

# Fascia: The Poo Connection

with Julian Baker

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## TRANSCRIPT

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Steven:

Concentrated on the nature of fascia and its connections throughout the body. Good afternoon. Once again, welcome to the Academy of physical medicine for another lunchtime CPD session. I feel quite privileged today. My guest is Julian Baker, who is the man who brought the bone therapy to Britain in 1992 gentlemen, welcome.

Julian:

Hello Steven lovely to be here.

Steven:

It's a great treat to have you and you also, when we were talking just before we went live, I mean you were saying that actually you've made it your mission to tackle the sacred cows of various therapies. Which I think is always popular because as we said, it's the, it's the spirit of scientific research isn't it? That you throw something up there and we shouldn't be upset if it gets destroyed or reinforced. The point is to explore the science behind what we think is happening. In our case, the human body.

Julian:

No, I think there's a lot of, a lot of stories we tell, there's a lot of language we have that we understand as therapists what we're saying. And so I'm interested to say, what's your, you know, is it, is this true, you know, what is it we are actually saying? And then what is, what is the truth behind it and how much is the story and does it matter? But can we reconfigure our narrative around to, to sort of have it a little bit more evidence-based, a little bit more reasonable and a little bit more logical in some instances. Some of the stuff you hear in various fields is bonkers sometimes.

Steven:

I think you're absolutely right and probably a lot of the theories that I personally hold are bonkers, but I've never bothered to challenge them. You've been asked to come on today to talk about fascia, which is a particular passion of yours, isn't it? You do lots and lots of dissection, which isn't something I would have associated necessarily with Bowen therapy itself. But I guess because you're the one who's brought it here, you're the brains behind the Bowen Institute and It's a very important part of what you do as an instructor.

Julian:

Yeah. I mean I sort of came across the idea of fascia and I've sort of moved to the idea of encompassing that in terms of also some of the bonkers, things that people are saying in terms of the idea of fascial release and, the various loading we give on to fascia. So to imbue all kinds of magical qualities. And I get a little bit tired of that as well. That says, well actually, you know, you, we're releasing fascia or adjusting fascia or stretching fascia with our hands. And we're almost certainly not. So you know, that gets lumped into that as well. So fascia is a passion of mine. It is part of the overall picture in terms of questioning. You know, what it is that we're doing. So almost, I might, I'm happy to throw cold water on or pee on the strawberries of anybody's deeply held belief. Nothing else.

Steven:

I think one of the problems I find in osteopathy in my case, but in manual therapy is that we often say, I think I'm stretching this or affecting that. And this happened. Therefore that's what I did. And you know what, whether we think we're stretching fascia or muscles or, or doing whatever else, the outcome is what mattered. And sometimes it may not be the mechanism we think which achieves that outcome. Is that what you're suggesting?

Julian:

Well, I'm saying, you know, Gil Headley who I learned my, you know, my dissection skills from, and I have a therapy to hang my, my dissection on. So that's kind of where I've gone with that. But he always said hold onto your practice dearly and your theory lightly. And so we have to let go of that theory if it turns out that what we are doing isn't actually what we are doing. So you're right in as much as the outcomes are important. But along the way, some of the stories that we tell, are what sort of puts a noose around our neck and in this current climate, you know, I have to question why aren't we as manual therapists at the front line of helping people. We know, we all know that we can help people respiratory wise.

Julian:

We can help people with post recovery prevention and all that kind of stuff. And I think some of the language that we've spoken has alienated us from that. From that idea of academic, clinical frontline, you know, in the Western medical approach, we have no touch therapy as a standardized clinical speciality. And I think that's crazy. So on the one hand of the scale, we've got the sort of the academic idea that says anything that doesn't have the evidence base that we approve of is baby out with bath water when it's unscientific, you know, quackery. And then on the other hand, we have the conspiracy theorists and the, you know, the G five people. Now somewhere in the middle, we know that touch is really important. Now how we go about that touch is the discussion we can all have, whether it's osteopathic, chiropractic, massage, you name it.

