

workshops

W1

Graded motor imagery

Tim Beames, Ben Davies, Lorimer Moseley

NOI UK instructors and clinicians, Tim Beames and Ben Davies join forces with the ubiquitous Lorimer Moseley, neuroscientist, to present the scientific and clinical basis for the exciting new GMI therapy. Three nice guys with lots of new information from a clinical science base. GMI is no longer embryonic, it's a newborn!

Graded motor imagery is an emerging therapeutic strategy for complex pain states such as Complex Regional Pain Syndrome and phantom pain. It integrates established principles of graded exposure and response prevention with current theory in the neuroscience of pain and the brain. The original aim behind graded motor imagery was to expose the brain to movement-related, threatening cues in a manner that would be sufficient to induce positive reorganisation of the brain but not sufficient to trigger the pain neurotag. Since its development, other theories about its mechanism(s) of effect have emerged. This workshop will consider the role of graded motor imagery in a wider therapeutic model, introduce the neuroscience of central pain states, body representations, movies in the mind and contextual changes. It will introduce strategies such as laterality reconstruction, visual imagery, mirror feedback and contextual changes that may be required prior to any physical rehabilitation. The workshop will fit these strategies into a reasoning framework that is truly holistic.

W2

Could altered breathing contribute to persistent pain?

Laurie McLaughlin

Well known Canadian clinician, educator and perpetual student, Laurie brings us in a small group workshop, something often forgotten in rehabilitation – the importance of understanding and managing altered breathing patterns.

Breathing has both reflex and higher centre control. Higher centre control can be either conscious (e.g. talking, swimming) or unconscious. Pain, stress and fear are known ventilatory stimulants and are examples of unconscious higher centre input leading to altered breathing. These changes in breathing impact respiratory chemistry, reducing CO² levels to result in hypocapnia. Because arterial CO² represents the denominator of the pH equation, a decrease in arterial CO² causes an increase in pH (alkaline) of bodily fluids including blood, cerebral spinal and extracellular fluid. This is important for our understanding of persistent pain and stress states because increased pH of body fluids is associated with a cascade of physiological events, some of which could have profound effects on the hardware of the nociception/pain systems. For example, increased pH leads to smooth muscle activation, including those in blood vessels. These effects, induced by pH changes, are not trivial - blood flow to the brain can decrease by as much as 50%. There are other known physiological effects of hypocapnia - sympathetic and hormonal regions of the brain are stimulated, tissue oxygenation throughout the body is diminished, which results in increased cellular excitability. All body systems can be affected including the muscular and central, sympathetic and peripheral nervous systems. This workshop will present the theoretical argument that respiratory manifestations of pain and stress can be significant contributors to persistence of the problem, and then present an approach to clinical evaluation and management of hypocapnia, using capnography, including current evidence of its effects.

Conflict of Interest: Laurie McLaughlin is a distributor for and a minor shareholder in Better Physiology, a capnograph manufacturer.

W3

Neurocognitive deficits are related to central sensitization, psychological reactions and outcome. They can be rehabilitated with primitive reflexes and sensorimotor function.

Sean Gibbons

Lateral in brain and body, well known Newfoundland based international educator, Sean Gibbons teaches a fascinating small group workshop linking sensitivity and learning difficulties.

Approximately 10% of children have learning difficulties (LD) which require specialist care. Another 25% - 45% have a mild learning difficulty. Children keep their LD into adulthood. Children with LD are different in several ways when compared to children without LD. These include: reduced postural stability, disturbed gait, altered trunk coordination, reduced sensory motor function, sensory hypersensitivity, reduced cognitive learning function, decreased negative thinking, psychological disturbances, increased neurological soft signs. A subgroup of low back pain patients also present with these characteristics. This sub-group has been called 'Central Nervous System Coordination', which reflects the ability of the central nervous system (CNS) to process sensory motor and cognitive learning function. The Motor Control Abilities Questionnaire is an instrument that was developed to identify cognitive learning and sensory motor deficits along with related symptoms in adults. Research has found that approximately 20% of the chronic pain population has significant CNS coordination deficits. Patients with cognitive and sensory motor deficits are less likely to respond to interventions that require skills such as reading, memory, concentrating, or problem solving. The rehabilitation of sensory motor function and primitive reflexes has been shown to help cognitive learning and aspects of psychological function in certain types of LD. The same strategies that help cognitive learning function may also be used to reduce central sensitivity. This workshop will highlight the relationship between CNS Coordination, sensory motor function, cognitive learning function and chronic pain. The practical aspect will go through four common primitive reflexes and two aspects of sensory motor function (tactility and oculomotor).

