Welcome

Dear Colleagues and Friends,

The conference will appeal to all physiotherapists, and specialists in rehabilitation working in psychosomatic medicine, psychiatry and mental health. This International conference of physiotherapy in psychiatry and mental health has been organised in the spirit of an informal and true collaboration to obtain an exchange between physiotherapy and rehabilitation clinicians and researchers. The focus of our conference is on dialogue, contact and interaction.

The number of submissions was greater than expected and we are excited about the program that has taken shape. This conference is aimed at presenting the present state of art in the field of physiotherapy and rehabilitation related to mental health. We expect 110 delegates from at least 19 countries.

The program includes four plenary sessions, different concurrent scientific paper sessions, eight workshops and 14 posters. A guided plenary poster session will take place ending in the conference “Best Poster Award” based on the votes of all delegates. A debate in the tradition of good old parliamentary system is also integrated in the program. We hope that you all find the opportunity to compose your personal congress program. We look forward with enthusiasm and excitement to the opportunities to have inspiring and challenging dialogues with old and new colleagues from every continent.

Finally, we would like to thank the members of the scientific and the organising committee, the Board of the Faculty Kinesiology and Rehabilitation Sciences, the Direction of the University Centre at Kortenberg, the Webmaster, the staff and the co-workers of the congress venue in Kortenberg and all the contributors for all the support and their excellent work.

Last but not least we are delighted to offer you the Belgian hospitality coming from the heart and do hope that you enjoy your stay in Leuven, a town that is bustling with life!

We wish all the participants a fantastic and memorable conference.

Michel Probst
Eddy Neerinckx

International Conference of Physiotherapy in Psychiatry and Mental Health.

Organised by

Katholieke Universiteit Leuven, Faculty of Kinesiology and Rehabilitation Sciences
www.kuleuven.ac.be
&
University Centre Sint Jozef Kortenberg, Physiotherapy and Psychomotor therapy
www.uc-kortenberg.be

in collaboration with

Arteveldehogeschool Gent
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Provinciale Hogeschool Limburg
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Programme overview

Wednesday, February 15, 2006	
15.30	Conference Registration
16.15	Official Opening
17.45	Welcome Reception

Thursday, February 16, 2006				
08.30	Conference Registration			
09.15	Plenary Session			
10.45	Coffee Break			
11.15	Scientific Session A	Scientific Session B		
13.00	Lunch Break			
14.15	Workshop A	Workshop B	Workshop C	Workshop D
15.30	Coffee Break			
15.45	Workshop C	Workshop D	Workshop E	Debate
17.00	End of debate & workshops			
19.30	Conference Dinner			

Friday, February 17, 2006					
08.30	Coffee				
09.10	Plenary Session				
10.45	Coffee Break				
11.15	Scientific Session C	Scientific Session D	Scientific Session E		
12.15	Scientific Session F	Scientific Session G	Workshop F		
13.00	Lunch Break				
14.15	Workshop B	Workshop E	Workshop F	Workshop G	Workshop H
15.30	Coffee Break				
15.45	Plenary Poster Session				
16.15	Plenary Session				
16.45	Plenary Session: Summary, conclusion, business meeting				
17.15	Farewell Reception				

Program

"International Conference of Physiotherapy in Psychiatry and Mental Health"

Wednesday 15 February 2006

15.30: **Conference Registration**:

Auditorium, Building Denayer, Faculty of Kinesiology and Rehabilitation Sciences, Katholieke Universiteit Leuven, Tervuursevest 101, 3001 Leuven-Heverlee

16.15: **Official Opening**

- Prof Dr. Rik Gosselink, Dean of the Faculty of Kinesiology and Rehabilitation Sciences, K.U.Leuven

- Prof. Dr. Michel Probst, Faculty of Kinesiology and Rehabilitation Sciences, K.U.Leuven
Why a Conference about Physiotherapy in Psychiatry and Mental Health?

- Ass. Prof. Liv Helvik Skjaerven, Bergen University College, Department of physiotherapy, Norway
"Physiotherapy in Mental Health. A Scandinavian approach"

- Prof. Dr. Herman. Van Coppenolle, Faculty of Kinesiology and Rehabilitation Sciences, K.U.Leuven
"Aging and Mental Health: Challenges for Physiotherapy?"

- Prof. Dr. Eddy Neerinckx, Faculty of Kinesiology and Rehabilitation Sciences, K.U.Leuven
Presentation of the program and introduction of the speakers

17.45: **Welcome Reception**: Ground Floor, Building Denayer, offered by the Faculty of Kinesiology and Rehabilitation Sciences.

22.00-23.30: Meeting place: Blauwe Schuit, Vismarkt 16
(See page: 59-60)

We thought it would be nice to have a meeting place, late in the evening for a last drink after having an excellent meal (see page). The deliberation was extremely difficult but finally we decided to meet at the “BLAUWE SCHUIT”, Vismarkt 16. See you there …

Thursday, February 16, 2006

08.30: **Conference Registration**:
University Centre Sint Jozef Kortenberg,
Conference centre, Leuvensesteenweg 517,
3070 Kortenberg

08.30: P**oster presentation (non-stop)**

09.15: **Plenary Session**: *Room: Aula*
Chair: Michel Probst, Belgium

09.15-09.30: Prof. Dr. J. Peuskens, General Director of the University Centre

09.30-09.55: Michel Probst, Belgium
PHYSIOTHERAPY IN PSYCHIATRY AND MENTAL HEALTH: TIME FOR REFLECTIONS.

09.55-10.20: Rebecca Thorne and Jane Briscoe (New Zealand)
PHYSIOTHERAPY AND THE RECOVERY MODEL

10.20-10.45: Gerd Hölter, Germany
CURATIVE FACTORS OF MOVEMENT THERAPY WITH PSYCHIATRIC PATIENTS

10.45-11.15: **Coffee break**

11.15-13.00: **Scientific Sessions (in parallel; 15 minutes)**

Scientific Session A **"Physiotherapy and Eating disorders".**
Chair: M. Probst, Belgium
Room: Aula

11.15 DO PATIENTS WITH EATNG DISORDERS BENEFIT FORM PHYSIOTHERAPY? AN APPROPRIATE GUIDANCE.
Michel Probst, Belgium

11.30 WORKING WITH CHILDREN AND ADOLESCENTS WITH EATING DISORDERS
Majewski Marie-Louise, Sweden

11.45 PHYSIOTHERAPY AND EATING DISORDERS
Marit Nilsen, Marit Danielsen & Grete Ege Grønlund, Norway.

12.00 THE BODY IMAGE IN ANOREXIA NERVOSA AND BULIMIA NERVOSA: MIRROR DESENSITIZATION THROUGH AN OCCUPATIONAL THERAPY TREATMENT.
Christine Goffin, Belgium

12.15 STATIC AND DYNAMIC BALANCE OF PATIENTS WITH ANOREXIA NERVOSA
Svenja Troska & Gerd Hölter, Germany

12.30 QUALITY OF LIFE ASSESMENT FOR PATIENTS WITH EATING DISORDERS
Ulla Thörnborg, Lena Nordholm, Ulla Svantesson, Sweden

12.45 BODY IMAGE IN EATING DISORDERS. PRESENTATION OF THE COMPUTER PROGRAM BODY FIGURE.
Helén Lönning, Sweden

Scientific Session B **"Physiotherapy: a Biopsychosocial Approach".**
Chair: Peter Vaes
Room: Zaal 1

11.15 DOES THE IBS –PATIENT OF TODAY GET AN OPTIMAL TREATMENT?
Elsa Eriksson, Kristina Andrén, Henry Eriksson, Göran Kurlberg, Sweden

11.30 GAIT IMPROVEMENT IN UNILATERAL TRANSFEMORAL AMPUTEES BY COMBINING ORTHOPAEDIC WITH PSYCHIATRIC PHYSIOTHERAPEUTIC TREATMENT AND A PSYCHOLOGICAL THERAPEUTIC APPROACH
Sjödahl C, Jarnlo G-B, Persson BM, Sweden

11.45 TRAUMATIC BRAIN INJURY AND PROBLEMATIC REHABILITATION: AN ADVENTURE THERAPY APPROACH
Marie De Wispelaere, Belgium.

12.00 GASTROINTESTINAL SYMPTOMS IN 50 YEAR OLD WOMEN SHOWS A STRONG CORRELATION TO PSYCHOSOMATICS. CONTINUATION OF THE EPIDEMIOLOGICAL STUDY OF MEN BORN IN 1913.
Elsa Eriksson, Saga Johansson, Marianne Wallander, Catharina Welin, Göran Kurlberg, Henry Eriksson, Sweden,

12.15 THE EFFECT OF INTERFERNTIAL THERAPY ON PATIENTS WITH LUMBOSACRAL RADICULOPATHY: NEUROPHYSIOLOGICAL STUDY
Abulkhair Beatti, Saudi Arabia.

12.30 COGNITIVE FUNCTION AND ITS EFFECT TO QUALITY OF LIFE STATUS IN PATIENTS WITH COPD
Yeşim Salık, Sevgi Ozalevli , Arif H. Cımrın Turkey

12.45 – 14.15: **Lunch Break**

14.15- 15.30: **Workshops (in parallel)**

Workshop A *Room: S. Sporthall*
TOUCH AND MOVEMENT APPROACHES USED WITH SURVIVORS OF SEXUAL ABUSE
Diane Beaven, UK

Workshop B *Room: Aula*
BASIC BODY AWARENESS METHODOLOGY
Liv Helvik Skjærven, Norway

Workshop C *Room: L. Sporthall*
CREATIVITY IN THE FIELD OF PSYCHOMOTORTHERAPY.
Petra Chudejova, Czech Republic

Workshop D *Room: zaal 1*
DEVELOPMENT OF BODY AWARENESS IN A PHYSIOTHERAPEUTICAL GROUP IN A PSYCHOSOMATIC CLINIC
Klein, C., G. Jantschek, Germany

15.30-15-45: **Coffee Break**

15.45- 17.00: **Workshops (in parallel)**

Workshop C (repetition) *Room:L. Sporthall*
CREATIVITY IN THE FIELD OF PSYCHOMOTOR THERAPY.
Petra Chudejova, Czech Republic

Workshop D (repetition) *Room: S. Sporthall*
DEVELOPMENT OF BODY AWARENESS IN A PHYSIOTHERAPEUTICAL GROUP IN A PSYCHOSOMATIC CLINIC
Klein, C., G. Jantschek, Germany

Workshop E *Room: zaal 1*
EXPERIENTIAL WORKSHOP TO LEARN AND EXPLORE MANUAL TECHNIQUES TO FACILITATE THERAPEUTIC BODY AWARENESS AND PROMOTE PHYSICAL AND MENTAL RELAXATION
Ann Childs, England.

Debate *Room: Aula*
SHOULD PHYSIOTHERAPY IN MENTAL HEALTH BE REGARDERD AS A PSYCHOTHERAPEUTIC INTERVENTION?
Chair: P. Calders, Belgium
Pro:
Contra: D. Vancampfort

Pro: Yes, it is. Physical dysfunctions are an important typical feature of mental health problems. Consequently physiotherapists get to work with a mean part of the mental health problem and therefore their interventions should be considered as psychotherapy.

Con: No, it is not. Physical dysfunctions are only side effects of mental health problems. It is the task of the physiotherapist to reduce the impact of the physical symptoms so that psychotherapists can work under the best conditions

This debate is chaired by a chairman. One colleague gives arguments pro (support by a power point presentation) followed by a colleague who argues con (also with power point). After this both presentations the audience debate about the thesis and the arguments pro and con.

19.30 : **Conference Dinner** at “Infirmary” of the Faculty Club, Groot Begijnhof 14, 3000 Leuven

Welcome
Prof. dr. L. Van Hees, Chair of the Department of Rehabilitation Sciences
Prof. dr. E. Neerinckx, Chair of the conference

Menu

Aperitif suggestion

Hûre of young rabbit and fresh garden herbs, crusty salad and a soup of dried prunes and bacon

Piece of halibut in “Papillot” with olives, artisjok and lime, a bruschetta toast with a tapenade of capers, anchovy and dried tomato

Suprême of duck “lacked” with adrak and a lavender honey, chutney of quince, peppers and rice vinegar

Trio of desserts created by our pastrychef

Including coffee and home-made sweets.

House wines

Friday, February 17, 2006

08.30**:** **Coffee**

09.10- 10.45**:** **Plenary Session** *Room: Aula*
Chair: E. Neerinckx

09.10- 09.35:
BODIES TALK: CAN PHYSICAL ACTIVITY BE A COMMUNICATION PARTNER?
E. Neerinckx, Belgium

09.35-10.00:
BASIC BODY AWARENESS THERAPY AND POST TRAUMATIC STRESS DISORDER – A PILOT STUDY.
Anne Reitan Parker, UK and Liv Helvik Skjaerven, Norway

10.00-10.25:
THE ROLE OF PHYSICAL THERAPY IN PSYCHIATRY IN THE USA: A CASE STUDY
Paul Ogbonna, USA

10.25- 10.45:
PHYSIOTHERAPY IN MENTAL HEALTH IN ENGLAND AND THE BENEFITS OF INTERNATIONAL RESEARCH
Caroline Griffiths, UK

10.45- 11.15: **Coffee Break**

11.15- 12.15: **Scientific Sessions** (in parallel; 15 minutes)

Scientific session C: "**Physiotherapy and Basic Body awareness therapy"**.
Chair: A Parker (UK)
Room: Aula

11.15 OPENING UP FOR AWARENESS: BASIC BODY AWARENESS METHODOLOGY IN SHORT-TERM GROUP THERAPY. - A PILOT STUDY
Ingeborg Landstad & Liv Helvik Skjærven, Norway

11.30 EVALUATION OF FUNCTIONING AND BODY AWARENESS OF YOUNG PATIENTS WITH SCHIZOPHRENIA
Anna-Liisa Leikas, Heidi Harju-Villamo and Merja Sallinen Satakunta, Finland

11.45 EXPLORING NARRATIVES AND UNDERSTANDING IN THE PROCESS OF MOVEMENT HARMONY WITH BODY AWARENESS RATING SCALE ASSESSMENT - A PILOT STUDY
Ingela Martikkala, Sweden & Liv Helvik Skjaerven, Norway

12.00 BREATHING AS AN INNER FRIEND, BASIC BODY AWARENESS THERAPY WITH HYPERVENTILATION PATIENTS – A PILOT STUDY
Tiina Granö, Finland

Scientific session D: "**Physiotherapy and Depression**"
Chair: Peter Van de Vliet
Room: Zaal 1

11.15 PHYSICAL FITNESS AND PHYSICAL SELF-CONCEPT IN PATIENTS WITH DEPRESSIVE AND ANXIETY DISORDERS
Jan Knapen, Belgium

11.30 PHYSICAL ACTIVITY AS A TREATMENT FOR DEPRESSION: CURRENT SITUATION IN SPAIN.
Rubén Fernández García, Daniel J. Catalán Matamoros, (Spain).

11.45 LESS DEPRESSED THROUGH MORE EXERCISE
Peter Van de Vliet, Belgium

12.00 EXERCISE ATTITUDES AND BEHAVIOURS AMONG PERSONS IN TREATMENT FOR PSYCHOGENIC OBESITY AND BINGE EATING DISORDERS.
Atilio Carraro, Italy

Scientific session E **"Physiotherapy & Psychatric disorders"**:
Chair: Petra Chudejova, Czech Republic
Room: Zaal 2

11.15 THE STATUS QUO OF PSYCHOMOTOR THERAPY AS A TREATMENT OF PSYCHIATRIC PATIENTS IN THE CZECH REPUBLIC.
Petra Chudejova, Czech Republic

11.30 THE RELATIONSHIP BETWEEN PERCEIVED AND ACTUAL MOTOR COMPETENCE IN A GROUP OF ADOLESCENTS WITH PSYCHIATRIC DISORDERS
Johan Simons, Belgium

11.45 NEGATIVE BODY IMAGE AMONG YOUNG WOMEN WITH BORDERLINE PERSONALITY DISORDER
Karin Hulting, Sweden.

12.00 THE BODY-CONCEPT OF ADOLESCENTS WITH SELF-INJURIOUS BEHAVIOR
Annette Degener, Germany

12.15-13.15 **Scientific Sessions C** (in parallel)

Scientific Sessions F: "**Physiotherapy and Fibromyalgy"**
Chair: Neerinckx E.
Room: Aula

12.15 DEPRESSION AS EXPERIENCED BY FEMALE PATIENTS WITH FIBROMYALGIA
Sallinen Merja, Finland

12.30 THE RELATION BETWEEN THE BODILY EXPERIENCES WOMEN HAVE DURING THE YEARS PRIOR TO THE FIBROMYALGIE DIAGNOSIS AND THE DEVELOPMENT OF FIBROMYALIGA
Anne Kristin Grønn Wanvik, Norway

12.45 BODY CONSCIOUSNESS AND NORWEGIAN PSYCHO MOTOR PHYSIOTHERAPY. EXPERIENCES FROM PATIENTS WITH CHRONIC WIDESPREAD PAIN
Dragesund T and Råheim M., Norway.

