

identity, projected identity, and displayed identity) revealed 3 identity profiles (A: Physiotherapist profile 17.6%, B: Physio-fasciatherapist profile 55.5%, C: Fasciatherapist profile 26.9%) that appeared significant, characterized and opposed to one another (change to patient base, use of Fasciatherapy modality, Fasciatherapy session, Professional and Personal impact). (Table 1)

Conclusion: Practising Fasciatherapy has an impact on professional practice and identity traits. A significant proportion of practitioners combine the identities of physiotherapist and fasciatherapist, and few of them remain physiotherapists. These profiles are defined with regards to the statutory, professional and practical characteristics of Fasciatherapy.

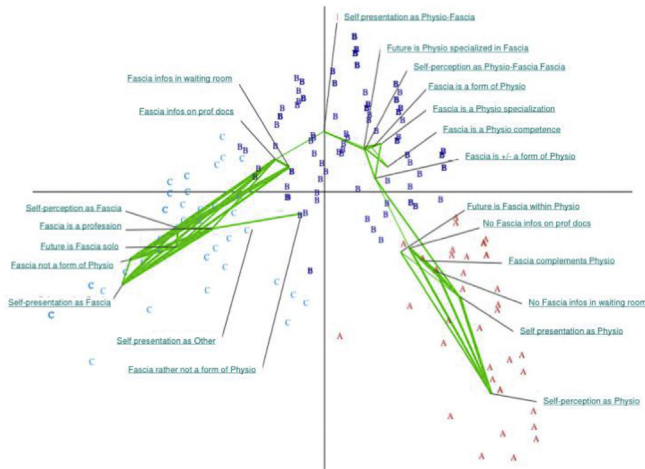


Fig. 1. Results of a Correspondence Factor Analysis (CFA).

Characteristics	Physiotherapist (Type A: n=42, 17.6%)	Physio-fasciatherapist (Type B: n=32, 35.3%)	Fasciatherapist (Type C: n=64, 26.9%)
Change to patient base	No change	Increased patient base Patients' fasciatherapy demand (25 to 50%)	Decreased patient base Patients' fasciatherapy demand = 100% of consultations
Use of Fasciatherapy modality	Smaller part Within or in addition to physiotherapy techniques Used with other techniques	Larger part Replacing or within physiotherapy techniques Not used with other techniques	Solely Replacing physiotherapy or outside its scope No used with other techniques
Fasciatherapy session	<1 session/day 20 to 30 min	5 to 10 sessions/day 30 to 45 min	5 to more than 10 sessions/day 45 to 60 min
Professional impact	More pleasure To improve practice	To find a more personal style and to differentiate from other physiotherapist Renewed motivation Better financial outcome Greater confidence	Using a passion Innovation More pleasure More satisfaction and worth
Personal impact	More self aware	More adaptable Needs/boundaries balance Finding solutions	Better self-esteem Fuller more joyful life Better physical and mental health

Table 1 : Characteristics of the 3 identity profiles

References

Table 1
Prevalence of intestinal symptoms in control and experimental groups before and after intervention.

	Control group			Experimental group		
	Pre-intervention	Post-intervention	p	Pre-intervention	Post-intervention	p
Abdominal pain/discomfort	53.3%	53.8%	0,75	66.6%	14.2%*	0,006
Soft or watery stools	13.3%	15.3%	0,9	6.6%	7.1%	0,93
Very hard stools or unable to eliminate stools	73.3%	69.2%	0,9	66.6%	28.5%*	0,009
Strain required to move bowels	53.3%	53.8%	0,9	66.6%	35.7%*	0,02
Sensation of urgent need to move bowels	6.6%	7.6%	0,85	0%	0%	
Abdominal swelling or distension	26.6%	30.7%	0,85	20%	14.2%	0,15
Difficulty passing gas or excessive passing of gas	40%	38.4%	0,9	53.3%	21.4%*	0,03
Sensation of incomplete bowel movement	53.3%	53.8%	0,9	66.6%	28.5%	0,009
Anal pain at time of moving bowels	33.3%	38.4%	0,8	46.6%	14.2%*	0,02

Legend: Post-intervention: one week after last session; *statistical significance level assumed at p<0.05 (X² test)

Courraud C, Lieutaud A, Bois D. The Sensible and Identity Crisis of Healthcare Workers: The Perspective of Physio-therapists Practicing Fasciatherapy. *Sociology Study*. Volume 8, Number 1, serial Number 75 2018.
 Courraud, C. (2012). Au carrefour de la kinésithérapie et de la fasciathérapie – Approche exploratoire des reconfigurations

identitaires des kinésithérapeutes formés à la fasciathérapie. *Réciprocités*. n°6 novembre 2012. Revue du CERAP. p. 20-35.
 Kwong, E. H., Findley, T. W. (2014). Fascia-Current knowledge and future directions in physiatry: Narrative review. *The Journal of Rehabilitation Research and Development*. Volume 51. n° 6. p. 875-884.

VISCERAL MANIPULATION TO TREAT FUNCTIONAL CONSTIPATION IN STROKE SURVIVORS: A RANDOMIZED, CONTROLLED, DOUBLE-BLIND, CLINICAL TRIAL

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Introduction: Chronic functional constipation is common among stroke survivors. Visceral manipulation can be used as a form of treatment, as it acts on the structures surrounding the bowels that may have lost their normal capacity of resilience. The aim of the present study was to evaluate the effect of visceral manipulation on symptoms of functional constipation in stroke survivors.

Methods: Thirty stroke survivors met the eligibility criteria and were randomly allocated to an experimental group and control group. Both groups were submitted to conventional physical therapy to rehabilitate the functional sequelae caused by the stroke. The experimental group was also submitted to a visceral manipulation approach (sphincter inhibition and mobilization of the large intestine), whereas the control group was submitted to a sham procedure (superficial touching over the intestines). Evaluations were conducted prior to the intervention, immediately after the first intervention session, and one week after the end of the five sessions. The intestinal symptoms rating scale was administered during the pre-intervention evaluation and one week after the end of the intervention.

Results: Significant results were found in frequency of bowel movements of the experimental group after intervention, especially with: reduction of the percentage of patients that had bowel movements once every 3 days (from 53% to 21.4%, p=0,02) and increase of the percentage of patients that had bowel movements once or twice a day (from 0% to 14.2%, p=0,04). Significant improvements were also found in intestinal symptoms of the experimental group (Table 1).

Conclusion: Visceral mobilization can be part of a neurologic rehabilitation program to improve symptoms of constipation in stroke survivors.

**Sensory Aspects
THE ROLE OF THE AUTONOMIC NERVOUS SYSTEM IN THE DEVELOPMENT OF EXERCISE INDUCED MUSCLE DAMAGE: RESULTS OF AN RCT**

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