W4

Normal and impaired nerve movement – visualisation with dynamic ultrasound imaging

Michel Coppieters, Andrew Dilley, Alan Hough

Nerves move and slide around as we do. Here, three of the world's experts in neurodynamics – Michel Coppieters (one of Belgium's more famous exports) and the redoubtable Alan Hough and Andrew Dilley get together with an ultrasound machine to show their movies of normal and impaired nerve movements and then talk about what it all means.

Thanks to improvements in image quality, ultrasound is gaining popularity in the diagnosis of certain neuropathies. For example, evaluation of swelling of the median nerve at the wrist has been advocated as an alternative method in the diagnosis of carpal tunnel syndrome. Also in research, quantification of longitudinal and transverse nerve movement is used to better understand some of the potential mechanisms involved in common neuropathies and other musculoskeletal conditions. In this workshop, we will demonstrate optimal ways to visualise longitudinal and transverse nerve movement. The two methods frequently used to quantify longitudinal nerve movement will be discussed (Speckle Tracking and Doppler). Findings from recent studies assessing nerve swelling, and longitudinal and transverse nerve movement in various pathologies, such as carpal tunnel syndrome, tarsal tunnel syndrome, whiplash and non-specific arm pain, will be discussed. The value of the use of ultrasound to study the impact of different nerve gliding exercises on nerve biomechanics will also be illustrated.

W5

Quantitative Sensory Testing – science and clinical application

Gunnar Wasner

We are thrilled to have Gunnar Wasner, a consultant neurologist at the University of Kiel and professor at Christian-Albrechts-University (neatly rounded off with a few years of work in Australia!) and a true star in the world of neuropathic pain research present this important workshop on QST.

Neuropathic pain develops after lesion within the nociceptive pathways. Methods to investigate the function of neurons that are involved in pain processing are limited, because nociceptive neurons are so called small fibre afferents that cannot be measured by conventional electrophysiology. Quantitative Sensory Testing (QST) is a psychophysical method closing this gap. Furthermore, it provides information for a better understanding of the underlying pain mechanisms that can lead to an improved therapy of neuropathic pain due to a mechanism-based treatment approach.

QST has been recently advanced by the German Research Network on Neuropathic Pain (DFNS) which has established a large database of more than 1200 pain patients including epidemiological, clinical and history data for investigation of neuropathic pain. The standardized QST protocol of the DFNS consists of 13 thermal as well as mechanical testing procedures by which the function of nociceptive, thermal and somatosensory neurons can be measured. This test battery allows generation of a somatosensory profile for each individual patient. By comparison these results with a normative data set of 180 volunteers revealed (Rolke et al., Pain 2006) not only sensory deficits, but also 'positive' sensory signs such as allodynia and hyperalgesia can be detected. By analysing the combination of signs and symptoms and comparing these with results from basic research and somatosensory profiles derived from human surrogate pain models, hypotheses can be generated about the underlying pain mechanism in each individual patient. These hypotheses need to be verified by testing the therapeutic efficacy of drugs on sensory signs and symptoms. Apart from this ideal application of QST as a diagnostic tool with direct implication on treatment strategies, also limitations of the method, such as dependency on the subjects' compliance need to be considered.

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W6

Educating the Preoperative Patient

Adriaan Louw

Adriaan Louw, NOI US instructor, fresh from the plains of Iowa and previously out of the veldts of South Africa presents a compelling evidence based and practical workshop on the power of pre-operative education to assist recovery.

In 1975 and 1978 two pioneer studies by Hayward and Boore showed that structured pre-operative education had an effect on post-operative pain, anxiety and recovery. Since then pre-operative education has been used to try to alleviate post-operative complications. Pre-operative education has been used extensively in cardiac surgery, abdominal surgery, dental surgery, surgery for cancer, anaesthesia, total knee replacement and total hip replacement. These strategies incorporate various teaching strategies and tools, including video, audio, phone calls, the internet and booklets/pamphlets. The outcomes of preoperative education is varied, however these educational sessions have been shown to help increase knowledge of the surgical procedure, reduce anxiety, reduce postoperative pain, decrease length of hospital stay and reduce the time to return to preoperative functional levels. This presentation aims to describe in detail the current utilization and educational delivery methods utilized in preoperative education. Additionally this presentation will analyze the preoperative programs from a pain science perspective and provide attendees with the ability to apply preoperative education for patients undergoing surgery in such a pain science and biopsychosocial framework.