13.00 DIFFERENT ASPECTS OF PAIN REHABILITATION AND RETURN TO WORK. A ONE- AND THREE-YEAR-FOLLOW-UP WITH A GENDER PERSPECTIVE
Monica Mattsson, Sweden

Scientific session G: **"Physiotherapy and psychomotor therapy":**
Chair: Johan Simons (Belgium)
Room: Zaal 1

12.15 TO DEVELOP BODILY KNOWLEDGE BASED ON PSYCHOMOTOR PHYSICAL THERAPY.
Aud Marie Øien, Norway.

12.30 FOLLOW-UP ON REAL AND PERCEIVED COMPETENCE
Johan Simons and M. Van Lent, Belgium

12.45 KINESIOTHERAPY
Hátlová, Běla & Adámková Milena Czech Republic

Workshop F: *Room: Fitness*
EVALUATION OF CARDIO-RESIRATORY FITNESS AND PERCEIVED EXERTION FOR PATIENTS WITH DEPRESSIVE AND ANXIETY DISORDERS:
Jan Knapen, Belgium

13.00 – 14.00 : **Lunch Break**

14.00 - 15.30 :

Workshop B (Repetition) *Room: Aula*
BASIC BODY AWARENESS METHODOLOGY
Liv Helvik Skjærven, Norway

Workshop E (Repetition) *Room: PE*
EXPERIENTIAL WORKSHOP TO LEARN AND EXPLORE MANUAL TECHNIQUES TO FACILITATE THERAPEUTIC BODY AWARENESS AND PROMOTE PHYSICAL AND MENTAL RELAXATION
Ann Childs, England.

Workshop F (Repetition) *Room: Fitness*

EVALUATION OF CARDIO-RESIRATORY FITNESS AND PERCEIVED EXERTION FOR PATIENTS WITH DEPRESSIVE AND ANXIETY DISORDERS.
Jan Knapen, Belgium

Workshop G *Room: S. Sporthall*

CHANGING TONE AND CHANGING MOOD
Diane Beaven, UK

Workshop H *Room: zaal 1*

CHANGING BODY IMAGE AND HYPERACTIVITY IN EATING DISORDERS. A PHYSIOTHERAPY APPROACH FOR INDIVIDUAL AND GROUP THERAPY
Michel Probst, Belgium

15.15-15.30: **Coffee Break**

15.30- 16.00 : **Poster Session** : a guided Plenary Poster Session
Chair: Calders, P. Belgium; Nilsen, M. Norway ; Majewski M-L. Sweden
Room: Aula

List of Posters

1. THE GENERAL SELF-EFFICAY OF EATING DISORDERS PATIENTS
Godelinde Hoop & Michel Probst, Belgium

2. EFFICACY OF A PROGRAMME OF PHYSICAL ACTIVITY IN PSYCHIATRY: AN EXPERIMENTAL STUDY
Marta Alberti, Massimo Lanza, Mario Giacopuzzi, Marco Bortolomasi , Attilio Carraro

3. USING EXPERIENCES AND EXPRESSIONS AS A PSYCHOMOTOR THERAPY WITH ADOLESCENTS WITH BEHAIOUR DIOSRDERS;
Lieve Rutten, Belgium

4. EFFICACY OF A PHYSICAL ACTIVITY PROGRAM IN THE RESIDENTIAL TREATMENT OF PATIENTS WITH ALCOHOL-RELATED PROBLEMS
Attilio Carraro, Sara Costan, Davide Mioni, Gloria Pessa, Italy

5. LIGHT THERAPY AS A TREATMENT FOR DEPRESSION: A LITERATURE REVIEW.
Daniel J. Catalán Matamoros & Rubén Fernández García, Spain

6. REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION AS A TREATMENT FOR MAJOR DEPRESSION
Daniel J. Catalán Matamoros & Rubén Fernández García, Spain.

7. THE EXAMINATION IN NORWEGIAN PSYCHOMOTOR PHYSIOTHERAPY: AN EMPIRICAL MODEL
Kirsten Ekerholt & Astrid Bergland, Norway

8. DO PHYSIOTHERAPY PRACTIONERS ATTACH STIGMA AND PREJUDICIAL PRACTICE TO PATIENTS WITH SECONDARY MENTAL HEALTH PROBLEMS?
John Harris, South Wales

9. THE MASSAGE IN NORWEGIAN PSYCHOMOTOR PHYSIOTHERAPY.
Kirsten Ekerholt & Astrid Bergland, Norway.

10. KINESIOTHERAPY AS A PART OF THERAPY OF DEMENTIAS
Hátlová, Běla & Suchá Jitka, Czech Republic

11. THE EFFECTS OF STATIC RESPONSIVE CONTACT COMPARED WITH MITCHELL'S RELAXATION TECHNIQUE ON IN-PATIENT'S ANXIETY LEVELS WITHIN AN ACUTE MENTAL HEALTH WARD SETTING: A PILOT STUDY
Ann Childs, England

12. THE PROCESS OF CHANGE – A PILOT STUDY. RESULTS FROM BASIC BODY AWARENESS THERAPY
Anne Gilde & Liv Helvik Skjærven, Norway.

13. ADAPTED PHYSICAL ACTIVITY IN THE REHABILITATION OF ALCOHOL ADDICTION
Deimel, Hubertus, Germany

14. MENTAL & PHYSICAL REHABILITATION AND PHYSIOTERAPY TREATMENTS FOR ANKLE INJURY IN PROFESSIONAL ATHLETES
Ahanjan S. Hahram , Iran

To revalue the poster we organise a **Poster Award**
The participants choose from all exhibited posters the one which should in their opinion receive the first place according to the following criteria

- Scientific novelty and excellence
- Concise clear and informative introduction and objective (s)
- Brief methodology
- Logical and clear presentation of results
- clear concise comprehensible summary and conclusion
- A visual balance between text figures and tables
- Overall readability and impact (scientific an aesthetic)

Please return the questionnaire to the organising staff no later than Friday, February 17, before 2.00 pm

16.00: Plenary session *Room: Aula*

16.00-16.20:
LIAISON ROLE OF PHYSIOTHERAPY IN ACUTE ADULT MENTAL HEALTH
Sharon Greensill, UK

16.20- 16.45:
EFFECTS OF PHYSIOTHERAPEUTIC TREATMENT IN OUTPATIENT PSYCHIATRIC CARE - A PILOT AND A RANDOMISED STUDY
Monica Mattson, Sweden

16.45- 17.15: **Closing Ceremony**

Summary & Evaluation: Eddy Neerinckx & Peter Vaes
Business meeting- Assembly:
Do we start an international subgroup physiotherapy in mental health?
Do we organise a next conference? If yes who is a candidate?
Do we need a Board and if yes who is interested?

Conclusion:
Prof. Dr. Y. Van Landewijck, Chair of the Unit Adapted Physical Activity and Psychomotor therapy, Department Rehabilitation Sciences.

17.15: **Farewell Reception**, University Centre Sint Jozef Kortenberg

ABSTRACTS

Official Opening

WHY A CONFERENCE ABOUT PHYSIOTHERAPY IN PSYCHIATRY AND MENTAL HEALTH?

Michel Probst, PhD PT
K.U.Leuven, Faber, Rehabilitation Sciences, & University Centre Sint Jozef Kortenberg & Arteveldehogeschool, Opleidingseenheid physiotherapy, Gent

Today mental health is in different countries a key priority and a global challenge.

Mental health

The WHO describes mental health as: a state of well-being in which the individual realizes his or her abilities, can cope with the normal stress of life, can work productively and fruitfully and is able to make a contribution to his or her community

Mental ill health

Includes mental health problems and strain impaired functioning associated with distress symptoms and diagnosable mental disorders. In the year 2002 for instance psychiatric conditions accounted for one quarter of all European Ill health and premature death.

Mental ill health affects every fourth citizen in Europe. There is no health without mental health

What a physiotherapist can do or what is the place for physiotherapy as a therapeutic intervention in the management of people with mental (ill) health?

- Physiotherapy = Health care professional
- Regular physiotherapy with patients with mental disorders
- Specific developed physiotherapy techniques for mental ill disorders
- Specific developed physiotherapy approach for individuals or groups

Basics features of physiotherapy in mental health and psychiatry

- A focus on the individual
- A holistic concept of health and disease
- Respect for human dignity, equality and solidarity,
- Activities that emphasis the well-being of the patients
- A wise use of resources allocating resources to activities in accordance with their potential contribution to health

The objectives of this conference

With this conference we want

- To bring the contribution of physiotherapists and rehabilitation specialists in mental health into the spotlight.
- To stimulate the dialogue between colleagues,
- To facilitate and to promote the exchange of experiences and new ideas regarding physiotherapy in psychiatry,
- To improve the knowledge of possibilities of physiotherapy in mental health and to make an inventory of the possibilities of physiotherapy and occupational therapy in mental health.
- To start an European network around scientific and 'good clinical practice' approach in this field
- To develop models of good practice and establish guidelines and recommendations

Physiotherapists working in mental health are uniquely placed to provide an extensive range of physical approaches to treatment aimed at relieving symptoms, boosting confidence and improving quality of life. This is why mental health is an exciting and evolving area of work for physiotherapist.

PHYSIOTHERAPY IN MENTAL HEALTH - A SCANDINAVIAN APPROACH.

Liv Helvik Skjærven,
Bergen University College, Faculty of Health and Social Sciences, Møllendalsvei 6, 5009 Bergen, Norway, lhs@hib.no.

Chronic pain, long-lasting muscle-tension, psychosomatic and psychiatric illnesses and existential problems is a major health issue in contemporary society. During the last 50 years there has been a development of physiotherapy within the domain of mental health in Scandinavia; today the psychiatric and psychosomatic physiotherapy (PPT) is an established speciality. It builds on an understanding of the close relationship between physical, mental, social, cultural and existential factors seeking to integrate all aspects into physiotherapy. The PPT draws upon inspiration from different fields, especially on the works of Wilhelm Reich and of Western and Eastern movement traditions, emphasizing the interaction between physiotherapist and patient. The basic philosophy is the view of the human being as a carrier of individual life experiences, leaving their marks upon bodily functions and movement pattern. PPT embraces methods like physical activity, relaxation techniques, psychodynamic body therapy, expressive therapy and body awareness training. Scandinavia has, however, produced some of the leading figures in the field, with two pioneers that are worth mentioning: Ädel Bülow Hansen, Norway, the creator of The Psychomotor Physiotherapy and Gertrud Roxendal, Sweden, the creator of Basic Body Awareness Therapy. They are both well-established physiotherapeutic approaches currently offered in official educational programs and integrated in research programs.

The Psychomotor Physiotherapy is aimed at several levels of bodily experiences; it is based on the assumption that physical or emotional stress is expressed in the breathing, muscles and in movement. Through focus on the persons` posture, muscle tension and breathing pattern, the physiotherapist stimulates the body to stretch, and encourages proper breathing movement through massages and movements in the whole body. The aim is to open for a basic change in posture and more flexible respiratory functioning. The approach consists of individual therapy. There are two validated and reliable assessment tools: *The Comprehensive Body Examination* and *The Global Physiotherapy Examination.*

Basic Body Awareness Therapy is inspired by the French movement educator and psychotherapist J. Dropsy. It is founded on a four-dimensional approach to human movement. The training philosophy, based on a holistic view, invites the patient to train basic functions such as postural stability, free breathing and awareness. The awareness program includes movements in lying, sitting, standing, walking, using the voice and relational exercises. It offers a strategy to make the person equipped to handle life more ably. It is used in individual therapy, but is foremost a group-treatment. There are two validated and reliable assessment tools: *Body Awareness Scale* and *Body Awareness Rating Scale.*

Working with people suffering from psychosomatic and psychiatric problems represents challenges to the traditional role and tools of the physiotherapist, especially regarding the personal development as therapist. The post-graduate international course in Basic Body Awareness Methodology, Bergen University College, Norway offers an academic program that gives the therapist new insight and a concrete clinical tool.

"AGING AND MENTAL HEALTH: CHALLENGES FOR PHYSIOTHERAPY?"
FROM RESEARCH DATA INTO EUROPEAN-WIDE ACTION

Herman Van Coppenolle, Stefka Djobova, Iana Dobreva, Katelijne Huijsmans, Aldona Niemiro, Mieke Van Lent, Faculty of Kinesiology and Rehabilitation Sciences, K.U. Leuven, Belgium

One of the most important changes in Europe over the last 50 years has been the rapid increase in the number of people living into their 70s, 80s and beyond. Also the life expectancy of the persons with a disability has tremendously increased. Most of the ageing people have some physical and mental disability, regardless the fact if they acquired this disability at birth or obtained it later in life or just as it happened as a consequence of the normal process of ageing.

The 'Eurostat' data estimate that by the end of 2040 the severely impaired adults will be 6.5% of the total population in Europe, or 24.5 million people.

To-day 7.5% of the total European population is 75 years old and more. In 30 years this percentage will rise to 14.4%.

Recently the traditional disability model has changed to agree with the suggestion that disability develops not only from disease but also from lifestyle choices.

Ageing is a process that often affects and restricts the people who are growing old, on physical, psychological and social level. It is obvious that the quality of the physical fitness of the elderly person defines in a very important way the psychological health and quality of life.

As older adults are the fastest growing group, attention needs to be given to them as a special population in the area of exercise and sport.

Qualified professionals in the area of physical activity for the elderly have to be prepared now, so they can meet the new demands for the future.

A Thematic Network in which all European countries participate was started up (2004-2007) to create a basic profile and implement the subject of adapted physical activity (APA) for the elderly in the European Higher Education curricula of all caregivers to elderly persons: students in Physiotherapy, Physical Education, Sport Sciences, but as well future medical doctors, nurses, occupational therapists, etc need to be informed about all the physical and psycho-social benefits of physical activity. This curriculum was defined in the Forums of the Network in Malta (2004), Kaunas (Lithuania) and Oradea (Romania), (2005), and will be available at the end of 2006.

A second task of this Thematic Network is to stress the research data of Adapted Physical Activity intervention for the older persons with a disability by keeping them as much physical active as possible.

The Thematic Network has chosen for a co-ordinated approach of all caregivers to increase the physical activity and will start this year pilot projects in several countries (also in Flanders) to stimulate physical activity for a better physical and psychosocial quality of life for elderly persons with disabilities.

Plenary session
Thursday, February 16, 2006

PHYSIOTHERAPY IN PSYCHIATRY AND MENTAL HEALTH: TIME FOR REFLECTIONS.

Michel Probst, PhD PT
K.U.Leuven, Faber, Rehabilitation Sciences, & University Centre Sint Jozef Kortenberg & Arteveldehogeschool, Opleidingseenheid physiotherapy, Gent

The importance of physiotherapy within psychiatry and mental health depends on the theoretical views. We distinguish two basic views. One group of clinicians considers physiotherapy in the treatment of mental disorders as secondary, non useful, even superfluous
The second group of clinicians considers the physiotherapy with their specific therapeutic interventions as primary and essential. Physiotherapy as a part of a multidimensional treatment model can play an important role. It is also possible after all that different strategies are necessary for different categories of patients
Other discussion points as the integration of biopsychosocial model in physiotherapy, the impact of psychological theories in physiotherapy, the job demarcation, the evidence based physiotherapy in mental health, the job description of a physiotherapist in mental health will be elaborated.

PHYSIOTHERAPY AND THE RECOVERY MODEL

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Recovery, referred to as living well or living a life worth living, is the desired outcome for people who use mental health services (MHS). In New Zealand (NZ) the Blueprint for MHS (1988) obliges all people who work in MHS to use a recovery approach. This paper identifies ways in which the rehabilitation model, familiar to all physiotherapists, is a useful starting point for developing awareness of the skills and attitudes that support the recovery of people with experience of mental illness.
Drawing on the recovery literature and their experience as physiotherapists working in acute MHS and teaching institutions in NZ, the authors argue that physiotherapists not only understand recovery better than most health workers but also have a role to play in educating their medical and nursing colleagues in how best to support them to promote recovery of service users.
When supporting anyone to live a life they find fulfilling, the authors argue that while working in the rehabilitation model physiotherapists understand the importance of:

- holding the hope,
- promoting self-responsibility in service users for their own recovery,
- allowing time for healing and the development of healthy living habits,
- choosing pleasurable activities and a non–coercive approach based on respect of the individual,
- involving family members or carers in support of their loved ones
- developing community network

Details of a project in Auckland's acute adult MHS to involve nursing staff in the relaxation programme will illustrate how physiotherapists are able to work with and inform their fellow mental health workers.

