Welcome to IPBMs education and its practice

A clinical Integrated Psychophysiological Behavioral Medicine (IPBM) knowledge based practical approach including integrated biofeedback

Our mission is to provide internet based education and personalized tailoring of a biopsychosocial toolbox enabling patient to learn (reasonably not too complex levels) basics about what they can do, how they can use tools personalized step by step tailored – when needed – coached by well trained professionals.

We use IPBM as a platform by a number of reasons, where one is to concretize provided knowledge in easy understandable data enabling motivation for coached self-care activities – see what you do and do what you see (observe/understand) .. Other reasons will be emerging during the course of time …

Our approach is planed to function in terms of a number of pieces you organize and put together into a for you useful "puzzle". Our purpose is provide practical useful applied psychophysiological knowledge approach, which also can be used together with other approaches within health care services!

The plan here is that you can participate according to (mostly) your own preferences and possibilities. That means; (a) presentation are PPTs with recorded with speaker text possible to use via internet, including elaboration of the presentation, when appropriate, (b) practice is demonstrated via internet, different patient population of relevance – can also be not patients, e.g. focus on sport performance and coping with stress, (c) group follow-ups via Skype (or the like) and (d) examination and certification also via internet. To be observed is that examination and certification require much work to become approved by our board. More info about examination and certification at a separate PPT-program.

Our approach is based on "patient as an educated reasonable competent resource and coworker in own rehab", which is a development based on the manual in my (Bo von Schéele´s) dissertation at Uppsala University 1986. The biopsychosocial toolbox can also be used in prevention purposes.

"I" in IPBM refers here both to "Institute" (organization, www.ipbm.se) and "Integrated" (systems perspective). We have used our IPBM approach informally since 1983 and formally as a non-profit company from 1998. Our work within psychophysiology is partly based on and influenced by the organization Association of psychophysiology and Biofeedback, www.appb.org as well as developments within a number of other fields as e.g. medical engineering, personal construct theory (Kelly, 1955), biopsychosocial medicine (Engel, 1977)

As most human sciences there are no absolute knowledge, but with varying degrees of limitation. We can thereby of course questioning how physiology and even more limited psychology can be integrated – even more limited while we also expect vast amount of synergy within and between levels. So, why psychophysiology?

First, humans are integrating psychophysiology in real life and this is what we need to realize when we try to especially understand human health, its maintenances as well as its prevention and treatment of dysfunctions, both medical somatic and psychological, mostly integrated/interplaying

".. If we break up a living organism by isolating its different parts it is only for the sake of ease in analysis and by no means in order to conceive them separately. Indeed when we wish to ascribe to a physiological quality its values and true significance we must always refer it to this whole and draw our final conclusions only in relation to its effects in the whole" (Bernard, 1865) in A Despopoulos & Silbernagl (1991) Color Atlas of Physiology: N.Y.: Thieme.

Second, during the evolution, particularly the last part of our brain (see PPT 2, Dual code cross-talk between old and new brain; a psychophysiological interplay.PPT), we have learned of survival reasons to elaborate/reasoning/solve problems based on limited knowledge – something computers have not been able to do, so far. Important to remember this to avoid Bessrwisser status.

Third; in the the complex interplay there are some systems integration we do understand more of, e.g. the autonomic nervous systems interplay between psycho- and physiological levels. Parts of cell metabolic- (increasing in importance recently while we begin to understand mitochondria´s crucial role) as well as cardiovascular systems functioning. Those systems are what we will mainly focus as well as behavioral strategies to interplay with them.

Forth, to use psychophysiology in clinical work is, according to our experiences, important to really make understandable how patients (and others, including those not yet patients) how these systems work and its significance for identifying stress and many life style related dysfunctions and how they are developed. Understanding can influence motivations to do needed activities to normalize observed and identified dysfunctions. Moreover, we all (patients as well as clinicians) can see the result of behavioral interventions.

Fifth, to see or not to see makes a diference – or? See means both understand and observe – activating both cognitive (mainly human part of our brain) as well as spatial (older evolutionary parts of our brain, e.g. the Limbic system) understanding. To understanding both spatial and verbal .. (see more "PPT 2 Dual code cross-talk between old and new brain a psychophysiological interplay.PPT" presentation) is important not only while we assume placebo-processes are created/generated in our Limbic system (spatial) but also while here in our Emotional brain (another name for preferably our Limbic system) are the places were hormone and other emotional "activators" is created/generated.

Sixth, in general we also assume that in most (if not all) diseases/dysfunctions passive and active capacity to biologically relax is of importance directly or indirectly both for subjective as well as dysfunctional states. Therefore, we suggest simple biofeedback-assisted relaxation to be used in most patients in a very simple easy used way. Also, how an individual is feeling in terms of general condition is not to forgotten to considered, while general condition per se can be expected to have a general influence on dysfunctional states.