Goals

Upon completion of the workshop, attendees will:

1. Be updated on the current strategies for providing preoperative education for patients undergoing surgery.
2. Develop a critical analysis of the educational tools used to deliver preoperative education.
3. Be able to analyze current preoperative education strategies from a pain science perspective.
4. Be able to develop a greater understanding of the need and importance of preoperative education in the preoperative environment.
5. Develop tools and strategies for delivering education to patients prior to surgery.

W7

Adapting movement habits and therapeutic exercise to get the nervous system back to normal

Nora Stern

Looking for something practical, which draws many forms of exercise together under a neuroscience base? Nora Stern, well known physical therapist in pain management from the United States will get you on the floor doing brain restorative movements in this practical small group workshop.

This workshop will draw from yoga, Feldenkrais, and Laban-Bartenieff fundamentals to adapt therapeutic exercise to address the whole patient in normalizing their nervous system. We will explore yoga poses that mobilize the neural pathways, and work with kinesthetic awareness techniques that retrain the sensory and motor homunculus. We will provide ways of modifying your existing repertoire of therapeutic exercise to address the sensitive nervous system.

W8

Making a habit of explaining pain

Lorimer Moseley

Ex truckie, labourer, barrista and now raconteur and neuroscientist, Lorimer Moseley tries to imbed your brain with the notion that you should really chat to your patients and that there is quite an art to it. Releasing the "truth of modern biology" may well be linked to a yarn or two.

If you registered for this conference, you are probably less likely than most to need convincing that nociception is neither sufficient nor necessary for pain. Or, at least, you don't think you need convincing. I contend that it is one thing to be sufficiently convinced that you can recall the 'correct' answers for tricky questions about pain and nociception, but it is another thing altogether to be convinced, deep down in the 'belly of your nervous system' - in the 'marrow of your bones'. I think this is very important because if we are trying to convince our patients that 'pain is an output of the brain that emerges into consciousness in association with the brain's implicit evaluation of the threat to body tissue and the need to protect it', then our attempts will be hampered if we don't make the distinction between nociception and pain anything but crystal clear.

Through interactive group-based exercises, this workshop aims to:

- (i) increase our awareness of how we speak to patients and to each other, with vigilance for statements that are based on, or inadvertently imply, an outdated understanding of pain biology;
- (ii) give participants practice at biologising their patient's experience in a way that is accurate but not sedative;
- (iii) increase our ability to 'slowly release the truth' of modern pain biology.

W9

"Getting a Handle on the Median Nerve"

Fine median nerve handling and integration into managing peripheral and central sensitization

Sam Steinfeld assisted by Laurie Urban and the NOI team.

Winnipeggers, pride of the prairies and the essence of NOI Canada, Sam and Laurie and other NOI instructors provide a handling and scientific exploration of median nerve neurodynamics second to none. Touch, pull, and glide nerves and then apply the findings to peripheral and central issues.

This workshop will focus on the median nerve. A brief review of median nerve anatomy, muscle and cutaneous supply will be provided. A brief practical session on median nerve palpation will help participants identify the course of the median nerve. Practical presentation of the two base median nerve tests and their variations will be demonstrated and participants will have an opportunity to practice these. Discussion of incorporating active and passive neurodynamic techniques into treatment will be part of this practical session. Finally, integration of neurodynamic treatment techniques through the use of patient education, exercise and graded motor imagery for managing peripheral and central sensitivity will be discussed via a problem solving session.

W10

Is atypical facial pain always atypical? A challenge for physiotherapists

Harry von Piekartz

A legendary NOI instructor from Holland, Harry reminds us that pain is not only expressed through the face, it is experienced in the face. This is a small group workshop with practicals. Double the Dutch, double the fun, double the knowledge!