CURATIVE FACTORS IN MOVEMENT THERAPY WITH PSYCHIATRIC PATIENTS

HÖLTER, G.
University of Dortmund, Faculty of Rehabilitation Sciences
Adapted Physical Activity and Movement Therapy

The majority of research concerning possible effects of Movement Therapy focuses on physiological aspects. The interest to investigate effects on mental health is increasing, though, partly because it becomes evident that a great number of people with psychiatric diseases suffer from psychosocial restrictions too. As a consequence the character of the activities themselves is changing from a more exercise to a more psychotherapeutic orientation.
Although it is premature to conclude that there is a causal link between physical activities in general and different dimensions of mental health (e.g. anxiety, depression, self-concept etc.) it seems that physical activity can function as a buffer and as a mediator variable to influence selected psychosocial variables (MORGAN 1997, BIDDLE / MUTRIE 2001, ARENT et al. 2001).
In our research we investigated the impact of clinical Movement Therapy as perceived subjectively by patients at the moment of the end of their therapy. Following YALOM's theoretical model of curative factors in group psychotherapy (1970) we developed a questionnaire (Dortmund Questionnaire for Effects of Movement Therapy - DQEMT) which measures the following four factorised aspects of the intervention: the influence of a) biographical experiences, b) the experience of body and self, c) the actualisation of group relations and d) the actualisation of movement and well-being.
It turned out that generally all effects of clinical Movement Therapy were rated fairly high. Differences were visible between in- and outpatient groups.
The data will be discussed under aspects of duration of therapy, of the specific character of body and movement oriented interventions and of the validity of the instrument.
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Scientific session A: ”Physiotherapy and eating disorders”

DO PATIENTS WITH EATNG DISORDERS BENEFIT FORM PHYSIOTHERAPY? A PPROPRIATE GUIDANCE.

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An overview is given of therapeutic interventions aimed at improving the body experience in patients with eating disorders through the use of physiotherapy. General aspects such as clinical manifestations, objectives, therapeutic techniques and therapeutic procedures will be discussed. We suggest three possible starting points: the distorted body experience, the movement behaviour (hyperactivity/passivity) and the fear to lose self-control. A description of the possible goals such as reconstructing a realistic self-concept, curbing hyperactivity, learning how to enjoy the body is given. Attention is paid to particular therapeutic techniques such as relaxation training, breathing exercises, mirror exercises, physical activities, sensory awareness and self-perception, all of which are used in physiotherapy and psychomotor therapy.

Psychomotor therapy is currently defined as a method of treatment which uses corporality and movement as a lead in its approach and in which one tries – after having gone through a psychomotor examination in a methodical way – to realise clearly formulated goals which are relevant for the problems of the patient. The psychomotor therapy is based on a holistic approach of the human being. This view is drawn from the unity of body and soul. The notion integrates the cognitive, the emotional and the motion aspect as well as the capacity of being and acting in a psychosocial context developed as a non-verbal therapy but it also integrated a lot of psychotherapeutic elements. The physical activities and bodily exercises are used here as part of the psychotherapeutic approach. The experiences during PMT and the responses that arise through these experiences function as dynamic powers of change.

WORKING WITH CHILDREN AND ADOLESCENTS WITH EATING DISORDERS

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The Eating Disorder Unit for Children and Adolescents is a part of Child and Adolescent Psychiatry department, Lund University Hospital. The Unit opened in 1983 as a unit for outpatients, since then we also have two apartments where we treat one family at a time in each on inpatient basis. Our patient has an age ranging from 5-6 years – 17 year when they seek treatment. My work as a physiotherapist in the unit is to assess all new patients coming to our unit. The assessment consists of a Body Seize Estimation, The Body Attitude Test and Machover´s Draw a person. Patients that overestimate more than 50% have score high on the BAT or if they are under the age of 13 are the one’s that I see for treatment.
In an outpatient setting I see the patient one hour once a week, if she/he is in one of our apartments a see them one hour four days a week. In the treatment I use Body Awareness Training, different Massage techniques, Education about the Body and Relaxation combined with conversation about how/what she/he feels/experiences in the exercise. All methods have to bee adapted to the patient age, the younger the more of a playful way to work. The exercises need to be adapted to the patients actual

somatic status, the more emaciated the patient is she/he has to bee more still and I do the work. When they get better they are more active in the exercises.

PHYSIOTHERAPY AND EATING DISORDERS

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PURPOSE:
All authors work as physiotherapists with patients with eating disorders in Norwegian hospitals. We all found that there was a lack of literature about this field. In the year of 2004 the tree physiotherapists listed above where given money from the Norwegian directory of social and health in our government, to make a guideline about physiotherapy and eating disorders.
METHOD:
We searched the largest databases as Cinahl, Pubmed/Medline, ISI-Web of science and Academic Search Elite. We used words as "Physiotherapy and eating disorders", "Physical activity and eating disorders", and also "Body image". As we collected research done in this field we saw that there was not enough to make guidelines from. We also searched for guidelines about physiotherapy and eating disorders from other countries but only found general guidelines about eating disorders that did not say much about physiotherapy. We therefore had to include experiences in our guidelines. We went to conferences both in Norway and abroad to get in touch with the physiotherapists that were the most experienced in this field. We also went to see how some of them clinically worked with patients.
RESULTS:
From the information we had gathered, together with our own experiences from working with these patients, we made the guidelines. The guidelines include theoretical foundation, examination, the acute phase, physiotherapeutic treatment, examples of concrete treatment and physical activity.
CONCLUSIONS:
When collecting all this information we saw that there are a lot of experiences and very little research in this field. The guidelines gives en overview that we hope will encourage physiotherapists to do more research in this field. As this first foundation became 71 pages, we see the need of a short version, and wish to do that next.

THE BODY IMAGE IN ANOREXIA NERVOSA AND BULIMIA NERVOSA: MIRROR DESENSITIZATION THROUGH AN OCCUPATIONAL THERAPY TREATMENT.

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Objectives:
- Improve the body image.
- Correct the wrong vision of the body.
- Distinguish the perception, sensation and emotion which are operating in the private body talk.

Methods :
- Exposure to the mirror.
- Desensitisation to the mirror.
- Systematic learning of self-observation.
- Learning using graphic material to define the body vision in the mirror.
- Confronting the knowledge and beliefs of the body.

Results :

- The results are based on clinical observations.
- The confrontation with the mirror helps to re-establish self control.
- The patient is able to establish reasonable self-observations to correct the vision of the body distortion and to create critical thinking.

Conclusion :

Given the importance of body image, the treatment consists of working that body image in a systematic way as mentioned in the above methods.

STATIC AND DYNAMIC BALANCE OF PATIENTS WIT ANOREXIA NERVOSA

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Adapted Physical Activity and Movement Therapy

Reviews of the motor characteristics of patients with Anorexia Nervosa (AN) often refer to hyperactivity, hypertension, lack of force, difficulties in coordination etc. As far as we know static and dynamic balance have not been investigated yet.
The reasons why we are especially interested in this dimension of motor behaviour are hypothesized links to psychic 'instability', which might be positively influenced by forms of therapy, which includes a physiological stabilization as well.
By means of an electronic measurement of static and dynamic balance (the DELOS-System) we compared 20 young women being in a clinical treatment for AN with a widely parallelized control group of 20 'normal' persons.
The overall results don't show any differences between the two groups. But as soon as the tasks were differentiated (open vs. closed eyes; with/without support) there were significant differences: AN-patients perform worse, a result, which is discussed on the background of psychodynamic exploration of the pathology.

QUALITY OF LIFE ASSESMENT FOR PATIENTS WITH EATING DISORDERS

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The purpose of this study was to examine the construct validity of Visual Analogue Scale (VAS)-quality of life for patients with eating disorders in relation to the following instruments: BAS-H and its Interview Scale for Body Ego (ISBE), Eating Disturbances Scale (EDS-5), Body Attitude Test (BAT) and Comprehensive Body Examination (CBE), part of respiration, subscale 1. In total 87 individuals were examined: 26 patients with anorexia nervosa (AN), 20 patients with bulimia nervosa (BN) and 41 patients with eating disorders not otherwise specified (NOS). The highest significant correlations (0,43-0,61) were found between VAS-quality of life and BAS-H (subscale grounding), variables of EDS-5 (control and feeling of guilt), BAT (subscale 2) and CBE (breathing variables). In conclusion, this study indicated that VAS- quality of life seemed to more accurately capture mental and psychosomatic factors than physical and health-related factors.

BODY IMAGE IN EATING DISORDERS. PRESENTATION OF THE COMPUTER PROGRAM BODY FIGURE.

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To treat body image distortion in eating disorders, and also to assess and understand the body image in a certain patient as in groups of patients, instruments are needed. In a computer program "Body Figure", a schematic contour of a woman body, can be redrawn to form a picture of oneself, both from the front and from the side. The size of different parts of the body can independently be changed and in the same time it gives a whole image of the body. Three possible pictures can be drawn – a cognitive picture "Think", an affective picture "Feel" and an ideal picture "Want". These can be compared with the "Is- picture", constructed from real height and width of the body. Body perception index is calculated estimating the relationship between the actual picture and the estimated one.
A study was conducted to validate and test reliability of the computer program in one group of patients and one healthy group and to compare the pictures within and between the groups.
A number of 23 eating disorder patients and 30 wealthy women; senior high school girls and occupational therapist students performed the test. The results showed reasonable criteria validity compared to Figure Rating Test and Body Attitude Test, enough sensitivity to differ pictures, and good test retest stability.
After the study some improvements of the program were made and it has then been used in the clinical work for about three years. It gives a good educationally aid, where the pictures serves as a starting point for further reflection and discussion about the personal body image and conceptions about ideals.

Scientific session: "Physiotherapy and a Biopsychosocial Approach"

GAIT IMPROVEMENT IN UNILATERAL TRANSFEMORAL AMPUTEES BY COMBINING ORTHOPAEDIC WITH PSYCHIATRIC PHYSIOTHERAPEUTIC TREATMENT AND A PSYCHOLOGICAL THERAPEUTIC APPROACH

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PURPOSE: Physiotherapeutic treatment of amputees traditionally focuses on physiological aspects like strength, fitness, motor learning and recovery of function. Rehabilitation programmes do not automatically include taking care of psychological problems, loss of identity, self-confidence and self-esteem, which may follow a severe body injury. The patients also need to adjust psychologically to their prostheses and to modify their body image. The purpose of this study was to describe the principles of a new training method and evaluate this approach by means of gait speed. RELEVANCE: There is no description of what technique to use to help the patient to adjust psychologically after an amputation and to accept the artificial replacement of a lost limb and to integrate it functionally. Also, low back pain has been shown to be significantly more common in trans-femoral amputees (71%) compared to the general population and was rated even more bothersome than phantom limb pain or stump pain. MATERIAL: Nine unilateral transfemoral amputees, age of 16-60, where amputation was caused by trauma or tumour, participated in a special gait-training programme. They had worn prostheses for more than 18 months. Before treatment three participants used walking-aids and all had problems with low back pain. METHOD: A special gait-training programme, combining orthopaedic with psychiatric physiotherapeutic treatment and a

psychological therapeutic approach, was used. The method aimed at integrating the prosthesis in normal movements and increasing body awareness. Gait was measured with a three-dimensional motion analysis system. RESULTS: Self-selected comfortable and brisk gait speed increased from in mean 0.95 m/s and 1.29 m/s before to 1.40 m/s and 1.65 m/s after treatment, respectively. The results remained at a six-month follow-up. After treatment none needed walking-aids and almost all low back pain had disappeared. Seven participants learnt to jog. CONCLUSION: Results indicate that this new approach may add skills, mostly on participation level, to lead a relatively normal life.

DOES THE IBS –PATIENT OF TODAY GET AN OPTIMAL TREATMENT?

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Purpose: At the Division of Functional Gastroenterology we have examined and treated 152 patients with the medical diagnosis of IBS (Irritable Bowel Syndrome). The aim of the study was to use a "holistic/wider" approach for characterisation of the patients and to use Body Awareness Therapy as treatment.

Methods: The patients was examined with two body examinations ROBE (Resource Oriented Body Examination) and BAS-H (Body Awareness Scale–Health), questionnaires for gastrointestinal symptoms (GIS), psychological symptoms (SCL90, DS, LOC), psychosocial status (SOC, PRS), pain picture, food diary and biochemical analysis of stress parameters in blood and saliva,. The patients underwent Body Awareness Therapy (BAT) during 24 weeks and were examined according as described above, at 0, 12, and 24 weeks.

Results: *The examinations* showed that these patients as compared to a control group, to a greater extent

a) had symptoms from the GI tract more than 5 years (79%)
b) had seen a doctor for their symptoms, more than 5 times (64%)
c) had other medical diagnoses besides IBS
d) showed deviations in the body examinations
e) showed deviations in stress parameters in blood and saliva
f) reported "traumatic" experiences in their lives
g) seventy-five percent have autonomic nervous system disorder (ICD G90.8)
h) had poorer psychosocial status/Quality of Life

After treatment patients improved both in bodily and mentally status. The patients obtain less GI symptoms, less psychological symptoms and less pain. The patients affect their tensions/symptoms in such a way that they moved towards normalisation of their body tensions and biochemical stress parameters and they generally felt better (as measured by the questionnaires). With this treatment, the patient acquires tools with which they can counterbalance/delay symptom relapses. They also become more aware of their resources and their needs in life.

Conclusion:

Today, these patients are mostly treated pharmacologically, receiving temporary symptom relief. Our data suggest that our BAT-treatment produce a good effect on the tension pattern of the IBS patient. Most likely, more IBS patients would benefit from a combined body/mind treatment. Also, we strongly believe that treatment of our kind would prove beneficial both to the singular IBS patient in earlier stages of the disorder as well as to our health economics. Maybe these IBS patients are strongly related to the tension/psychosomatic/traumatic patients who seek medical care at many different medical services.

TRAUMATIC BRAIN INJURY AND PROBLEMATIC REHABILITATION: AN ADVENTURE THERAPY APPROACH

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A subgroup of patients with traumatic brain injury (TBI) experience problems in compliance with therapies in rehabilitation setting. Sometimes these problems are correlated with a lack of awareness (anosognosia) or other motivational or behavioural problems that lead to admittance in a psychiatric hospital.
As a result lack of awareness and/or denial lead to a failure to implement compensation strategies, and difficulty maintaining realistic goals for rehabilitation. TBI patients often do not benefit from therapy, and social exclusion and breaking of family ties is common. Anosognosia also limits vocational possibilities.
In our search for a suitable approach we explored the possibilities of experiential learning. The framework of adventure therapy has a potential in meeting the difficulties of motivating these TBI patients because of its new, challenging and irrelevant properties. We are able within this framework to motivate patients for activities focusing on self-efficacy, self-confidence, and rehabilitation and of course self-awareness.
We will present our clinical findings of these monthly-based adventure therapies. We did not use a comprehensive qualitative measure to asses any change in behaviour. We will expand on the principles of Adventure Therapy, on the adaptations for this target group, and the specific assignments.

GASTROINTESTINAL SYMPTOMS IN 50 YEAR OLD WOMEN SHOWS A STRONG CORRELATION TO PSYCHOSOMATICS. CONTINUATION OF THE EPIDEMIOLOGICAL STUDY MEN BORN 1913.

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Purpose: The study "men born 1913" started 1963 with examinations of 50 year old men. Every 10th year new cohorts of 50 year old men have been examined. The 5th cohort of 50 year old men and, for the first time, 50 year-old women were examined in 2003/2004. A random sample of 50-year-old women from the general population was studied. In this study the interest focused on gastrointestinal symptoms.
Methods: The women were examined according to descriptive data as age, length, weight, BMI and circumference. Somatic data i.e. blood pressure, cholesterol, triglycerides and plasma glucose. Vegetative symptoms as dizziness, perspirations etc., Psychological expressions among others sleeping disturbances, nervous symptoms, psychosocial parameters, i.e. work, economics, health parameters and extent of employment, experienced stress and sense of burn out. The variables, mostly ordinal and nominal data were analysed with Chi square, Kruskal Wallis or Mann Whitney U test. Calculation of significance was done in relation to the control group (no gastrointestinal problems).
Results: Totally 668/994 (67%) women participated. Gastrointestinal symptoms were divided into three groups. Of the 668 examined women 492 (73.7%) had no gastrointestinal symptoms, 64 (9.6%) reported diarrhoea, 85 (12.7%) stated constipation and 27 (4 %) reported a mixture of diarrhoea and constipation (both). No significant differences were seen between the controls (no gastrointestinal problems) and those with gastrointestinal symptoms regarding descriptive and somatic data. However, those reporting gastrointestinal symptoms had significantly more vegetative and psychological

symptoms, felt more stressed, had a worse psychosocial situation and were more on a sick-list and maintained more sickness pension.
Conclusion: Our epidemiological study showed that gastrointestinal symptoms were more related to stress and psychosomatics, rather than to somatic parameters. The gastrointestinal symptoms contributed to an increased degree of sick-leave and early retirement pension. These data underlines the significance of a more psychosomatic attitude at consideration when treating patients with gastrointestinal symptoms. A more psychosomatic approach to women with gastrointestinal symptoms might be rewarding.

THE EFFECT OF INTERFERNTIAL THERAPY ON PATIENTS WITH LUMBOSACRAL RADICULOPATHY: NEUROPHYSIOLOGICAL STUDY

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Study design: A randomised trial designed to determine if the interferential therapy has a neurophysiological effect on compromised nerve root in lumbosacral radiculopathy patients. Objectives : To determine the neurophysiological effects of prone position and IFT on the compromised nerve root and their relationship with pain intensity and distribution changes in LSR patients

Background: Management of LSR by IFT is common worldwide. IFT is administered usually in prone position for patients with LSR. Prone position is reported radiological to improve the alignment of the lumbar spine at L5-S1 level. It is not clear if the improvement in the alignment of L5-S1 or the effects of the IFT could cause enough decompression of the compromised nerve root leading to change in the intensity and distribution of radicular symptoms which usually reported by those patients. No previous studies for the neurophysiological changes of compromised nerve root from IFT were found.