Julian:

But ultimately what we do need is we do need to see touch as part of our frontline health approaches. And we don't have that. And why don't we have that? I think we don't have that because there is a disconnect between those two ends. And so my, my desire is to sort of, you know, be the shame and if you like to sort of bang heads together to say look guys, baby out with the baffles who approaches and helpful and also talking sort of conspiracy theories is also not helpful either. So let's reconfigure our languages, therapists, let's see, let's look at the evidence for touch and let's bring these two sides together. It's cheap, it's virtually free, there's no side effects. Why aren't we using it? And I think it's a real shame that, that we've sort of, our, our whole industry if you like, has been side-lined by a poor narrative and a lot of disagreement and bitching about what we do or don't.

Steven:

Interesting choice of words back there. You said that what I guess you're referring to as sort of the conventional world says your therapy isn't backed up by the evidence based, which we approve of as though there is an evidence base they approve of and an evidence base that doesn't match their

expectations and therefore they don't approve. Is that what you mean by that? Is that what you found?

Julian:

Yes. I mean, you know, there's, there's a certain degree of idea that says as well this journal has this impact and this journal doesn't have this, this impact of this on and so forth. And of course, you know, you've got to bear in mind that there is no such thing as the science. There are lots of sciences. And so the epidemiologists and the immunologists, so you know, there's, there's a confusion between the, and so the science of what we think is, is, is appropriate isn't necessarily began to be the science that's adopted by by, by medicine or clinicians around the world. You know, it takes a long time for that evidence to trickle down. So there has to be a weight of, it has to be repeated. It has to be ensure above all that it's safe and that it has some kind of efficacy.

Julian:

And so the tendency within our manual therapy field is to produce evidence that kind of preaching to the choir. We're sort of preaching to ourselves and convincing ourselves and patting ourselves on the back that what we do is the right thing. And meanwhile we're not, we still don't have the proof of the pudding being in the eating. We still don't have touch base specialties within our points of delivery. And I, I don't know, I can't work out why the, whereas you know, where is that disconnect? Why hasn't it happened when we know that there is a weight of evidence pushing against the dam? How have we not got through that?

Steven:

Yeah. Have you got any examples then of the, the type of language which you think is particularly unhelpful in terms of us getting our, our therapies into the mainstream?

Julian:

Well, I think, I think generally speaking we sort of, we use words that we all understand, like, you know, tight and stiff and restricted and then, you know, mobilize and release and, and, and we can apply that to where, you know, muscle knots and all these kinds of things. These are all things that you go, well, what are these things know what is it we are actually doing? And 30 years ago I'd given you a chapter verse and now I don't really know. You know, I've been putting my hands on people for many, many years and when things happen I can't really explain those physiologically. Anatomically. I think probably what we're doing most of all is having some kind of proprioceptive neurological effect. I think when you go down the HVT route, you might see more mechanical stuff. But I think generally speaking, we are making people feel better. However we do that by putting our hands on them. So, so narratives that sort of talk about adjusting, releasing, repairing, softening, all that kind of stuff. Is that what we're doing? And, and you know, it behoves the question, what do we think we are doing and what are we at versus what we are actually doing.

Steven:

So Tom, Maya's work has been quite popular, become even more popular over the last few years. The concept of anatomy, trains and fascial slings. Is that something which Ben, it's up to your scrutiny.

Julian:

I've got to be very careful here. I like Tom. I wouldn't be, I wouldn't be here today without Tom. I discovered Gill when I was with a workshop with Tom in New York city in Manhattan for Leslie Kamina for the breathing project. And he put me onto Gill. And so I might sound very much, I think anatomy trains as a work of art and the work of genius. But the point of about, and you'd have to remember about anatomy trains is that they're not real. They don't exist. They're not a thing. You, the first edition says they're imaginary lines, Australian. And it's a brilliant way of starting to, for us to get to look away from the direction of, right. I have back pain. So I treat it back, which, which is a model that just doesn't work. It's physiologically illogical and defies the laws of physics.

Julian:

So Tom's work in terms of creating these ideas is great. The problem that I have with it is that it's been taken on board. Is it being something that actually exists? You can't, just because you can cut them out of dead body, it doesn't make them exist. And I'm doing a webinar tonight on, on the hamstrings and gluteals and all that destroys the superficial back line completely. You know, there are no straight lines in nature. Everything's a spiral and everything in terms of loading and distribution has to be loaded through a spiral and it has to have distribution and dispersion by its very nature. So the moment we start to look for loaded lines in a body, I have, I have a problem with. So on the one hand it's, so it's a work of art. It's a genius. But on the other hand, they don't exist.