Some of the most common chronic pain conditions are manifested in the craniofacial region. The neuromusculoskeletal system is one of the main contributing factors. Diagnoses such as stomatodynia (burning pain in the mouth), atypical odontalgia, trigeminal neuralgia, atypical facial pain, post-herpetic neuralgia and other long term face pains may be strongly related to peripheral nerve damage (Zakrewska 2005, Woda 2008). Limited knowledge of the underlying pathophysiological mechanisms, pathogenesis and different neuropathic pain classifications are the reasons for a lack of efficacious management approaches for most patients with this type of pain (Benett 2004).

Neuropathic pain arises from axonal conduction blocks which are related to mechanical and ischemic changes. These changes influence the conduction system followed by neurological deficits (IHS-2004). There is evidence that increased neural tissue mechanosensitivity may be the cause for symptoms in many patients who present with chronic dysfunctions and pain (Allison 2002). The symptoms and clinical patterns of this increased mechanosensitivity or neurogenic pain are frequently not recognized by the clinician (Butler 2000, Hall 2005, von Piekartz 2007).

At present there is no readily available scientific test that categorizes cranioneuropathic neural tissue pain syndromes.

Tests for axonal conduction blocks have limited sensitivity, specificity and low positive predictive value (Dvorak 1996). Advantages in medical technology, particularly in MR - neurography and diagnostic sonography, may provide new scope in the future for more accurate diagnosis of cranial neuropathies (Hugh et al. 2000). At present diagnosis is based on comprehensive systematic subjective and physical examination (Bennet 2004, Hall 2005, von Piekartz 2005).

This presentation will discuss clinical patterns of neuropathic pain of the craniofacial region. A clinical classification of cranial nervous tissue assessment will be presented, clinical patterns of cranioneurogenic pain and treatment modalities will be discussed and demonstrated.

W11

Coping of health care practitioners with 'problem pain patients'

Martina Egan Moog, Max Zusman

Martina Egan Moog from the Black Forest teams with Crimean war veteran and physiotherapy icon, Max Zusman to present something close to us all – the physical rehabilitation of problem pain patients with a focus not just on the patient, but also on us. This workshop was called "patients as energetic vampires", pre-censorship.

'Problem patients' have long been described as, among other things, persons who have a fearful preoccupation with physical disease (health beliefs & psychological functioning); who present with numerous symptoms involving multiple body systems; place considerable demands on health care resources and personnel (biomedical); are dependent and demanding, yet non-compliant; and can create uncertainty, frustration, and anger among health care professionals (physician perception). It has further been shown that these patients are often at risk for overmedication and overtreatment, invasive procedures, and iatrogenic illness attribution (Whitenack and McGaghie 1984; Potter et al 2003). In particular, demands for diagnoses and treatments that are based on a purely biomedical approach could also contribute to the clinical challenge these patients impose on health care practitioners (HCP).

Substantial research supports the importance of patient's beliefs and expectations concerning the nature of their pain, appropriate treatment, and prognosis for factors such as return to work, distress and disability. It has been suggested that a variety of sources influence these beliefs - including interactions with HCP. Explicit and implicit attitudes guide human behaviour and determine how information is being passed on and processed. Implicit attitudes seem more reflected in spontaneous behaviour; explicit attitudes seem more expressed in deliberate and reasoned behaviour. For example, in this regard HCP attitudes towards the treatment of common low back pain can predict their perception of the harmfulness of physical activities, and therefore influence their recommendations regarding (delayed) return to normal activity (Houben et al 2005).

Where HCP attitudes and explanation for their patients' pain symptoms collides with the patients' view of their problem a possible source of conflict for patient-therapist relationship exists. In particular resistance is often met when the contribution of psychosocial factors (ie. 'yellow flags') is being suggested. General practitioners have noted that it is often difficult to modify or challenge their patients' view of their pain/cognitions as this could threaten continuance of their relationship (Watson et al 2008).

A sound neurophysiologically based pain explanation has been shown to improve coping abilities of pain patients and prepare them for more behaviour-oriented treatment strategies (Moseley et al 2004). This is said to help validate their suffering, decrease fears of cryptic sinister pathologies, and correct potentially maladaptive beliefs (eg Champion 2000). However, what if a patient constantly 'forgets' the given information, can't relate it to his/her own problems, or begins to 'doctor shop' anyway? In such instances the strategy would appear to have failed. So why bother at all – or, if persisting with it, what else needs consideration?