Materials and Methods: Two groups of subjects participated in this study; patient group of 28 males (mean age 39±12 y) with confirmed unilateral LSR and healthy group of 28 males (mean age 32±5y).The soleus H-reflex, pain intensity and pain distribution were recorded in four different conditions which were: immediately after 3 minutes of resting in prone position, immediately at the end of 20min of rest in prone position, immediately at the end of 10min of IFT (H-reflex was recorded during ongoing IFT) and immediately at the end of 20min of IFT.

Results: Both prone position and IFT had no statistically significant effect on H-reflex of healthy and patient groups throughout the four different conditions ($P < 0.15 - 0.57$).In contrary, they caused significant improvement of pain intensity and distribution($P<0.001$).

Conclusion: The results of this study indicated that neither prone position nor IFT had a decompression effect on the H-reflex of the compromised nerve root. However, all testing conditions showed a clear improvement in pain intensity and distribution which is most likely to placebo but not physiological or anatomical.

Key words: lumbosacral radiculopathy; interferential therapy; H-reflex; prone position; neurophysiological changes

COGNITIVE FUNCTION AND ITS EFFECT TO QUALITY OF LIFE STATUS IN PATIENTS WITH COPD

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Purpose: It's known that cognitive functions of Chronic Obstructive Pulmonary Disease (COPD) patients that decline by age, decrease due to hypoxemia and decondition. The objectives of the study are (i) to compare the cognitive functions of COPD patients with healthy elderly individuals and (ii) to determine probable effects of decreased cognitive functions on subject's quality of life status.
Method: A group of 26 healthly community residents (mean age 66.9 ± 8.1 **years**) and 27 patients with stable COPD (mean age: 70.2± 7.6years) of Department of Chest Diseases in Dokuz Eylül University Faculty of Medicine were included to this study. Cognitive status were measured with both Modified Mini Mental State Examination (MMSE) and mental category of the Short Form 36 Health Survey Questionnaire (SF-36) and health status were measured with SF-36 quality of life questionnaire.
Results: Physical and demographic characteristics were similar at both of the groups. Patients with COPD (24.3± 4.5) and healthy individuals (25.4±3.2) were not cognitively impaired. The SF-36 and MMSE scores were similar at both of the groups ($p>0,05$). We didn't determine a strong correlation between the SF-36 and MMSE values ($p>0,05$). In addition, there was not a significant correlation ($p>0,05$) between the MMSE and the Mental Health category of SF-36.
Conclusion: Therefore, it was found that respiratory symptoms didn't contribute to the cognitive functions' decline by age in COPD patients. Besides, it was found that SF-36 Mental Health quality questionnaire didn't give any clue about patients' cognitive functions. However, further data on the clinical tests with larger sample sizes are needed to serve as a reference for patient comparisons.

Plenary session
Friday, February 17, 2006

BODIES TALK: CAN PHYSICAL ACTIVITY BE THE COMMUNICIATION PARTNER,

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Somatizing patients are not the favourite patients of most health care workers. They are found to be difficult to deal with. Especially the indirect way in which these patients communicate their lack of well-being seems to be an important obstacle to develop a good therapeutic relationship and, as a consequence, an easygoing rehabilitation process. Patients often feel not being understood and/or taken seriously; health care workers feel frustrated because they experience difficulties in "convincing" the patient about the importance of psychosocial aspects in the development of the health problem. Consequently, a positive relationship is quite often replaced by a trench warfare.
In most rehabilitation programmes physical activity has an important place and patients spend a lot of time with physiotherapists. It is argued that, due to this reality, the physiotherapist may be a key person to stimulate the communication between the patient and different health care workers. In many cases the physiotherapist even may be the pioneer to get the patient on the track of psychotherapy. It is clear that a physiotherapist aiming at these goals should have some particular competence. Moreover there is growing evidence that the treatment and the rehabilitation of somatizing patients should be based on a multidisciplinary approach. Both aspects will be discussed.

BASIC BODY AWARENESS THERAPY AND POST TRAUMATIC STRESS DISORDER – A PILOT STUDY.

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PURPOSE: This pilot study aims to explore how Basic Body Awareness Therapy (BBAT) is experienced by two patients suffering symptoms of Post Traumatic Stress Disorder (PTSD) and how the physiotherapist can observe change in movement quality using the Body Awareness Rating Scale (BARS). PTSD is mainly treated with psychotherapy and cognitive behavioural therapy. There are few reports of physiotherapy involvement despite evidence for the physical aspects needing a body centred approach. METHOD: A qualitative study of two patients attending for individual physiotherapy. BBAT is a person-centred modality aiming at improved movement quality. It consists of everyday movements and use of voice with focus on improving balance, free breathing and awareness. BARS is a 7 pt assessment scale, consisting of patient report on movement experiences and therapist's observation of movement quality. BAS-Interview is a 4 pt scale based on the Comprehensive Psychopathological Rating Scale with added body items measuring psychological state and attitude to body symptoms regarding frequency and severity during the last 3 days. Two patients attended weekly: A for 7 months and B for 18 months and were assessed initially, at 3 months and the present using the Body Awareness Rating Scale (BARS) and the structured interview Body Awareness Scale (BAS Interview). FINDINGS: Analysis of data from BARS revealed that A initially experienced "dizziness" in sitting. In standing A felt "dizzy" when turning. This was observed as stiff movements with poor flow. The assessment at the present, 7 months A, "finding it easier to focus my eyes" in sitting. This was observed as more integration of balance, and more flow. Assessment of standing at the present A comments "I feel I can do this". This was observed as still a bit stiff but sometimes more integration of balance. BAS Interview, initially A had severe symptoms of anxiety and panic, phobias, low mood, sleep disturbance, aches and pains, at 7 months A has fewer symptoms and those relating to anxiety and phobia are less severe. Initially B comments "I cannot do this" in sitting. This was observed as stiff movements, and inability to balance. In standing B found it "hard to breath and focus the eyes". This was observed as poor contact with the midline and stiff movements. At 18 months B in sitting, "finds it hard to maintain contact with a straight line". This is observed as improving balance. In standing B found it easy and comfortable, observed as stable balance with increased awareness. BAS interview: initially B had severe symptoms relating to anxiety, panic, phobias, low mood, aches and pains, muscle tension, concentration, sleep disturbance, physical ability. At 18 months B has some symptoms of panic but is able to control them with only intermittent pain. CONCLUSION: BBAT seems to improve quality of movement, and balance. Regaining balance requires a learning process, which perhaps explains the time element. It might be interesting for a future study to explore to what extent BBAT can contribute to improvement from symptoms of PTSD.

THE ROLE OF PHYSICAL THERAPY IN PSYCHIATRY: A CASE STUDY IN THE USA

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The purpose of the paper is to explore the important roles of physical therapy services in a psychiatric setting as they are, in a typical state hospital in the USA. A review of the literature has presented with few information and materials about what roles physical therapist play as member of the medical team in the treatment and management of psychiatric patients.
The hospital in its policies and procedures manual has defined various roles for physical therapists as important members of the health care team.
This paper will attempt to enumerate the numerous roles of physical therapist can play in providing adequate and quality care to different types of psychiatric patients in both in and out patients basis.
Suggestions will be made on how physical therapists can be actively and visibly involved in the care and treatment of psychiatric patients in any settings.

PHYSIOTHERAPY IN MENTAL HEALTH? WHATEVER FOR?

Caroline Griffiths, UK

As a clinical specialist and more recently chair of the Chartered Physiotherapists in Mental Health I have often faced surprise, not least from other physiotherapists, that there is anything for me to do in mental health.
Well this conference supports everything I have ever said in answer.
So perhaps I am preaching to the converted or even the converting but I will endeavour to tell you a little about the state of Physiotherapy in England, Wales , Scotland and maybe Northern Ireland.
Describe the national drivers which may help us and give
a short resume of the work of the CPMH and a description of the first pre-pilot project on posture in mental health disorder which we hope to begin with colleagues in the neurology special interest group ACPIN.
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Scientific session: "Physiotherapy and Basic Body Awareness Therapy"

OPENING UP FOR AWARENESS BASIC BODY AWARENESS METHODOLOGY IN SHORT-TERM GROUP THERAPY -A Pilot Study

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Background: People on long-term sick leave suffering from muskuloskeletal problems, chronic pain, psychosomatic problems, stress and burnout syndromes are a challenge for today's health personnel, as the problems often are complex. Also, relational problems in family or working life often seem to be present in this group. **Purpose:** To search for ways to increase patients' awareness of interrelated bodily and psychological functions, as well as to find ways for patients to learn relational aspects connected to the problem situation. **Research Question:** How can Basic Body Awareness Therapy (BBAT) in groups be a useful approach to increase the participant's body awareness in a treatment period of 4 weeks? How can BBAT groups be a help for persons with relational problems? **Material:** A group consisting of 12 patients, (3 males and 9 females, age 25-55 years) received Basic Body Awareness Therapy (BBAT) as one of the approaches during a 4 week multidisciplinary, work-related rehabilitation stay. **Method:** The patients received Basic Body Awareness Therapy in groups of 1 hour and 15 minutes 6 times during the 4 week stay. The sessions included exercises in lying, standing and sitting, as well as exercises in pairs and reflections in the group. The guiding was led through the key elements balance, free breathing and mental awareness, focusing on movement resources. Qualitative method was used by open-ended questionnaires and therapist's diary notes from observation. Focus for the therapist's observation and questionnaires were on the participants' subjective experiences of the awareness in physical and psychological functioning as well as in relational aspects. **Results:** All participants in the group reported that BBAT sessions gave the patients a more conscious awareness; seeing connections between body and mind. A better ability to relax and learning to become aware of bodily tensions and breathing patterns was also reported by some, as well as improvement with coping of pain and new movement strategies. Positive experiences in group relations were for instance to give and take, closeness/ distance, body contact, interpersonal learning and reflecting and listening in a group. The participants reported a trust in the relevance of BBAT, and many are motivated for practising at home after the 4 weeks. **Conclusion:** BBAT sessions during a 4-week period gave participants an experience of opening up for awareness in every day's life- concerning the connection

of bodily and psychological function and issues relating to others. Participants report a genuine motivation for continuing doing the exercises at home. The experiences are stimulating in order to continue exploring the use of BBAT in this patient group, practically and by further research.

EVALUATION OF FUNCTIONING AND BODY AWARENESS OF YOUNG PATIENTS WITH SCHIZOPHRENIA

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The purpose of the study was to evaluate functioning and body awareness of young out-patients with schizophrenia using BAS- movement test, observation and a drawing test. The evaluation was done before and after a six week group training intervention. Five out-patients aged 20 to 27 participated in the project.

The results of the study show that functioning of the participants was characterized by decreased social contacts and withdrawal, as well as adherence while performing the exercises. Features in the drawing test varied individually, e.g. in the intensity of the outline, in faulty dimensions of the body parts and in decreased number of details. The individual drawings seemed to reflect one's relation to the body and body-awareness. In the BAS- movement test no changes were seen between the first and second measurement. The results of systematic observation showed increased communication and activity during the exercises. Also support to other members of the group increased.

Drawing test could be considered as a good measurement tool of body image in clinical physiotherapy when working with psychiatric out-patients. The movements in the BAS test were too simple and thereby insensitive to show changes in functioning with these patients. Six weeks was maybe too short time for the intervention to see major changes in functioning but the experiences expressed by the participants were very positive.

EXPLORING NARRATIVES AND UNDERSTANDING IN THE PROCESS OF MOVEMENT HARMONY WITH BODY AWARENESS RATING SCALE ASSESSMENT - A PILOT STUDY

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Background and purpose: In my work in primary care with patients suffering from long-term pain I have found Basic Body Awareness therapy (B-BAT) rewarding. With a holistic perspective based on a four-dimensional (physical, physiological, psychological and existential) human-view it aims to enhance integration of body/mind. Health and well-being are promoted through improved movement harmony in movements of daily life. Basic Body Awareness Scale (BARS), a tool to assess movement quality, consists of two parts; observation of key-elements (relation to ground, postural stability, free breathing and awareness) and catching the spontaneous lived experience of being in the movements. Observations are scaled from 1 (low harmony) to 7 (very good harmony). 4 is the midpoint where contact to postural stability/free breathing/awareness becomes visible.
I wanted in a pilot-study; see how BARS reflects development of movement harmony; explore how the subjective experiences/narratives in BARS reflected the patients understanding of/coping with symptoms and explore how subjective experiences connected to observed movement quality.

Research question: 1) How does Body Awareness Rating Scale reflect the integration of the four human dimensions before and after a period of group therapy with B-BAT in two women suffering from long-term pain problems? 2**)** How can BARS reflect the understanding and coping with the problems described by these women? 3**)** How do the subjective experiences in BARS correlate to the observed movement harmony?
Method and material: In this qualitative study two women with long-term pain (from 5 to 20 years) were assessed with BARS before and after a treatment period of 4 months (12 sessions). Narratives, as direct quotations, were categorized in four human dimension and compared with observations by three sub-scales within BARS; (1-3), (3-5) and (5-7).
Result – the process:
1) *Observations*: Movement harmony increased in Woman A from 4,2 to 5,5. Woman B from 3,3 to 4,2. Postural stability improved, although still fragile in Woman B. Coordination between upper/lower body, left/right side improved with less compensations in both. Awareness and intention improved although more clearly observed in Woman A.
Narratives: Both women reported increased awareness of movement qualities. Woman A expressed trust towards further development, other people and life. She increasingly connected to existential/ relational/psychological aspects in movements with improved contact to self. Woman B reported symptoms more frequently. Positive experiences increased in second assessment and her will and needs were expressed more often.
2) Increased understanding of and coping with symptoms was expressed by both women.
3) Woman A expressed experiences and showed development of movement harmony within middle(3-5) and upper(5-7) part of BARS. Woman B expressed experiences and developed movement harmony within the middle part of BARS. Narratives correlated to observations.
Conclusion: This pilot-study shows, through BARS, how movement harmony seemed to correlate to human view, as described by the patients understanding of symptoms. It deepens my interest for the lived experience of being in body/movement in connection to human view, health and well-being.

BREATHING AS AN INNER FRIEND, BASIC BODY AWARENESS THERAPY WITH HYPERVENTILATION PATIENTS - A PILOT STUDY

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Background I have noticed at my work that with pain, anxiety are often connected with disharmony in breathing and movement, tension in the body posture, with lack of grounding, stability and flow in movement. In Basic Body Awareness Therapy (B-BAT) the aim is to find more firm postural stability, a more free breathing and mental awareness.
Purpose The purpose was to explore and describe how it is to use B-BAT in physiotherapy focussing on breathing with hyperventilation patients in a group situation.
Research questions How is it to use B-BAT in group physiotherapy with hyperventilation patients? What are the experiences of the participants in the B-BAT group?
Method and material Qualitative methods as observation and field notes were used in this pilot-study. The focus for observation was on how breathing was expressed in movement, looking at flow, coordination, centring and contact to the midline and the ground. Information about the experiences of exercises and bodily changes was also collected by questionnaires from the participants. There was five participants, aged 25-45 years, in the group, one male and four female. All the participants had anxiety and problems in breathing. Some also had chronic pain. The group met once a week 1 ½ hours 12 times. B-BAT exercises, which were simple movements from daily life were used. After movement sessions there was situation for talk about participants´ experiences. Different themes were added to discussion for example: coping with stress and connections between body and mind. Participants also chose a photo of nature from the collection of pictures to illustrate how they felt in

their body. They chose the most describing picture at the third and the last group session. Then the two chosen pictures were put together to look at the changes for example in colours and shapes.
Results Participants reported that they found B-BAT exercises helpful as home-exercises and noticed more free flow and relaxation in their breathing and better ability to relax. They reported that they could react in stressful situations instead of getting exhausted. They found new coping strategies for panic by being more aware of their body-signals. Participants reported the importance of sharing experiences of movements and situations of panic-attacks. The participants were observed to be more grounded and to have more flow in breathing and movements. Also the awareness and being present in the movement developed and was seen in concentration and reflection during exercises. Change was also seen in the photos that participants chose to illustrate their feelings and sensations. In the end the photos with more colours and stronger trunks and roots were chosen to describe themselves and the change. Using photos helped the participants also to find words to describe the bodily sensations and helped the use of metaphors in guiding.
Conclusion This small pilot-study showed the usefulness and creative possibilities of using B-BAT with hyperventilation patients. Participants reported more relaxation and well-being in their bodies, especially in breathing and the same phenomenon was seen in more grounded postures and movement quality. Awareness of the connections between body and mind and listening to own bodily signals was the key to better coping in stressful situations.