Seventh, in our clinical work with very different kind of patient populations we usually use biofeedback a few minutes each visit to follow patients development in their training program. Biofeedback can be used everywhere quite soon while patients learn to feel changes and thereby to not need equipment, which is used only in the beginning. NB that is finger temperature biofeedback where our instruments measure 1/100 C which is much more sensitive than we can fell but quite soon we learn (by operational conditioning) to feel more and more sophisticated and thereby can use own body as the "equipment".

Lastly, as we measure dynamic behaviors of the above-mentioned parameters, we can not only identify the nature of observed dysfunctions but also, we can measure each individual´s capacity to influence in real time observed dysfunctions in representative parameters. Not very seldom this inspire patient to do more than their best. Therefore, we need to really carefully discuss qualitative and quantitative suggested tailoring and use of tools in the toolbox. Furthermore, this self-observation of own capacity to influence systems never thought of usually for patients can influence their "placebo skills", a not very well understood powerful intervention (see e.g. http://biopsychosocialmedicine.com/projects/rd-international-projects-2/placebo-rd/) in ways we today can speculate on but really not exclude I spite of limited knowledge – including how we can methodologically identify it!

My clinical way has been based on the above and also "center my clinical work/approach" on "the patient as an educated, reasonable competent resource and coworker in own rehab" based on my dissertation manual 1986, a context actually initially suggested by Thales and Protagoras some 2,500 years ago. The education concerns learning to use a biopsychosocial medicine toolbox and coaching to individually tailor the tools. That is (reasonably) understand and see hypothesized reason for their symptoms/problems as well as ways how to rehabilitate using the tools in their personalized way. An potential possible exiting journey for all of us, patients (and their social contexts) as well as clinicians!

Summarizing: Our mission here is to present Integrated Psychophysiological Behavioral Medicine, IPBM (NB in our version – see more about our knowledge and practice paradigm in the theoretical part of this education series) as easy and useful clinically as well as not clinically as possible

Moreover, as there is no absolute knowledge within addressed disciplines but different levels of limited knowledge in physiological medicine as well as psychology, to try to integrate both must be even more uncertainty to rely on – or?

Perhaps, but within each field we do have some parts we understand more .. and knowledge in our fields are improving …. as well as our careful confidence .

We solve the above problem while using subparts of the our disciplines that we know quite well, including its dynamic interplay. We can also identify individuals´ capacities to influence observed dysfunctions also in real time psychophysiological measures and then follow individual's development during their actions/training/behaviors. Of course, we do add different adjunctive tools of relevance (more later), but in the beginning we choice biofeedback assisted strategies which is easy to understand by patients – about what their data refers to – as well as how they themselves can see (observe and understand) the effects of their own activities/doings! This is so far always very motivating and patients easily do their tasks too much motivating, so we are warning them to be carful not overdoing, which can generate negative side effects.

Perhaps the above is one of the most positive effects of IPBM. But this require carful adjustment of information so patients can understand during group education, especially also get time to reasoning, discussions and practice and over time find their version, tailored in cooperation with their coaches/clinicians.

See more “what is biofeedback”-PPT where we introduce one as concrete and practical as possible useful strategy where it is easy to see the effects of one´s own doings. “Learning while doing while seeing” where seeing refers to bot observe and understand! At the same time!

Briefly, in “cross-talk between old and new brain”-PPT we discuss particularly complex interplay between spatial and verbal systems, e.g. enabling conscious control of (not conscious) autonomic nervous systems dynamic behaviors as well as some more systems.

As basics about biofeedback is still not well known, I present here the way I have found most effective during clinical and scientific work since 1986.

NB as said above; we do not have assesses to absolute knowledge. Therefore careful, humble consideration is needed while using present knowledge as well as possible. This we do by using a paradigm platform (see more http://biopsychosocialmedicine.com/paradigm/, which this educational program rests on! This means that there are some other psychophysiological including biofeedback solutions to choice amongst! Our version try to be more of a systems integrating biopsychosocial perspectives as well as make priorities for patients learning while doing while seeing processes. This requires knowledge and its implementation hand in hand in the educational process!

Some personal info; At 78 I cannot be sure of another 20 -25 effective clinical years. As I have not earlier got time to publish my clinical work/version of IPBM, this ongoing education/WS projects are a kind of very late publication and clinical testament but in terms of a prototypical practice program trying to enable its personalization of those clinicians interested to use it – very much in line with George Kelly´s (Personal Construct Theory) intentions which many of his follower by some reasons did not really understand

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