The transtheoretical model of behavior change (TTM) could serve as a valid instrument in any behaviourally based treatment approach. It defines behaviour change as a process that unfolds over time and only after passing through a series of stages (Prochaska 2008). Clinical reasoning, assessing choice of content as well as timing of education followed by active treatment strategies, should determine what can realistically be expected from a patient at a given time and also how to move him/her more rapidly along the stages of change. The TTM is therefore particularly important for patients who are seen as being 'stuck' in the early stages of change, and therefore provisionally labelled as 'problematic'. In addition, acceptance and understanding of those natural stages and their treatment limitations could well help reduce the stress level experienced by HCP.

Finally, it is necessary to recognise that pain patients can be difficult for everybody involved, especially where there is seemingly no detectable biomedical explanation for their pain. Remaining up-to-date with pain and behavioural sciences research can assist the HCP in feeling appropriately armed to deal with these patients in clinical practice. Improved understanding, in combination with empathy expressed via both verbal and non-verbal communication may, in the final outcome, also assist in harnessing a valuable placebo effect when dealing with our patients (Kaptchuk 2008).

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W12

Rethinking whiplash: Evidence based view of the role of physiotherapy in whiplash management

Esther Williamson and Mark Williams

Whiplash rears its head again. Here is an interactive workshop based on recent findings that will really make you think. From the University of Warwick, Esther and Mark present a workshop based on finding from the Managing Injuries of the Neck Trial (MINT). Are we doing the right things and what can we do better?

The Managing Injuries of the Neck Trial (MINT) compared different types of advice given in an Emergency Department (ED) setting for acute whiplash-injured patients (n=3851). There was no statistically significant difference in disability measured by the Neck Disability Index between an active management approach based on the Whiplash Book and usual care delivered in UK ED's. Twelve months after injury a significant proportion of participants are still experiencing disability due to their injury so are we providing patients with the optimal initial management?

Five hundred and ninety nine participants with persisting problems were also randomised to receive one of two physiotherapy interventions – either a one off advice session with a physiotherapist or a physiotherapy package. The physiotherapy package produced some symptomatic improvements, but no statistically significant difference in long term outcomes. Furthermore, it had minimal impact on health related quality of life and was not cost effective from an NHS perspective. In fact, participants who received physiotherapy tended to visit their GP more and took more pain medication. Has the provision of physiotherapy actually encouraged greater health resource use? Is this a case of less being more? However, the physiotherapy package did result in significantly less days off work so how do we equate these differences in outcome to decide what we should provide for this type of patients?

The aim of this workshop is to challenge the way we think about the management of Whiplash Associated Disorders. Participants will consider what we have learnt from MINT along with the current evidence base to try and answer some of the questions posed above.

W13

How to examine and manage movement control impairment

Hannu Luomajoki

The fabulous Finn, Hannu Luomajoki (NOI Switzerland) beautifully blends motor control strategies with changes in brain plasticity. Come on this truly modern exploration of motor control.

This workshop presents a simple test battery for movement control impairment of the low back. This test set has been shown to be reliable, validated and its correlation to a distorted body image has been shown in previous studies of the author, which are the subject of a PhD project of his. The practical usage of the test set, its embedding to a pain assessment system and future directions will be explained.

W14

“Pain – it’s all in your head, get used to it”. The delicate art of conceptual change.

David Butler

How do you tell someone about the head part of their persistent pain state without being punched out? David Butler takes us through some of the key features of conceptual change theory. There will be lots of helpful neurone based stories and a few new jokes.

Educational strategies for chronic pain are widely recommended. Most modern strategies include fear avoidance models, but only a few include the deeper biology models introduced by Lorimer Moseley. Fewer still integrate educational science.

The world of health science rarely interacts with the world of education science. This is a pity because education has far more sophisticated and developed science, philosophy and debate which health could use.

This presentation is about pain conceptual change and is part of an attempt to bring conceptual change theory and practice into mainstream rehabilitation. Concepts are the essence of knowledge and pain perception exists as a conceptual change in the brain. This is the main thrust of the workshop.

A new model of conceptual change constructed from an educational base and adapted for pain education is presented. The model is believed to be useful for educating clinicians about education; it has been the basis of educational research and it is likely to have clinical applications. The model includes concepts of peripheral and central learning pathways, elaboration and integration of precursor, process and outcome variables in conceptual change.