Scientific session: Physiotherapy and Depression

PHYSICAL FITNESS AND PHYSICAL SELF-CONCEPT IN PATIENTS WITH DEPRESSIVE AND ANXIETY DISORDERS

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Background. Generally, depressed and anxious psychiatric patients have a weak physical fitness and low physical self-concept and global self-esteem.
The objectives of this randomised controlled trial were (1) to compare the changes in cardio-respiratory and muscular fitness, and the changes in physical self-concept after participation in one of two psychomotor therapy programs in a sample group of depressed and anxious psychiatric patients; (2) to study the relationship between the changes in physical fitness and the changes in physical self-concept; (3) to investigate the relationship between changes in physical self-concept, global self-esteem, depression and anxiety.
Setting. Three treatment units of the University Centre Sint-Jozef in Kortenberg (Belgium).
Subjects. 199 patients with severe symptoms of depression and/or anxiety, and/or personality disorders.
Interventions. A general program of psychomotor therapy, consisting of different forms of physical exercises and relaxation training, and a personalized psychomotor fitness program, consisting of aerobic and resistance training. These programs were followed three times a week for a period of 16 weeks.
Outcome measures. Cardio-respiratory fitness and muscular strength were measured by means of a graded exercise test on a bicycle ergometer (Franz test) and the 1-repetition maximum method. Physical self-concept, global self-esteem, depression and anxiety, were evaluated using the Physical Self-Perception Profile, the Rosenberg Self-Esteem Inventory, the Beck Depression Inventory and the Trait Anxiety Inventory, respectively.

Conclusions: At the end the 16-week programs, both groups exhibited an improvement in muscular fitness, but only the psychomotor fitness group had improved in cardio-respiratory fitness. Both groups showed a more positive physical self-concept. The two programs seem to be equally effective in enhancing physical self-concept. The improvements in physical self-concept were not related to the progress in physical fitness. The gains in fitness did not play an essential role in the enhancement in physical self-concept. In both groups, the improvement in physical self-concept was correlated with increased global self-esteem and decreased depression and anxiety levels. This relationship supports the potential role of the physical self-concept in the recovery process of depressed and anxious psychiatric inpatients.

PHYSICAL ACTIVITY AS A TREATMENT FOR DEPRESSION: CURRENT SITUATION IN SPAIN.

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Actually, physical activity (PA) practice and researches get a special interest due to lifestyles of Western European countries. Competition, information and stress have increased the prevalence of mental disorders with specific disorders, such anxiety, chronic fatigue syndrome and depression. Physiotherapists may lead treatments to patients with mental disorders through PA programs. Today in Spain, physiotherapists do not focused a PA therapeutic approach to patients with mental disorders. Instead some other professionals, like psychologists or physical activity masters, have done a deeply research and practice focused in relation of physical activity and mental health. The role of exercise in improving mental health is a growing area of research interest to Spanish physiotherapists. The existing evidence suggests four main functions of physical activity for impacting mental health (Fox et al 2000):

1. To prevent mental health problems.
2. To improve the psychological well-being of the general public.
3. To improve the quality of life for people with mental health problems.
4. As treatment or therapy for existing mental illness.

Principal theories of positive effects of PA in mental disorders are analysed in this work. It is needed to grow awareness of the importance of physical activity in mental health and to promote the figure of the physiotherapists into mental health teams.

LESS DEPRESSED THROUGH MORE EXERCISE ?

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As an emotional state, depression and anxiety are experienced by most of us at some time in our life as we deal with frustrations and stress within the context of daily living. Clinical depression and clinical anxiety, however, are less common, debilitating, and potentially lethal. They represent serious states of psychological malaise and self-dejection, and are considered as prevalent problems in today's society. The common practice for treatment is a combined intervention of antidepressant or anxiolytic medication and group or individual psychotherapy. But despite the availability of drug and psychotherapeutic treatments, much remains inadequately treated due to high personal, social, and economic costs and the high ratio of non-response to treatment.
Exercise has been forwarded as a therapeutic means for the treatment of clinical depression since population studies have shown clear correlations between physical activity and mental health at a given point in time. In the case of clinical depression, it has been concluded that (a) exercise significantly decreases depression, and the antidepressant effects persist in time (from 2 months to 1

year); (b) all modes of exercise is effective; (c) the longer the exercise program, the greater the decrease in depression; and (d) exercise is at least as effective as psychotherapy.
Some of the existing research, however, has led to cautious conclusions about how much benefit physical activity and exercise might have. It has been suggested previously that as experimental rigor improves, the positive effects of exercise become less obvious, although the smaller number of true experimental studies make it difficult to be confident about such a conclusion. However, the observation that both field and laboratory research report the same beneficial effects of exercise can only strengthen the position that exercise has excellent potential to impact positively on mental health in clinical populations.
Based on the present findings, more randomised trials are needed before poor mental health should be considered to be directly improved through exercise, although there might be a difficulty to conduct true double blind RCT in therapeutic circumstances. Besides that, small but consistent changes, which in a group design would not emerge to be statistically significant, can be of major importance for the individual. With a focus on applied issues such as the effect of exercise interventions on e.g. mood disorders, this calls for a need for a methodology or instrumentation that is sensitive enough to register constancies and idiosyncrasies in emotional and behavioural reactions to the treatment conditions.
Examples of such 'case-study' approaches will be presented and discussed. The conclusion is that there is cautious support for the proposition that exercise is associated with enhanced affect and mood in clinical populations, but the strength of the relationship largely depends on population, environmental and individual characteristics. From a clinical perspective however, research findings should be viewed in support of earlier epidemiological evidence, suggesting that depression is indeed associated with low activity/fitness and that those who maintain activity are less likely to develop depression.

PHYSICAL ACTIVITY AS A TREATMENT FOR DEPRESSION: CURRENT SITUATION IN SPAIN.

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Actually, physical activity (PA) practice and researches get a special interest due to lifestyles of Western European countries. Competition, information and stress have increased the prevalence of mental disorders with specific disorders, such anxiety, chronic fatigue syndrome and depression. Physiotherapists may lead treatments to patients with mental disorders through PA programs. Today in Spain, physiotherapists do not focused a PA therapeutic approach to patients with mental disorders. Instead some other professionals, like psychologists or physical activity masters, have done a deeply research and practice focused in relation of physical activity and mental health. The role of exercise in improving mental health is a growing area of research interest to Spanish physiotherapists. The existing evidence suggests four main functions of physical activity for impacting mental health (Fox et al 2000):

5. To prevent mental health problems.
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8. As treatment or therapy for existing mental illness.

Principal theories of positive effects of PA in mental disorders are analysed in this work. It is needed to grow awareness of the importance of physical activity in mental health and to promote the figure of the physiotherapists into mental health teams.

EXERCISE ATTITUDES AND PHYSICAL BEHAVIOURS AMONG PERSONS IN TREATMENT FOR PSYCHOGENIC OBESITY AND BINGE EATING DISORDERS

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INTRODUCTION: Obesity is a chronic multifactor condition in which excess body fat may expose the individual to serious health risk (e.g. diabetes mellitus, hypertension, heart disease, etc.) and to severe alteration of the psychosocial functioning and quality of life. Moreover it can be associated with disordered eating, as overeating or binge eating disorder, depression, low self-esteem and impulsivity. This coexistent psychopathology may worsen the treatment outcome and produce early relapse. Basic treatment of overweight and obese patients requires a comprehensive approach involving diet, regular physical exercise and cognitive and behavioural changes, with an emphasis on long-term weight management rather than short-term excessive weight reduction. The intrinsic motivation is one of the most important factors supporting the compliance with patients in treatment, in particular, the motivation to physical activity and the change in the attitude of patients towards physical experience are determining elements of the weight control treatment success (Berger, 2004; Dietz, 2004).
METHODS: In a clinical psychiatric setting, we have been running a program of adapted physical activity (APA) for overweight and obese in-patients with psychiatric symptomatology. We have developed a specific multidimensional program for these patients including an energy-restrict diet, individualized physical activity daily program, nutritional education, together with individual and group cognitive-behavioural psychotherapy. The chief aims of our obesity APA program are: ameliorate the physical conditions, improving the exercise capability, the readiness to the physical activity, self-esteem, and increasing social relationships.
RESULTS: Our sample consisted of 35 inpatients (5 male e 30 female) with a mean age of 37,5 years (SD=14,4). The most frequent psychiatric diagnosis were Binge eating disorders and Borderline PD. On the basis of the BMI estimate 5 presented an overweight, 9 were in obesity class I, 7 were in class II and 14 were in class III; the mean BMI was of 39.23 kg/m^2 (SD=8.5). Results have been evaluated with several tools, including: bio-medical parameters, improving BMI, psychometric scales (SCL-90, University of Rhode Island Change Assessment Scale, Dieter's Temptations of Eating Inventory, Body Image Avoidance Questionnaire, SF-36, Borg scale), physical measurement, recording of fitness performance, and specific observation for physical activity patterns. The results obtained so far are compatible with the recommendations of the international guidelines for the cure of obesity(NHI, 1988): the mean weight loss was 5.9 kg corresponding to 5.5% of the initial weight.
Our findings lead us to support that APA could be an important functional element within a multidimensional therapy program aimed at the treatment of obesity with psychiatric comorbidity.

SCIENTIFIC SESSION: PHYSIOTHERAPY IN PSYCHIATRIC DISORDERS

THE STATUS QUO OF PSYCHOMOTOR THERAPY AS A TREATMENT OF PSYCHIATRIC PATIENTS IN THE CZECH REPUBLIC.

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The article focuses on psychomotor therapy (PMT) as a treatment of psychiatric patients in the Czech Republic. Assuming that PMT is used as part of a complex treatment of psychiatric patients, the article investigates what the content of such PMT treatment is, what kind of professionals work in the field, and what kind of techniques are being used. A description of the actual problems in this therapeutic field is provided and potential solutions are discussed.

THE RELATIONSHIP BETWEEN PERCEIVED AND ACTUAL MOTOR COMPETENCE IN A GROUP OF ADOLESCENTS WITH PSYCHIATRIC DISORDERS

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To examine the relationship between perceived and actual motor competence in adolescents with psychiatric disorders, 43 adolescents with a mean age of 14.96 years completed the Physical Self Perception Profile (PSPP) for Adolescents. The participants' actual motor competence was measured with the Körper-Koordinationtest für Kinder. Pearson's correlations indicated a rather weak correlation between perceived and actual motor competence in adolescents with psychiatric disorders ($\underline{r}$ = .03- .38).

NEGATIVE BODY IMAGE AMONG YOUNG WOMEN WITH BORDERLINE PERSONALITY DISORDER

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Aim: To investigate have young women with borderline personality disorder relate to and express their body image.
Methods: In a qualitative study eight women aged 22 – 29 years were interviewed using a semi-structured interview scheme. The material was analysed according to a phenomenographic approach. The study was approved by the local ethical committee.
Results: The body image of the interviewed young women were classified in ten different categories. The women expressed a dissatisfaction with their appearance and their body shape. They viewed themselves as large, disproportional, ugly and clumsy. The body was not experienced as valuable. They had thoughts about the body as disgusting, dirty and something that was worth to be punished. Further, they expressed difficulties to perceive their bodies as an integrated entirety and sometimes they suppressed their body sensations. Body signs were neglected and the interviewed persons expressed a wish to hide their bodies from other persons looks. They also wished their bodies not to occupy space and attention in the environment. Physical touch was regarded as unpleasant. However, the interviewed women expressed the importance to like themselves and to experience and accept their bodies as subjects. The women also maid clear that the pleasure in body motion contributed to a positive body image. The result verify the diagnostic criteria that these women are emotionally vulnerable linked to the way they used their bodies to handle their feelings.
Conclusions: The study indicates that young women with the diagnose borderline personality disorder have a negative body image and also relate negatively to their bodies. Physiotherapy using Basic Body Awareness Therapy, massage techniques and different types of movement therapies is recommended as a possibility to improve body and self image for persons with this problem.

THE BODY-CONCEPT OF ADOLESCENTS WITH SELF-INJURIOUS BEHAVIOR

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Cutting the forearms with raisers, scissors and shards of glass and burning the skin with cigarettes and steam; self-injurious behaviour amongst adolescents seems to increase.
Teachers, counsellors and therapists are being confronted with this behaviour more and more. Self-help forums on the internet are increasing, where those affected are able to discuss the ways and means of self injury.
Research into the attitudes of those injuring themselves towards their bodies is minimal. Therefore a study has been conducted with the help of the internet forums. The electronic questionnaire also incorporated the Frankfurter Scales of body-concept from Deusinger.
Over 100 of those affected between the ages of 14-22 took part in the research and about 90% were female. The results of this study form the basis of this presentation where striking findings in certain aspects of the body-concept are seen.
An additional overview of epidemiological issues and the current situation in scientific research will be given. The dynamics of the act of self-injury, and its accompanying cognitive and emotional factors will be explained, as well as intra- and inter-personal issues.
The reasons for, and the background of self-injurious behaviour will be briefly outlined. In the conclusion the implications of the study for possible adapted physical activity for stationary treatment is discussed.

Scientific session: Physiotherapy and Fibromyalgy

DEPRESSION AS EXPERIENCED BY FEMALE PATIENTS WITH FIBROMYALGIA

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PURPOSE: Depression is one of the most common symptoms associated with chronic pain in fibromyalgia. Every third patient with FM suffers from clinical depression. The purpose of this study is to describe and analyse the experiences of depression among female patients with fibromyalgia. SUBJECTS: Five female patients aged 42 -62 with a long history with FM were included in the study. METHODS AND MATERIALS: A qualitative theme interview method was used to collect the data. Each patient was interviewed in a session of 1,5-2 hours. Interviews were recorded and transcribed word by word for the analyses. ANALYSES: The interviews were analysed using both narrative and phenomenographic approaches. The stories were analysed in perspective to storyline, highlights, the beginning and the end as well as roles that were given to patient herself, to professionals or to pain. The phrases used by the patients were categorised and analysed in-depth. RESULTS: Although the experiences of disability varied from person to person, common features connected to mental well-being could be categorised as 1) solitude and loneliness 2) mood variations 3) changes of self-perception 4) body image issues and 5) overwhelming fatigue. The role of professional helpers, e.g. physiotherapists, was seen as essential support. Experience of not being heard or believed seemed to lead to uncertainty and experienced helplessness. Diagnosis was a meaningful turning point where a name to the symptoms was given. The patients could be in a role of a “princess” waiting for some someone to save her from the monster (=pain). Another type of story was more heroic, finding ones own resources and learning to live with the disability. CONCLUSIONS: Positive experiences in physiotherapy strengthen the coping of the FM patient where as negative experiences lead toward exhaustion and cause drop-outs from therapy interventions. Therapeutic discussion where both the

patient and the physiotherapist are seen as experts, enforces the commitment to therapy and should be seen as an essential part of physiotherapy when treating patients with fibromyalgia.

THE RELATION BETWEEN THE BODILY EXPERIENCES WOMEN HAVE DURING THE YEARS PRIOR TO THE FIBROMYALGIA DIAGNOSIS, AND THE DEVELOPMENT OF FIBROMYALGIA.

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Purpose: To study how women with a newly acquired fibromyalgia (FM) diagnosis experienced the years prior to the diagnosis.

Method: The design is retrospective and the method is qualitative life world interview, with 5 women, analysed after Giorgis phenomenological scientific method. **The preconception** is that life and illness are interdependent and interacting and that life experiences will play an important part in the development of FM.

Results: All 5 women had problems with their bodies for many years before the FM diagnosis. All of them had gone through prolonged stressful periods, due to some sort of crises, loss, deaths, serious illness in the family and things like that, which had affected both body and soul tremendously. When in these situations, the women had gone out of their way to help others, like family members, friends, workmates. They had put themselves and their own needs away, and for long periods of time they had been working, not paying attention to pain and tiredness in their own bodies.

Symptoms: The most common bodily experiences in the years before having the diagnosis FM, were pain, tiredness, exhaustion and stiffness. Some of the women reported nausea, stomach pain, headache and depression, difficulty concentrating and remembering. Some of them also felt " strange " body experiences, being by the side of their own body, and like they were acting in a theatre, among other things, and later on, closer to getting the FM diagnosis, some women reported feeling their bodies are strange and queer, being swollen without being it and feeling very heavy.

How the women handled their experiences. They were trying not to think of the bad things happening, and trying to suppress what they felt in their bodies were quite common. They also reported about not understanding what was going on with their body, and of being afraid of what they felt in theirs bodies. Their bodily experiences had stopped to be useful information for them in their lives. Even when they knew that their bodily symptoms were telling them that they were exhausted, they could not respond to that in an adequate way, like giving the body the needed recreation.

They also reported about a split between themselves and their bodies, like" my body did not want the same as I wanted, it was OK with me, but not for my body, my body did not want to come with me, " and the like.

Conclusion: The women reported about a strong alienation from their bodies. Their experiences were that their bodies had ceased to be part of themselves, and their bodies were experienced more like an enemy or antagonist to themselves. The women were putting the needs of others before their own needs.

BODY CONSCIOUSNESS AND NORWEGIAN PSYCHO MOTOR PHYSIOTHERAPY. EXPERIENCES FROM PATIENTS WITH CHRONIC WIDESPREAD PAIN

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Purpose: Norwegian Psycho Motor Physiotherapy (NPMP) is a method for treatment, developed by the Norwegian physiotherapist Bülow-Hansen and the psychiatrist Braatøy during the period 1946-53. NPMP has been used to treat pain and tension in the musculoskeletal system and for adjuvant treatment of patients with neurotic disorders. The phenomenon of body consciousness is considered to be essential when it comes to improve body functions. This study explores experiences of and thoughts on body consciousness of patients with widespread chronic pain, and how this phenomenon changes due to undergoing NPMP.

