it painful.

It is interesting to contrast these somewhat negative descriptions about previous treatment experiences with the participants' experiences of BT. One participant, for example, who was very concerned that her shoulder would be 'roughly handled' described her initial feelings about her referral and then the way she felt after having met the therapist and been treated:

[Before meeting the therapist] I'd no, no idea at all [about BT]. To tell you the truth I was a bit ...nervous and a bit frightened. I thought – 'Oooh, am I going to go through a lot of pain in moving it.....?' [The first session was] very relaxing,I was really, really at ease. I was surprised. 'Oh, I thought it's going to be painful. He's [therapist] going to be asking questions. He's going to have me moving this way, that way and I'm going to be in pain when I come out!'. And there was no pain at all.... just an odd twinge. Like there was a part in my back he touched and I had a twinge there and in my shoulder. He touched one or two places and that did [twinge] at first. But after the second session it was all right, you know. It was really relaxing [when the therapist left the room] I think if I just hadn't have heard his door open knowing he was coming back I think I'd of been well away!.

The good interpersonal skills of the therapist were emphasized by all of the participants and many of them described how the therapist was 'exceptionally friendly and welcoming,' engendered confidence because he was 'a very genuine person' and created a feeling that they believed in what they were doing. One participant summed up the therapist's approach:

I mean, I have gone to specialists before and it's been very much 'Yes', 'No'; you answer a question

that they ask – but you don't have confidence to make conversation yourself. It's the way I felt 30 years ago when I went to a doctor, my normal GP. But with him [therapist], he had such a pleasant face and I think he got the best out of me. I can only speak for myself. But I was able to talk openly with him and I genuinely felt he was doing his best to help me.

The experience of and satisfaction with BT

The number of Bowen treatment sessions varied between three and five visits and no adverse experiences were reported. All the participants said that BT had been a pleasant, gentle, relaxing and non-invasive therapy. All the participants reported a tingling sensation (to a greater or lesser degree) whilst the therapist was undertaking the moves during a treatment session:

You got a kind of tingling, just a tingling.. I'm not sure if that's normal...the tingling was close to where [therapist] was working..... I felt fine when [therapist] was doing the treatment...it was an interesting feeling!

Twelve participants reported that they felt 'quite light and dizzy' at the end of the treatment session. However, this light-headedness was not unpleasant and only lasted 'for just about a minute or so'. Some participants also reported a '... kind of a warm sensation in my shoulderit was a pleasant heat, it wasn't tremendously hot, just a slight hotness. The tingling was more spread out round the shoulder than the heat.... It was a good sensation'. Again this was seen as a positive experience and some felt that it was 'evidence' that their body was responding to the therapy and healing was starting to occur.

The participants emphasized how relaxed they felt during and after their treatment. The period lasted between 2 hours and 2 days: the majority of people felt relaxed for between 4 and 8 hours. Participants felt that the therapy encouraged them to relax and it also engendered a sense of deep relaxation and well-being:

... just after the 1st treatment, and just walking down the road, I just felt really good... because I came in with quite a pain in my shoulder and down my arm. It was great walking down the road; I thought 'Oh, yes, this is really super!' I began to feel it at night again and when I was really beginning to get tired. But as the days went on and each subsequent week it got better and better. I was very relaxed during the treatment.. I'm not usually relaxed – just ask my wife! – I'm usually wanting to get on with next jobso I was surprised at how much I enjoyed the treatment especially lying there when [therapist] had gone out the room....

All the participants who stated that they would recommend it to their friends and family as a

'good therapy', especially compared to their previous interventions. Many participants commented at their amazement at how such a gentle therapy could actually be so powerful. These comments were particularly apparent in the 15 participants who responded very positively to their first treatment session, for example:

I still had a bit of pain, but not as much though, but the movement was coming back. I could tell after the 1st treatment that my arm was a lot better even though the treatment didn't feel strong.

It just felt like you were being touched and I was surprised at how little you had to do to make it work. It was nice as well... I wasn't sure that it was going to work with it being so little movements but it did... I thought it was good that it wasn't heavy movements.....

After the first treatment it got a lot better and now I'm a lot more cheerful. I met my dad after one session and he thought I was a completely different person... a lot happier – he was dead pleased.

He didn't aggravate the joints or anything, it's quite quick and you don't really notice that it's happening so you can't really strain against it or anything like that.. It's just.... relaxing and like your body trusts the treatment....and relaxes into it.

DISCUSSION

Overwhelmingly, the participants perceived BT to be gentle, relaxing and non-invasive and of help with significantly improving or eliminating the symptoms associated with frozen shoulder. It is worthwhile noting that no participants withdrew from this study and yet withdrawal from shoulder pain studies is recognized as problematic (van der Heijden 1997, Winters et al. 1997).. Participants experiencing pain were unwilling to subject themselves to more rigorous treatment options, as they believed that they would be adding to their pain load. Participants who had experienced physiotherapy reported that they did not always comply with the regime of exercises, as the exercises were time consuming and painful. The advantage of Bowen was that the participant experienced no pain during the treatment process and the associated exercises were gentle and non-threatening. Participants who expressed an initial degree of scepticism about the therapy were won over by the fact that it produced results. For many of the participants it was the first time they had experienced any form of complementary therapy. They were impressed by the consultation, the therapists' interpersonal skills, and the technical moves undertaken by therapist. Although the therapist leaving the room after completing a set of moves

initially surprised the participants, they soon found this to be a positive experience and one that helped them to relax. All of the participants stated that they would consider using BT again and would recommend it to their friends and family.

BT was successful for the majority of participants and it certainly provided reduction, to a greater or lesser degree, in each individual participant's baseline symptoms. Thus it can be seen that the participants' associated morbidity was reduced by BT. This then impacted on their ability to engage with their usual daily activities and their general sense of well-being. The participants were satisfied by this improvement. The combination of improved mobility, functional status and decreased pain contributed to a feeling of enhanced well-being as evidenced through the improved scores for the participants' daily activities. One measure of success could be seen in participants returning not just to the 'required' activities of living such as shopping, cleaning, and working but also to their hobbies, such as gardening, bowling, curling, sewing, and woodwork. The sense of pleasure was very evident in the interviews about the return of the ability to 'just do the things you want to, without thinking about it or it hurting.'

This small study suggests that Bowen is a positive intervention for participants even with a very long-standing history of frozen shoulder. The participants evaluated the therapy as being highly satisfactory. This study represents an initial contribution to the literature on Bowen technique and the findings suggest that further studies are warranted.

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