One section of the model is then explored in a practical sense - the place of enriched heuristics (‘rules of thumb,’ or ‘ways of solving a problem’) as tools to assist people move from peripheral learning into a deeper, elaborative and longer lasting learning. Many examples are given. Heuristics can be short statements such as ‘motion is lotion’ or a short story ‘biologising’ features of a presentation such as the changeable chemistry of catastrophisation or the immune base of mirror pains. Even phantom pains can be given a positive story. The aim is to validate, make real, reduce threat and enhance the placebo interactive power as a part of the shift to deep learning outcomes.



L1

Pain and the Brain Art Exhibition

Curated by Juliet Gore, David Bolton and Stephanie Poulton - open all conference

Pain of some description has provided the inspiration for artistic expression for centuries, and the beauty of biological systems form so much of the basis for abstraction and artistic and architectural exploration. This exhibition gathers together international works which deal with themes of pain, anxiety, intoxication, injury and recovery and the space where science meets the arts in many different ways. You’ll need some time to explore this multi-media collection, which includes some original sculpture, paintings, poetry, film and video footage.

L2

Applications of new media in healthcare

Heidi Allen

What are the practical advantages for a clinician in using social media tools and how do you use them professionally? How are journals like the BMJ and Nature using new media and what are other clinicians and researchers doing online?

Twitter is not just for tweets!

With over 15 years experience in publishing and health industries, working internationally in the UK and Australia, Heidi advises on digital strategies and how to use new media to increase online visibility.

Questions she has been asked:

- What is the professional angle for social networking?
- I'd rather get lobotomised than use twitter (do I really have to use facebook?)
- Seriously how do people get any real work done?
- I've got nothing to say and no time to say it.
- Writing online? How?
- Connecting online? How?
- Is it really going to make a difference?

Heidi develops professional online profiles with clinicians and researchers. She is currently developing the digital strategy for Body In Mind, a site focused on research into the role of the brain and mind in chronic pain disorders with Lorimer Moseley and collaborators.

L3

The Mobile Nervous System – Watch Your Nerves Glide

Michel Coppieters and team, University of Queensland and various other parts of the planet

Call into 'The Mobile Nervous System' show during your lunchhour and take a look at your peripheral nerves moving under ultrasound. Have a chat to the scientists and clinicians about what it all means, pick up some literature and do a few nerve mobilisation exercises.

The science of neurodynamics has been around for some time, yet it is certainly not mainstream. In the physical domain, the world of rehabilitation focuses on muscles and joints and may downplay the fact that the extraordinary electrochemical communication in neurones has to occur in a system which must tense and glide as we move. The physical abilities of the nervous system are quite marked, yet many clinicians are unaware of this.

L4

Stretch Armstrong Lives! – and other useful bodily illusions

Roger Allen and Catherine Preston - Department of Psychology, University of Nottingham

Ever lost a limb in the lunch hour? Here is your chance. Roger and Catherine from the School of Psychology provide short sessions and discussions on the power and place of illusions.

Touch and pain are susceptible to illusory changes in the visual appearance of the limb. For example, reducing the apparent size of a mirror-reflected limb can reduce the magnitude of phantom pain and the sense of touch can be improved by simply looking towards a body part, looking towards the hidden location of a body part or viewing a magnified image of that body part. The sense of touch can also be modulated by the sense of ownership, for example, as manipulated by apparent limb orientation. The potential for changing the sense of touch or perception of pain through visual manipulation of the limb deserves further exploration. This hands-on display will demonstrate a recently developed system that allows real-time manipulations of the viewed limb that can quickly change perception of the seen and felt limb (e.g. stretching or shrinking individual digits) or the sense of ownership over the seen limb such that the viewer will report that the hand they see is no longer theirs.

L5

Self-soothing via guided meditation

Daniela Schoeller

We are delighted to have Daniela, a well known London psychotherapist take interested conference participants through a guided meditation session.

This specific meditation - the Body/Feelings/Mind Disidentification Exercise - as it is originally called was perceived and developed by Roberto Assagioli, founder of Psychosynthesis Psychotherapy, in the middle of the 20th century.

The lunchtime sessions aim to provide a real taste of the experience of the identification/disidentification exercise through guided meditation. The aim of the exercise is eventually for the person to learn and do it for themselves with the ultimate aim of using it with their patients. It is a powerful therapeutic tool for self-soothing and 'self-treatment'.