Methods: The focus group interview was chosen as a relevant methodological approach. A total of 4 groups with 3, 2, 5 and 3 informants, respectively, were interviewed. Two groups included men and women from a waiting-list for NPMP, while the other two included men and women undergoing such treatment, all participants living in the city of Bergen. Each interview was audio recorded. The interviewer was supported by an assistant, taking field notes. The data collected was transcripted and further analysed.

Findings: Three dimensions of the phenomenon of body consciousness were highlighted:

1) Body awareness: a) To be aware of and understand own body - a new awareness of body; an opportunity to relieve pain. b) Body experiences and associations 2) Feelings for own body. a) Positive feelings b) Negative feelings 3) Body perceptions. a) Symptoms b) Positive sensations.
Conclusions: Body consciousness is experienced and thought to be; an awareness and understanding of how feelings and life situation influence muscle tension, movements and respiration and how body works during daily activities. Those informants who, due to Norwegian Psycho Motor Physiotherapy, experienced a new awareness, were more capable to cope with pain.

DIFFERENT ASPECTS OF PAIN REHABILITATION AND RETURN TO WORK. A ONE- AND THREE-YEAR-FOLLOW-UP WITH A GENDER PERSPECTIVE

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At the department of rehabilitation medicine, patients with prolonged musculosceletal pain are assessed and participate in a pain-management-program with an interdisciplinary (physician, social worker, physiotherapist, occupational therapist, psychologist) approach.

One of the main treatment methods is basic body awareness therapy in a group format.

The overall purpose for the program is to develop coping strategies, to achieve improved function and level of activity in order to improve quality of life in general and to make it possible, for the patients participating, to return to work. At discharge a rehabilitation plan is constructed, often with a vocational approach. A common recommendation is to practice physical exercise, for example body awareness.

Purpose: The aim of the study was to evaluate the rehabilitation plan made after a 5-week interdisciplinary pain-management-program, and to find out to what extent the plans were accomplished and the effect they had on return to work for the individuals participating. A gender perspective was applied.

Method: The plans made at discharge (N=17) were evaluated at a one-year follow-up. In a semi-structured interview the plans were assessed as well as the actual working situation. After three years data from the social insurance office was obtained in order to evaluate to what extent the plans made had resulted in return to work in a long-term perspective.

Results/Discussion: At the one year follow-up there was no effect at all of return to work. At the three year follow-up 3 out of the 17 had returned to work. The plans were accomplished fairly well. The patients had low own belief in a vocational return and return to work was poorly affected of the treatment program, especially in a short perspective.
Results on different aspects of rehabilitation, plans for rehabilitation and return to work will be presented and discussed with a gender perspective.

Scientific session: Physiotherapy and Psychomotor Therapy

TO DEVELOP BODILY KNOWLEDGE BASED ON PSYCHOMOTOR PHYSICAL THERAPY.

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PURPOSE: The purpose of the study was to elucidate how the patient and the therapist gain knowledge concerning the following perspectives:

- Which kind of knowledge does the patient develop about herself throughout psychomotor physical therapy, based on bodily experiences, reflection and insight?
- How is the development of knowledge based on patient-therapist relationship?
- How does the therapist contribute to the development of knowledge?

RELEVANCE: The body is understood as a biological and socio-cultural being. Strain of physical or emotional character expresses itself in respiration, muscle tension and movement. The complexity of the strain may have consequences for choice of approaches of physical therapy.
SUBJECTS: One experienced physical therapist and two patients from her waiting list with long-lasting muscular pain. Two treatment courses were followed for six months.
METHODS AND MATERIALS: The main theoretical perspective with regard to choice of methods has been phenomenological-hermeneutic. Patients were in-depth interviewed before and after therapy sessions that were video-taped. The therapist was interviewed after the observation period.
ANALYSIS: The interviews were analysed according to Giorgi`s phenomenological based method and Kvaale`s three levels of interpretation. The video material was analysed according to part process analysis, highlighting elements of interaction and development.
RESULTS: The study demonstrated how patients gained knowledge about themselves by getting in touch with their own body through experiences of movement and reflection. Through the treatment course, the body was gradually experienced more distinct and differentiated. Knowledge development during therapy was made evident as interaction. Central phenomena of the therapeutic process were attentive presence as well as reciprocity of acknowledgement and recognition. The therapist considered knowledge development as a process over time, consisting of long and short term aims.
CONCLUSION: In psychomotor physical therapy knowledge development was made evident as an interaction process of self-understanding based on bodily experience and reflection.

FOLLOW-UP ON REAL AND PERCEIVED COMPETENCE

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Real and perceived competence were examined in Flemish primary school children, 27 girls and 17 boys, ages 8 to 12. The Movement Assessment Battery for Children (Smits- Engelsman, 1998) (MABC) measured real motor competence. Measures of perceived competence were obtained using Veerman' s (1989) Dutch version of the Self-Perception Profile for Children (SPPC). The Mann-Withney U Test examined gender differences. Age- related evolutions were controlled by ANOVA. Girls score better than boys on real motor competence in grades 4 and 5 ($p<.05$). Third grade girls score better on behavioural conduct ($p<.05$), 5th grade boys score better on social acceptance ($p<.05$). Results of the SPPC stayed stable over the 3 grades. Fourth grade girls are able to give an accurate estimation of their motor competence. More profound research on larger sample-sizes is needed.

KINESIOTHERAPY

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Passive as well as active motoric activity helps to improve motoric functions. Active motoric activity develops the personality, the self-concepts, and the self-evaluation.
Dance therapy, psychomotoric therapy, adventure therapy, kineziotherapy and other unnamed movement therapies, which work with the own activity of participants, have been developing since the 30s of the last century, at the time when different approaches that use active motoric activity as the means of change started to arise, independently of each other. There are many individual people as well as institutions who take part in the movement therapies. These therapeutic methods are often closely connected with the personal experience of the therapist. They often lack the theoretical anchoring, diagnostical methods and only few of them work with the control of biological feedback and the knowledge of neural mechanisms. The possibility of wider use of them is dependent on personal transfer of experience and thus their efficiency diminishes when carried out by a different therapist.
The Czech Republic, as well as the other eastern countries, was separated from information sources to a certain measure. That is why it was a good ground for creation of its own theories. In the field of the motoric therapy of psychiatric illnesses it was Kineziotherapy that started to develop in 1990.
We come from the presupposition that every illness and every psychic change will be mirrored in the function of the central nervous system and thus in the function of all organs.
We suppose that the experience of the corporeal I, the corporeal scheme to be the deepest intention, which is the basis of all the corporeal movement in its co-existence with the world.
Motorics is closely projected into the ability to perceive, to evaluate and to use the space relations. Perception and movement form the whole – intencionality. If this whole is broken, there arise disorders in the perception of one's own body. The psychically ill people have their corporeal scheme and motoric ideas permanently or temporarily changed. The time-space schedule, special harmony (equilibrium, proporciality, frequency of changes, dynamics of changes) are disbalanced. This gives evidence for a very close relationship among motorics, nervous system, central nervous system, the state of the internal environment and the quality of relations between the internal and external environment.
The motoric manifestations are influenced by motivational processes, which we place into the emotive brain, anatomically into the limbic system. Positive emotional experience from the learning of motoric programmes enable transfer into other areas of the life of the patient.

The closest relation to the kineziotherapeutic effects are psychotherapies based on the knowledge from the areas of theories of learning, behavioural theories, cognitive theories and cognitively behavioural theories.

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Plenary session
Friday, Afternoon

LIAISON ROLE OF PHYSIOTHERAPY IN ACUTE ADULT MENTAL HEALTH

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Evidence shows that physical pain and the emotional suffering of depression are interwoven and interact in each direction. Depression all too frequently complicates physical illness. It may profoundly worsen the already poor quality of life of patients with pain or other physical problems and can also affect the patients response to and their ability to cope with physiotherapeutic treatment and rehabilitation. Depression often goes unrecognised and untreated in physical illness but its presence can have a significant impact for the patient, the therapist and the service.

EFFECTS OF PHYSIOTHERAPEUTIC TREATMENT IN OUTPATIENT PSYCHIATRIC CARE - A PILOT AND A RANDOMISED STUDY ARE PRESENTED

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Two consecutively selected groups of patients at an outpatient psychiatric clinic were studied. Both groups (experimental (E) and control (C) group) received conventional treatment (treatment as usual= TAU) and in the E-group psychiatric psychotherapeutic treatment (PPT) was added (4 sessions). The effect of PPT was assessed immediately after termination of PPT and after 6 month from intake. Instruments used for assessments were SASB, measuring the self-image, the SCL- 90 , measuring symptoms, and a semi structured interview focusing on satisfaction with treatment and treatment outcome. Immediately after the E- group´s termination of PPT, both groups had a less consistent self-image with lower self- control and more self-attack than a sample of “normals”, and the people receiving PPT hade even less normal self-image. However at the second assessment 6 month from intake, the E-group had a more normal self-image and the same symptom ratings as the “normals”, whereas the C-group seemed to have deteriorated over time both in self-image and symptoms. The value of PPT and how it might take part in the process of improvement is discussed.

The second study has a similar design as the above one but is randomised and enlarged.
The aim was to study the outcome of Basic Body Awareness Therapy (Basic BAT) added to treatment as usual (TAU) compared to TAU only. Seventy-seven patients were randomised to Basic BAT and

TAU (*n*=38) or TAU only (*n*=39). Patients were assessed at baseline and after 12 sessions of Basic BAT, 3 months after baseline. At the termination of Basic BAT sessions, patients receiving Basic BAT in addition to TAU showed significant improvements concerning the quality of movements using the Body Awareness Scale-Health (BAS-H), and psychiatric symptoms and attitudes towards body and movement using the Body Awareness Scale interview, compared to the TAU-only patients. A significant improvement in favour of the patients receiving Basic BAT was also shown with regard to self-efficacy, physical coping resources and sleep. Age and sex showed no significant influence on outcome. The results indicate that Basic BAT in addition to TAU, in a relatively short intervention period improves the body awareness and attitude towards the body as well as self-efficacy, sleep and physical coping resources compared to TAU only. Both studies indicate a positive outcome of the PPT and Basic BAT treatment. However, studies of the long-term outcome remain to be undertaken.

Poster Presentation Abstract

THE GENERAL SELF-EFFICACY OF EATING DISORDERS PATIENTS

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One's perception of one's general competence is of great influence on one's behaviour and performance. The purpose of this investigation is to compare the general self-efficacy from a hierarchical perspective between eating disorder patients and healthy peers.
The experimental group consists of 69 female eating disordered patients. The control group comprises 82 female students from the region of Gent. All subjects are between 14 and 26 years old. The Self Description Questionnaire III (SDQIII; Marsh, 1989) and the abridged form have been used.
This investigation to the general self-efficacy of eating disordered patients is a recent development. Both versions of the SDQIII show good psychometric marks. The hypothesis is confirmed that the general self-efficacy of eating disordered patients is significantly lower than peers of a normal population. Both versions seem to be valid and reliable instruments for measuring the general self-efficacy.

EFFICACY OF A PROGRAMME OF PHYSICAL ACTIVITY IN PSYCHIATRY: AN EXPERIMENTAL STUDY

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INTRODUCTION

Scientific literature generally agrees with the beneficial effect of physical activity for psychiatric patients (Artal & Sherman, 1998; Hale, Koch & Raglin, 2002; Morgan, 1997), however, in many European countries programmes of physical activity are still poorly applied as therapeutic support in the psychiatric care settings.

METHODS

The aim of this research was to individuate the essential characteristics of a fitness program that could improve health and autonomy in psychiatric patients. The study was conducted from March to August 2005 at the Casa di Cura "Villa Santa Chiara" in Verona, Italy, where was activated for the first time a program of physical activity for psychiatric inpatients.

A total of 224 patients (76 male, 148 female), aged between 17 and 70 affected by personality disturbances as well as depressive and sleep disorders were included in the study. The average admission time was 26.8 ± 12.4 days. Upon admission and discharge, patients were subjected to a psychiatric evaluation (BPRS, BDI, WHODAS II) and an evaluation protocol to test their fitness condition. The experimental group was composed of 31 selected patients (13% male, 18% female). The control group was composed of the remaining patient population stayed in the hospital during the same period.

RESULTS

The interest of patients in physical activity, as emerged from the colloquies with psychiatrist and psychologists, was noteworthy and there were several elements that sustained this observation. The constancy of physical activity was significant in itself, the overall presence score was 89%. Patients also declared that found a space of time to dedicate to themselves, without having to speak about their sensations, and can simply let their bodies "speak" freely. This was a new way to know and feel oneself. Movement situations were often perceived as a way to let off tensions and worries and provided the means to copy with problems, to feel themselves in an holistic manner and to have a realistic self image of oneself, to communicate in silence and yet in a loquacious and reflective manner. Patients referred a greater satisfaction during recovery. Participation in Fitness Therapy also led to a greater adherence to psychotherapeutic protocols. Physical therapy was well-accepted by all patients and did not lead to a single traumatic event or disturbance. The results of the fitness tests was extremely variable, which was most likely due to the heterogeneity of the sample (e.g. pathologies and therapeutic strategies). In spite of pharmacological therapies, fitness tests showed a significant improvement in both groups; there were no significant differences between the experimental and control groups, even if the Fitness Therapy group showed increases in nearly all tests. An analysis of scores using the BDI scale on 10 patients that followed Fitness Therapy and 10 patients in habitual therapy under the care of a single physician showed that the two groups were statistically homogeneous in terms of scores at admission and discharge.

CONCLUSIONS

In this first experience physical activity appeared to be useful and had no contraindications in patients undergoing psychiatric therapy. Psychiatric evaluations revealed an important gratification from the motor experience during the hospital stay, that may stimulate greater adherence to the therapeutic protocols.

USING EXPERIENCES AND EXPRESSIONS AS A PSYCHOMOTOR THERAPY WITH ADOLESCENTS WITH BEHAIOUR DISORDERS;

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Psychomotor therapy offers a variety of situations creating new learning opportunities for adolescents. Having to deal with different emotions within themselves and in relationship to others broadens their world of experiences. The interaction of these experiences is an essential element of psychomotor therapy.
Key concepts of psychomotor therapy with adolescents: (1) Impression i.e. come in to touch with one’s own body, (2) Communication i.e. relationships with others, (3) Expression i.e. express oneself

EFFICACY OF A PHYSICAL ACTIVITY PROGRAM IN THE RESIDENTIAL TREATMENT OF PATIENTS WITH ALCOHOL-RELATED PROBLEMS

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INTRODUCTION: Alcohol abuse is one of the most serious health risks over the world. Patients with alcohol-related problems (ARP) require specific therapies, frequently reveal psychomotor difficulties and aren't enough fit. "Alcohol abusers are also body abusers" (Ermalinsky et al, 1997): in addition to their alcohol intake, they are frequently heavy smokers, with an unbalanced nutritional behavior and signs of alcohol-related organic damages. Such damages include muscle weakness, unstable joints, a reduction in VO_2 max and a disturbed conduction of motor nerve stimuli. In addiction, it was documented an higher risks of falls. This physical deterioration includes an increased feeling of fatigue, reduced enthusiasm and occurrences of antisocial behaviour (Read et al., 2001; El-Sayed et al., 2005; Krumm-Merebat & Meyer, 2005). The low level of fitness in patients with ARP can be considered at the same time as both an effect and a cause of alcohol abuse, to such a degree that the passive, inactive attitude of alcoholics is one of the main causes of the physical deterioration observed in these patients. Despite the positive correlation between physical exercise and various psychological factors, and the evidence of an association between alcohol abuse and poor physical condition, only few studies have been devoted to evaluate the effect of physical exercise programs in patients with ARP.
METHODS AND MATERIALS: The aim of this study is to investigate how a program of physical activity could improve the psychopathological conditions in a sample of hospitalised patients in treatment for ARP. The sample is composed of 60 inpatients (54% males and 46% females, age ranged form 25 to 65 years, medium hospitalisation 40 days), treated at the Addiction Unit of the Parco dei Tigli private psychiatric clinic. The inclusion criteria required the presence of an alcohol abuse disturbance according to DSM-IV-R criteria. All subjects were diagnosed current and past conditions using SCID-I, SCID-II, SCL-90, MAST and MINI. Both clinician-administered and self-administered instruments were used for the present study. The treatment program is based on a multidisciplinary approach, including general medical treatments, psychological group therapies, problem solving group, health education group, art therapy and adapted physical activity. The adapted physical activity program consists in 3 time per week sessions. Before starting physical activity the participants were submit in a set of test, they are retested at the discharge and at six months follow –up. Physical fitness test measured: aerobic capacity (by means of the Åstrand three levels test), balance, flexibility, abdominal strength, general strength (by means of the hamstring test) and hands speed and coordination. At the same time the participant completed a set of questionnaire including: SF-36, PSPP (Physical Self Perception Profile, PACES (Physical Activity Enjoyment Scale) and the Decisional Balance Test. Moreover, background, personal socio demographic and occupational information, details of any family history of psychiatric or alcoholic illness were obtained from patients.
RESULTS: The preliminary results of the study indicate significant improvements in the physical performances of participants, and a general modification in the attitudes and motivation toward physical activity. Our communication will underline particularly the correlation between fitness.
improvement and the modification in the psycho-pathological conditions of patients

LIGHT THERAPY AS A TREATMENT FOR DEPRESSION: A LITERATURE REVIEW.

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Light therapy (LT) involves exposure to intense levels of light under controlled conditions. The recommended light therapy system consists of a set of fluorescent bulbs installed in a box with a diffusing screen, and set up on a table or desk top at which one can sit comfortably for the treatment

session. This study is based in a literature review of latest advances in LT for the treatment of depression. Efficacy of light therapy for non-seasonal depression has been studied without any consensus on its efficacy. However, great results have been found in the use of LT in seasonal depressions (SD). Early research studies used "full-spectrum" bulbs producing bright light similar in colour composition to outdoor daylight, in contrast to the colour of ordinary fluorescent or incandescent light. Some studies, but not all, show that patients with SD have a less pronounced cycle of melatonin secretion than people without SD, and light therapy appears to restore a normal pattern. The mechanism by which bright lights work is still unknown and some theories of it are presented in this work. Light therapy as a part of phototherapy may be a therapeutic treatment used by the physiotherapist in the field of psychiatry health and to promote the figure of the physiotherapists into mental health teams.

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION AS A TREATMENT FOR MAJOR DEPRESSION

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It has been argued that clinical depression is accompanied by reductions in cortical excitability of the left prefrontal cortex (PFC). In support of this, repetitive transcranial magnetic stimulation (rTMS), which is a method of enhancing cortical excitability, has shown antidepressant efficacy when applied over the left PFC. rTMS is a recent treatment for affective disorders. Several studies have demonstrated antidepressant effects of TMS in patients and have suggested that repetitive transcranial magnetic stimulation (rTMS) of the dorso-lateral prefrontal cortex might be effective as a treatment for major depression (MD). Few studies have been done with other mental problems, for instance in schizophrenic but with not positive results. This study is based in a literature review where various studies of rTMS were analysed to show evidence about this treatment. Although research has not showed clear evidence yet, most of them agree in creating positive effects for patients with MD. Magnetic stimulation might be another therapeutic tool for physiotherapists in order to work in the field of psychiatry.

THE EXAMINATION IN NORWEGIAN PSYCHOMOTOR PHYSIOTHERAPY: AN EMPIRICAL MODEL

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10 former patients that had suffered from psychosomatic or musculo-skeletal disorders and that had been treated with Norwegian Psychomotor Physiotherapy, were interviewed. The main items in the interview were:
What happened, and how did you feel about the examination in Norwegian Psychomotor Physiotherapy?
Can you describe your situation before you started with Norwegian Psychomotor Physiotherapy?
Results:
Three categories were identified from the patients' experiences:

- The situation before the treatment
- Establishing the relationship
- Examination is interaction

Two dimensions emerged from these categories:

- The body: A biological and sociocultural being
- Communication is the essence: Understanding, recognition and interpretation.

The material reflect the great impact the examination had on the informants. Being undressed represent a significant element of distress. It was very important to get the feeling of being "seen" and acknowledged. A patient-centred approach should emphasize the necessity to include the patient's view in the examination process. The physiotherapist and the patient should co-operate in order to understand the meaning of the body's symptoms.

DO PHYSIOTHERAPY PRACTIONERS ATTACH STIGMA AND PREJUDICIAL PRACTICE TO PATIENTS WITH SECONDARY MENTAL HEALTH PROBLEMS?

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Ethnographic studies show a perception that the mentally unwell 'carry a public stigma' (George 2000). As part of a change management project a focus group of physiotherapists taking referrals of patients with primary physical impairments and secondary mental health problems within Gwent Healthcare NHS Trust were recruited. They were asked for their views of stigma and prejudicial practice as physiotherapy practitioners. Themes identified by the Physiotherapists were, lack of confidence in handling different groups, expressions of fear and recognition that stigma and prejudice affects clinicians in different ways. Potential solutions were identified that include better referral information to manage risk, the development of improved knowledge and understanding of specific mental health conditions and supervision.

THE MASSAGE IN NORWEGIAN PSYCHOMOTOR PHYSIOTHERAPY.

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10 former patients that had suffered from psychosomatic or musculo-skeletal disorders and that had been treated with Norwegian Psychomotor Physiotherapy, were interviewed. The main items in the interview were:
How did you like being massaged?
Can you remember any particular impressions in connections with the massage?
Results:
The results will be attached to three categories that emerged during the analyses:

- The ambiguity: Pleasure and provocation
- Losing control – gaining control
- The interpersonal dialogue

Two dimensions emerged from these categories:

- To be touched and to get access to one's own bodily information
- Interaction and mutual interpretation.

The material reflects the importance of massage. Informants discovered that their own feelings and experiences depended both on outside and inside events, and how they were interpreted. Their

perception about their lives was stimulated, and they talked about many forces that had shaped earlier experiences. By sharing the experiences, the patients developed a framework they could use in their daily life.

KINESIOTHERAPY AS A PART OF THERAPY OF DEMENTIAS

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Introduction: The objective of this work is, on the basis of practical experience, to prepare a special kinesiotherapeutical programme for seniors with Alzheimer dementia. Character of the study is randomised controlled experiment with double blind evaluation before and after intervention by kinesiotherapeutical programs. Study takes place in Geronto Centrum in Prague-Kobylisy, in the part of daily centre. There are examined groups formed by 10 patients (4 men and 6 women) in the age 62 – 89 years, diagnosed with Alzheimer dementia. Patients took part in everyday kinesiotherapy (5times in a week) during 18 months.

Intervention:

According to the level of handicap, the therapy could be applied. Every exercise unit has:

starting part

Before commencing the goal oriented main sections of the exercise unit it is very important to decrease overall tension, motivate the patient in order to participate on exercises and to evoke the ability of mind concentration.

1) The exercise is usually commenced with a short dialogue concentrating at actual state.
2) We emphasise positive circumstances, we remind the pleasures coming from the meeting.
3) Our attention is directed to our breathing, we deepen the breath (full yoga kind of breath).
4) We increase and gradually fully relax muscle tension (skeletal muscles) in particular body parts (Jacobson's method). The goal is to increase the perception of ones own body.
5) We gradually actively exercise in the performance of small movements of particular parts of kinetic system. The goal is to increase the awareness of controlling ones own body and in this way also to control yourself.

The main part

The main part of the unit has predetermined intention defined by the volume of an illness, actual psycho-somatic state and the intention of treatment.

The volume of physical strain is from low to medium. We commence with low decreased physical strain at TF 80-90, that has relaxing effect. Aerobic strain could be increased later, but only in the case when the patients performing the exercise are ready for the strain increase and positively motivated. Any kind of forced leadership could lead towards the loss of interest and permanent demotivation.

The closing part

We proceed towards leisure positional and breathing exercise.

Methods

The course of disease, their behaviour etc. is described together with the results of tests MMSE (Mini Mental State Exam and BEHAVE-AD test (evaluated behaviour of patients) before, after 3, 6, 9, 12 and18 month of kinesiotherapy.

Conclusion

Results showed that participation of patients in kinesiotherapeutical program made only little changes of their psychic state.The tendency is to stabilize the quality of life were succesfull. Changes of psychic state of patients through different focus of programs seem to be non specific.

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THE EFFECTS OF STATIC RESPONSIVE CONTACT COMPARED WITH MITCHELL'S RELAXATION TECHNIQUE ON IN-PATIENT'S ANXIETY LEVELS WITHIN AN ACUTE MENTAL HEALTH WARD SETTING: A PILOT STUDY

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Empirically, the use of static responsive hand contact, during physiotherapy treatment on the mental health wards, was seen to reduce anxiety.

Objectives:

- To identify which of the two therapeutic procedures chosen for this study is the most effective in reducing anxiety levels
- To compare any changes of attitude of the patient in their acceptance of touch by the therapist before and at the end of the therapeutic intervention
- To help verify the acceptability of responsive touch to patients experiencing anxiety in acute mental health settings.

Methodology:

Following ethical approval, this randomised single blinded controlled study in which 16 in-patients were assigned into one of two groups. The intervention group (n=8) received active intervention of static responsive contact, using two handed pressure on three, commonly used, pre-selected areas in clinical practice; head, shoulders and heels.

For the comparative group intervention (n=8), the therapist uses the Mitchell's Method of Relaxation script (reciprocal muscle relaxation of antagonistic contracted muscles) found to improve physiological relaxation. Additionally, diagnostic/procedural touch was used only as a means to demonstrate and clarify the movement involved in the relaxation script.

Treatment interventions were applied for 15 minutes on three consecutive days including only necessary conversation to highlight the non-verbal aspect of touch.

Outcome measures included physiological status as represented by pulse and respiratory rate by blinded assistants. Self assessment questionnaires measured sleep, vitality, pain, body tension, acceptability of touch both in general and by the physiotherapist and the desire for continuation of treatment. Space was provided for open comments. The Hospital Anxiety and Depression scale provided an externally validated tool.

THE PROCESS OF CHANGE – A PILOT STUDY. RESULTS FROM BASIC BODY AWARENESS THERAPY

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Background: The project is inspired by my own experience of change during the practise of Basic Body Awareness Therapy. My experiences have been mixed with the knowledge from an earlier study of personal supervision, with focus on personal development.

Purpose: The purpose is to explore the process of change, described by Jacques Dropsy, philosophers and psychologists like Nina Karin Monsen , Piero Ferrucci, Fritz Perls and others. I will compare the experiences of my client, to the description of "the process of change", and the results from the assessment tools, the Body Awareness Scale Interview (BAS-I) and the Body Awareness Rating Scale (BARS).

Research question: *What signs of change can be found in a women participating in a Basic Body Awareness Therapy group in a short period, and how can the change be seen from different perspectives?*
Method and material: The research method is qualitative, using participant observation of the client, with written notes from the observation, notes from the clients comments during the training, and from the talk after the exercises and the use of the assessment tools, the BAS-Interview and the BARS. The client attended a group of Basic Body Awareness Therapy 8 times through 11 weeks, and she did a few exercises at home.
Result: The process of change is by Dropsy considered to be a rehabilitation back to nature; an activation of unconscious regulations, like the breathing or the postural reflexes. Due to problems, not solved on the emotional level, most people have muscle tensions in their bodies, suppressing the free expression of these reflexes, giving freedom of movement, breathing and mind. Dropsy is describing human life in four dimensions: the physical, physiological, psychological and the purely human level. He considers consciousness and time to be important factors in the process of change, and that the result will be harmonisation of body and mind. The client made rather great progress in both the BAS-Interview and in the exercises, assessed by the BARS. She experienced, improvement in the following areas: Increased mobility/ reduced muscle tension; less pain, vegetative changes, increased energy and ability to be in control during stress.
Conclusion: **1**) Just a short time practise of Basic Body Awareness Therapy has led to experiences of change. The BAS-Interview and the BARS showed improvement on all levels, but the experienced change is knit almost only to the first two (physical) dimensions of Dropsy, most likely due to the time needed for growth to take place. **2)** Increased energy was experienced early, and the level of energy can influence a lot of mental and physical factors, and in that way be important for the speed of the process of change. **3)** The exercise" The invisible movement" could be an important exercise, for the process of change. It would be interesting to follow a B-BAT group, from the same perspective.

ADAPTED PHYSICAL ACTIVITY IN THE REHABILITATION OF ALCOHOL ADDICTION

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Adapted physical activity and sports are integrated in rehabilitation programs for alcohol addict persons in most clinics in Germany. Due to the length of addiction you find serious disorders in the psychomotor behaviour, for example

- disorders of emotions and affections
- psychosomatic disorders
- reduced physical fitness and coordination
- disorders in social behaviour.

Surprisingly you will find only a small number of researches in this area concerning the benefits of adapted physical activity and movement therapy. The poster presents the results of a clinical program in a specialized institution which offers a short time therapy over eight weeks. The treatment includes physical fitness activities, relaxation therapy and a body centred therapy. For the study different psychological variables (body concept; psychosomatic disorders; health outcome) were measured beside motor behaviour and the state of physical fitness in a pre – post design. The results (n = 25) showed significant improvements in psychomotor functions as well as in body concepts and different variables of general health outcome. In comparison to non-addicted persons important differences remained in some variables.

MENTAL & PHYSICAL REHABILITATION AND PHYSIOTERAPY TREATMENTS FOR ANKLE INJURY IN PROFESSIONAL ATHLETES

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This research is going to study and identify the rate of prevalence of ankle injuries on national athletes of football ,Greece- roman and free still wrestling and basketball that their ankles bears greatest pressure. So mental - physical rehabilitation and physiotherapy treatments for them. Essential advices about treatment and rehabilitation doings has been considered. The research aim is to raise athletes qualifications and coaches knowledge at such circumstances and also it tries to give them suitable curing strategies. At this study 229 athlete, invited to the national team were studied that 31 people (%13:5) complained of ankle problem at exercises time. from the above amount 21 people (%9.1) had unstable ankle that (%8.6) was related to free wrestling ,(%59) European wrestling,(%14) football and (%7.3) basketball (%74) of injured s with previous record suggesting that the curing process has not been accomplished completely.
Some suggestions for avoiding such damages.
1-at the time of activity use ankle supporting tools (taping)- (basketball shoes)
2- in the long term , proneal and tibialis posterior muscles should be strength tended
3- prior to each competition ankle and its related muscles should be properly warmed up .
4- in cases of trauma and damage to the ankle, complete treatment and follow up should be persuaded.
5-immediate care after acute damage with controlling inflammation and pain of pricier.
6. rehabilitation and physiotherapy treatments institute: PRICER.
7. Mental rehabilitation and physiotherapy treatments for professional athletes(mental problems is very important for improve physical rehabilitation and come back athletes as soon as possible to training.

WORKSHOPS

A. TOUCH AND MOVEMENT APPROACHES USED WITH SURVIVORS OF SEXUAL ABUSE

Diane Beaven

This workshop will introduce dance therapy approaches suitable for use with girls and women who have been sexually abused. Some approaches will also be effective with those who have been physically abused. The body does not lie; words can be used to disguise feelings, but posture and gesture reveal the true self. Movement can be used expressively as a means f exploring feelings relating to other people and gaining a positive experience of the self. There is a link between how a person views their physical self, and their self image. Working through the vehicle of the body can influence emotional and physical well-being. Movement is used creatively, explored by the patient, rather than imposed by the therapist. Movement of the body may bring to a patient's awareness, feelings which were previously locked up in tense muscles, time needs to be allowed to discuss these feelings.

In the workshop, there will be practical exercises, which will include body awareness work, relaxation and creative movement to help the abused person re-build the damaged body and self image. Music, voice work, breathing and touch will play a small part. Movement will be used to enhance self esteem, to increase assertiveness skills, and to encourage self acceptance. The themes of choice, giving and taking, saying "no" and boundaries, will be explored. The workshop is practical, so wear loose clothing. Movement is gentle and will not be a problem for those with pain or limited ability.

Diana Beaven, the workshop leader, is a physiotherapist who ran a group with clinical psychologist Geraldine Tollinton, for sexual abused teenage girls. A treatment report describing this group was published in "Physiotherapy", July 1994, vol. 80, no 7 (UK physiotherapy journal), under the heading "Healing The Split; A psycho-physical approach".

B. BASIC BODY AWARENESS METHODOLOGY – A NEW REHABILITATION METHODOLOGY IN AN INTERNATIONAL, POST-GRADUATE COURSE FOR PHYSIOTHERAPISTS

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Background: The international post-graduate, part-time course, Basic Body Awareness Methodology (B BAM) was made at Bergen University College, Faculty of Health- and Social Sciences as part of the Norwegian Governments` introduction of the Quality Reform in 2003. It builds on the physiotherapy modality of Basic Body Awareness Therapy. **Purpose:** The course offers a new methodology for physiotherapists to deal with the complexity of the ill human being, introducing a health- and resource oriented rehabilitation program focusing movement quality. **Relevance:** The course introduces an assessment- and treatment-tool based on a four-dimensional approach to human movement; it is evidence- and experienced based. The main objective is to enhance the physiotherapists` professional and personal competence in body-mind aspects. The course is designed to meet the increasing problem within the field of mental health, long-lasting pain syndrome, eating disorders, life style problems etc. **Description:** The course represents a training philosophy resting on humanistic philosophy, psychology and Western and Eastern movement traditions. It offers intensive floor-work to let the physiotherapist undergo self-experience in basic movement principles. The physiotherapist will be skilled in handling individual rehabilitation-processes, observing, interviewing and guiding, using structured assessment tools, handling group-processes, working in team, making qualitative oriented projects. The awareness program integrates simple movements from daily life, lying, sitting, standing, walking, training of the voice, including relational exercises. B BAM gives the student in total 60 ECTS and offers two levels on two years, each of 30 ECTS pr. year: Level 1 aims at basic methodology and individual therapeutic work, Level 2 aims at group leadership and qualitative project-work. There is in total 11 study-weeks in Bergen of which the first and second fall has 4 weeks at BUC, followed by 1 year of self-study. The third fall, the course ends with three weeks in Bergen with a final exam. The period of self-study focuses personal training, clinical work, literature study, report writing and project work. The students collaborate online using the Learning Management Program "*It`s learning*". **Observation**: Evaluation of the program shows that the students are enabled to work with body-mind aspects through a four-folded approach to human movement and to apply these aspects in therapy and research. It is reported that it offers a strategy to make the person equipped to handle life and therapeutic situations more ably**. Conclusion**: The significance of the course is the embodiment and empowerment through a set of simple movements. It prepares the student for a new intervention, for personal growth and research development through an embodied understanding of human balance and movement. It reintroduces the student to meet the patient as a person through the therapist own experiences.
Website: http://student.hib.no/fagplaner/ahs/basic_bam/

C. CREATIVITY IN THE FIELD OF PSYCHOMOTORTHERAPY.

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Every experienced therapist knows how important it is to create an open and communicative group environment. This workshop will introduce participants to simple interactive movement techniques that can be used during a therapy session to establish a creative environment. Within such an environment the therapist will be better able to acquire a sense for the atmosphere and dynamic of the group.

D. DEVELOPMENT OF BODY AWARENESS IN A PHYSIOTHERAPEUTICAL GROUP IN A PSYCHOSOMATIC CLINIC

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Purpose: Patients with different diagnoses (Eating disorders, Somatoform disorders, Pain disorders, Psychological disorders in medical disease), treated in a in-patient psychosomatic ward in a heterogeneous group. The purpose of this workshop is to show, how patients in a group with different body awareness can accept their limits of movements, how to learn by body experience with pleasure or difficulty. Pay attention to movement, symmetrical or asymmetrical positions in a right order can harmonize the body feeling.

Methods: Participants in this workshop learn by body experience about the basis of breathing, relaxation, movement, yoga.

Aim: The aim is to experience the importance of physiotherapy in the treatment of bodily disordered people and to show how patients with negative body self experience, body awareness and the lack of body border accept this form of body therapy.

E. EXPERIENTIAL WORKSHOP TO LEARN AND EXPLORE MANUAL TECHNIQUES TO FACILITATE THERAPEUTIC BODY AWARENESS AND PROMOTE PHYSICAL AND MENTAL RELAXATION

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The techniques taught are based on 30 years of study and empirical observation of Physiotherapy, and complementary therapies within mental health. These techniques involve the *therapist* to provide gentle ‘hands on’ contact to the heels and shoulders of the *client.* This static contact (over clothes) has been integrated into many therapeutic approaches such as Craniosacral Therapy, Reflex Therapy and Myofascial Release. The appropriate mental intention and physical stance of the therapist is crucial whilst the hands respond and communicate kinaesthetically to the patient’s tissues. In one sense, these manual techniques reflect a person centred communication / counselling approach.
These techniques have been shown to reduce autonomic arousal, promote a deep relaxation response and change body awareness in a positive and beneficial way. The improved proprioception and awareness in the legs and feet improve balance and ‘grounding.’ Clients’ feedback describes a “greater ownership of their body together with greater integration between different parts of their body.” Many clients report these techniques counteract their feelings of dissociation bringing their minds into sharper focus in the ‘here and now.’
Further self-help exercises will be suggested to reduce dependency on the therapist and promote client empowerment.
There have been no reported contraindications or side effects of the techniques which have been taught to a broad spectrum of healthcare practitioners, many of whom continue to use the techniques in clinical practice. Clinical benefits have been demonstrated across most mental health conditions; however, particularly therapeutic responses are seen in people with anxiety and panic disorders, eating disorders, PTSD, dementias, psychosis / dissociation / derealization.

Throughout the workshop, the meaning, experience and responses will be explored in terms of our understanding and philosophy of mental health, the therapeutic relationship and the embodiment of our humanity. Case studies will be shared to demonstrate the practical applications in clinical practice. Literature and research studies will underpin the discussions to facilitate an exploration of the theoretical concepts.

F. EVALUATION OF CARDIO-RESIRATORY FITNESS AND PERCEIVED EXERTION FOR PATIETNS WITH DEPRESSIVE AND ANXIETY DISORDERS

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Designing well-considered exercise programs for psychiatric patients requires a measurement of their physical fitness as well as perceived exertion during physical exercise. Direct measurement of maximal oxygen uptake (VO_2max) by way of a maximal exercise test is the most accurate indicator of cardio-respiratory fitness. But maximal tests have the disadvantage of requiring the subject's optimal motivation to work to 'near exhaustion', and require the supervision of a physician and the use of expensive equipment. In psychomotor therapy for psychiatric patients, however, submaximal measures are highly recommended for the reason that many patients have low levels of fitness, little experience of aerobic training, and less energy and motivation for heavy physical effort.
We demonstrate the submaximal Franz ergocycle test, as measure for the cardio-respiratory fitness, and the Borg Category Ratio 10 Scale, as measure for the perceived exertion. In the Franz ergocycle test the work load is increased by 10 Watts every minute, starting with a work load that corresponds to the body weight. Since such a work load is not feasible for many of the patients, the first stage work load is reduced by 30 Watts for male subjects and 50 Watts for the females. At the end of each stage the heart rate is registered by means of a heart rate monitor. Subjects are advised to maintain a steady pace of 60 rotations per minute. The graded exercise test is terminated when (a) the subject reaches the predetermined end point heart rate: 80% of the maximal heart rate reserve (MHRR), (b) the participant shows certain symptoms making it necessary to stop the graded exercise test, and (c) the subject can no longer maintain the pedalling frequency of 60 rotations per minute. The physical work capacity (PWC) at 60% MHRR and the PWC at 80% MHRR are retained as measures of cardio-respiratory fitness. Our research shows that the Franz test has a good reliability (r ranged from 0.74 to 0.90).
In these patients who often suffer from fatigue and low motivation, the rate of perceived exertion during physical exercise is an important parameter when designing an appropriate exercise schedule. For the evaluation of perceived fatigue we use the Borg CR 10 Scale. During the Franz test patient indicates at the end of each stage his/her perceived exertion. The Borg 60% MHRR and the Borg 80% MHRR are the rates on the Borg CR 10 scale that are related to heart rates of 60% MHRR and 80% MHRR respectively.

G. CHANGING TONE AND CHANGING MOOD

Diane Beaven

Postural tone both reflects and creates mood. Working with a person to release abnormal patterns of tone, can allow for a change in energy, pain and emotional health, body and self image. The technique introduced in this workshop is a combination of gentle massage and passive movement. The approach has evolved out of my experience of the Alexander Technique. The Alexander Technique is a way of changing habits of movement and posture. A person learns to inhibit unhelpful response patterns, and to become freer and more present. The Alexander Technique is an approach in which the client is an active participant. Many psychiatric patients are not well enough, or motivated enough, to take this active approach, but receive benefit from passive movement. In this workshop, you will learn how to move your hands to change muscle tone and you will feel what it is like when someone works to change your muscle tone. Practical work will be in twos or threes, with the recipient lying on a couch or mat. You will be more comfortable wearing trousers.

Passive movement and massage are used rhythmically and slowly. At all times clients have choice and can ask for modifications or a repeat of what is helpful. At the end of the session, I describe to the patient the changes that have taken place while they lie quietly and visualize these changes. The breathing pattern noticeably quietens. As well being improves, a person is more able to concentrate, and they can learn to make changes for themselves. Letting go can feel safe when a therapist provides a holding experience. For the patient too unwell to focus and listen to a talking method of relaxation, the process is achieved for them. Touch is the first sense through which we experience the world as infants. Apart from the effects already described in using our hands to change muscle tone and breathing, a person can feel acknowledged, accepted and validated. Some people benefit by learning to welcome kinaesthetic feelings, instead of distancing from their physical selves due to past negative experiences. Some clients describe the sense of different parts of their bodies connecting up, and at times the emotional and physical selves linking to give a sense of integration and completeness. People may want to talk about feelings which surface. Hands on work with a depressed person may be just for a few minutes, and may increase tone and quicken breathing. With an anxious person, passive movement and massage may last 20 minutes and reduce excess tone and breathing.

H. CHANGING BODY IMAGE AND HYPERACTIVITY. A PHYSIOTHERAPY APPROACH FOR INDIVIDUAL AND GROUP THERAPY

Michel Probst, PhD PT
K.U.Leuven, Faber, Rehabilitation Sciences, & University center Sint Jozef Kortenberg & Arteveldehogeschool, Opleidingseenheid physiotherapy, Gent

In this workshop an overview is given of therapeutic interventions aimed at improving the body experience (in patients with eating disorders) through the use of physiotherapy. Attention is paid to particular therapeutic techniques such as relaxation training, breathing exercises, mirror exercises, physical activities, sensory awareness and self-perception, all of which are used in physiotherapy and psychomotor therapy.

GENERAL INFORMATION

Dear colleagues,

I have an impossible task. I was asked to guide you through Leuven indicating good restaurants and nice pubs. But, as you may have seen, Leuven is one big restaurant/pub. Although I live here for more than twenty years, my choice is no choice because I did not had the opportunity to visit them all. Nevertheless, we thought it would be nice to advice you about some restaurants, not just for the food but maybe you can meet some other colleagues who followed the same advice …

Consequently, the following advice is just arbitrary. I only can mention those places where I was before and where I was happy to be there. Nevertheless other places may be at least as good. Just try them and use your personal creativity …

Please consider these just as an initial advice for new Leuven visitors :

snacks for less than 10€

- Domus — Tiensestraat 8
- Universum — Hooverplein 26
- Het kiekenkot — Mechelsestraat 46
  - (the best fried chicken in town, but just chicken …)

meals between 15 and 25€

- Wiering — Wieringstraat 2
  - romantic meeting place of students –Flemish dishes - try the "ribbekes" or "scampis" with a hugh choice of sauces
- Quo Vadis — Muntstraat 11
  - Italian kitchen – amazing pizza's
- Toareg — Parijsstraat 37
  - Berber kitchen – extraordinary "tajines"
- Nachtuil — Krakenstraat 8
  - Belgian kitchen for early and late hunger (open till 3 am)
- Lukemieke — Vlamingenstraat 55
  - place to be for vegetarians

Belgian gastronomy between 35 and 50€

o Zwart Schaap	Boekhandelstraat 1
o Blauwe maan	Mechelsestraat 22
o Ombre ou soleil	Muntstraat 20
o Mykene	Muntstraat 4

Belgian gastronomy for more than 70€

Belle Epoque	Bondgenotenlaan 94
Het Land aan de Overkant	Schruersvest 89

Extraordinary ice-cream and Belgian waffles

Croccantino	Tiensestraat 65
	Vanderkelenstraat 13

Chocolates

The most well-known Belgian chocolates are Godiva (expensive but extraordinary), Neuhaus and Leonidas (especially known for its with chocolates filled with cream). Some bakeries offer home-made chocolates which can be as good …

PUBS and Beers

It's impossible to advice you about the 350 existing Belgian beers, let alone about the Leuven pubs. Just make your choice about the pub and then ask the waitress for more information. They are supposed to have enough knowledge to guide you through a difficult choice.
In Leuven we have to local beers : Stella Artois and the "Witte Hoegaarden". Both are white beers of about 5° of alcohol. The "Witte Hoegaarden" is clearly more bitter – ask it with a slice of lemon - than its colleague (but I like it the most).

We thought it would be nice to have a meeting place, late in the evening for a last drink after having an excellent meal. The deliberation was extremely difficult but finally we decided to meet at the "BLAUWE SCHUIT", Vismarkt 16. See you there …

prof. dr. E. Neerinckx

How to reach Leuven?

By car: Leuven is located near the junction of two important motorways: E40 and E314
Be careful there is in Leuven speed control!
By train:
From airport:
There is a new direct and fast train connection between Brussels Airport and Leuven which costs about Euro 4.80 and takes approximately 15 minutes.
From Brussels
Leuven is situated on the important railway axis Ostende- Brussel – Leuven-Liege-Köln. By train it is only 30 minutes from Brussels.

The transfer Leuven- Kortenberg.

A**.** We organise ***a special shuttle*** from Kortenberg to Leuven.
Name of the firm: Bergkoning
From Leuven: 16/02 and 17/02 at 8.30 a.m.
Bus stop A: at the corner Bondgenotenlaan and Martelarenlaan (near Railway station)
Bus stop B: at the corner Bondgenotenlaan and Fochplein

From Kortenberg tot Leuven
16/02 at 5.15 p.m.
17/02 at 6.00 p.m. (after the farewell reception)

The price for this service is 7 euro for the four drives. This offer is not for Belgian delegates. We have 50 places and you can buy your reservation on Wednesday at the registration desk or on Thursday in the bus.

B. ***Regular bus services Leuven-Brussel***
Line 358: Railway station- Kortenberg – Brussels Nord.

To Kortenberg (weekdays):
Every hour there are two busses at x.04 or x.34 (till 21.00).
After 21.00: 21.04; 22.04; 23.04; 0.30; 1.30

To Leuven (weekdays)
Every hour there are two busses at x.02 and x.32
And also on 16.51; 17.21, 17.51, 18.18

C. By Car:
From Leuven: take the “Brusselsestraat” and than straight on till Kortenberg. The University Centre is 11 km from Leuven, beyond the “Volkswagen park”.

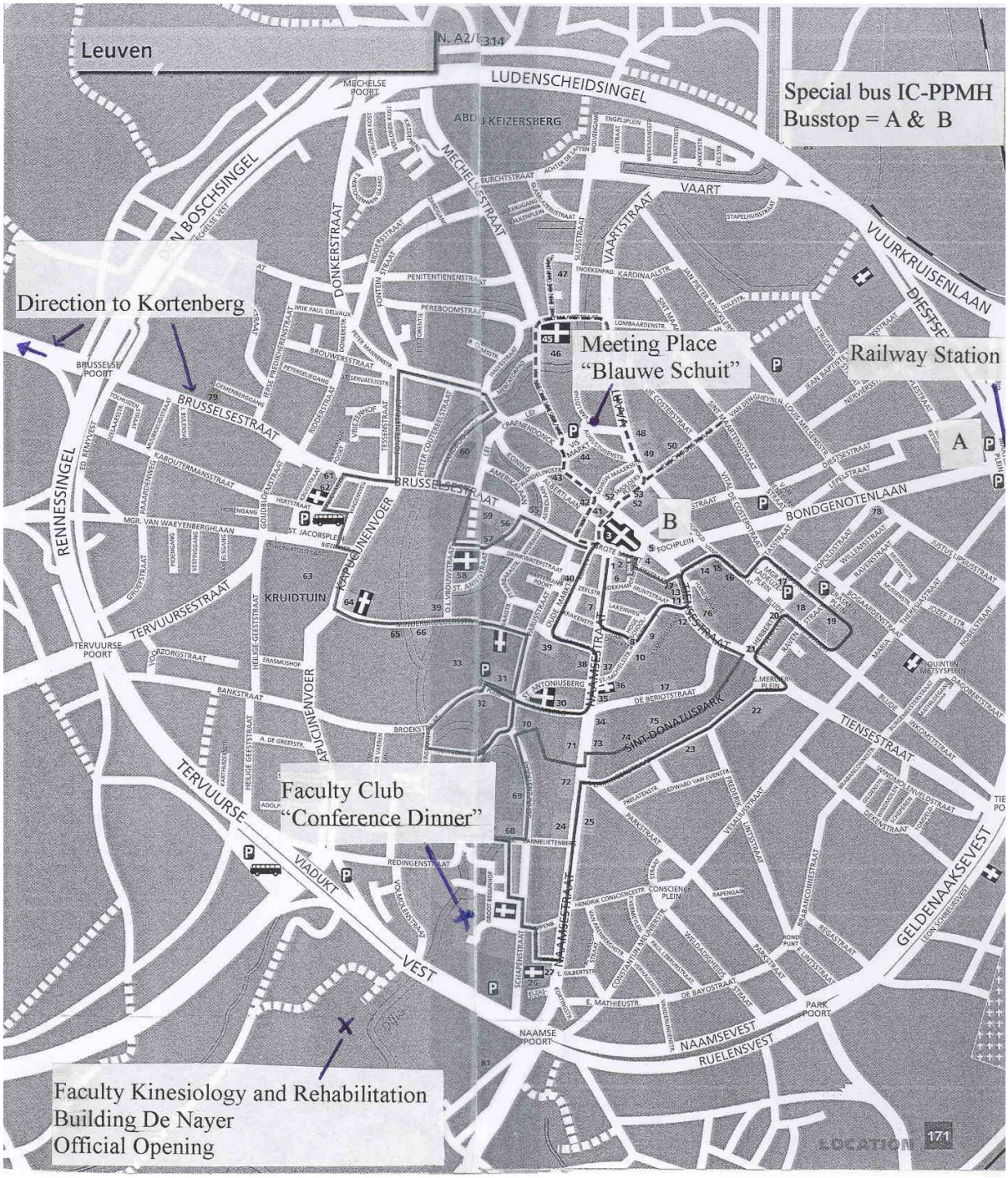
D. By train from Brussels or Leuven
There is each hour a train stop in Kortenberg. Consult the tables. The centre is on 10 minutes walking distance.

“Toerisme Leuven”
Naamsestraat 1; Open from Monday tot Saturday 10 a.m. till 5 p.m.

In Leuven everything is on walking distance. A taxi is expensive.

Train connections to other Belgian cities: Brussels in ± 30 minutes; Mechelen in ±20 minutes; Antwerpen in ±45 minutes; Gent in ±75 minutes and Brugge in ±90 minutes.

On the map you will find the most important places in Leuven.



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