Julian:

They're not real. They're just imaginary lines of strain. And somebody called me at the fascia conference last year in Berlin and she said, well, you're the person that doesn't believe in anatomy trains. And it's like, well, present the evidence and then belief isn't required. It's not a case of, I'm not joining the church here. I'm not signing up to a spiritual understanding. I can cut your unicorn out of the body if that's what you want with a sharp enough knife and a dead body. But that doesn't mean to say that they exist. So I'm a little cautious about taking a brilliant idea and trying to make something literal, you know. So that is the problem perhaps when people are thinking the ideas in the book too. Literally I think, I think is what's happened with anatomy over the last two or 300 years is that anatomy traditional anatomy is at best, incomplete and at worst flawed and incorrect and potentially unhelpful in terms of understanding how the body works.

Julian:

And this is why we've ended up with fixations on things like the psoas or the piriformis or the joint. Because we've taken, and we've taught anatomy to our manual therapists, our osteopathic chiropractor, massage therapist upon therapist, we taught them a medical model of anatomy, which is not functional. We don't, nobody puts that together. You know, I was in a lab watching, I'm a second year undergraduate anatomy study. They were doing the upper limb. And so there's five or six stations there and the upper limb comes out and it's in various degrees of dissection with pins in it. And they go around with our iPads and they, they identify what the pins are and then they're graded on that. And that's it. Next week we'll do the, the, the head neck. And you chat to these, these youngsters afterwards and you say, so tell me what you think might happen to this.

Julian:

Brachial plexus is radial nerve. If somebody's head was rotated and the shoulder was elevated and they said, Oh, we'll learn that later. And it's like, well, no, you won't. Nobody's putting that back together for you. So we're learning a model of anatomy, which doesn't fit the manual therapy model. So yeah, you know, and heard of fascia. They've just heard of connective tissue and understanding its potential for function within the body. So anatomy trains went down that route of joining things up but has gone too far in my opinion to say these lines of the strain of real rather than just being good examples of something. Any particular sacred cows in your gym science at the moment. Okay. I wanted to show you a couple of pictures actually just to start off with because again, it's one of those things that if I can illustrate this and it's if I can share the screen here, I'm ready.

Julian:

Is that okay? Yeah, please do this. Give this a guy. So this is what we're looking at with this is one of these pictures that you will very rarely, very rarely see. And so, so this is a picture, I've got a couple of pictures here. These are the psoas. This is what I was talking about last week in relation to the idea of the psoas. And so the sacred cow has been sort of one of mine for a while in terms of taking aim at it. And I believe really that we need start to look at this junction, which is just orientate you here. We've got the QL coming up here got raised on board. So as major and the picture showing me I hope so. What are you looking at? I'm looking at a full cadaver with someone times over his face.

Julian:

Oh, I do apologize. Yes, you will not. So this is, I'm sorry somebody, that's a different thing come up for me. So what you're looking at is you're looking at the a lady whose skin has been removed and you're looking at the superficial fascia. So this is the, this is the interface of the manual therapist. This is what we put our hands on. And it's very, very rare that you'll see this picture because nobody shows this in anatomy. Labs is all cutaway for medical practitioners. You don't see it in dissection books, either anatomy books, this is all removed. And so when you end up taking this away, you end up looking at muscle underneath. And the next picture along if I just go to the next picture is when we take the superficial fascia. So you have the, on the right hand side of the picture, you have this lady's superficial fascia removed.

Julian:

And on the other side you have her deep fascia and muscular layer. Now this is the layer that is defined and looked at within anatomy trains, within anatomy with all these structures. So what's the stuff on the right hand side? This stuff is the biggest organ in the body. It's full of, it produces hormones, it responds to hormones. It's has leptin in it. So cytokines, it has a massive immune system and massive lymphatic organ and it houses all the all the, all the lymphocytes. So it's how houses all the adipocytes as well. So it's a housing of connective tissue for adipose tissue, but also housing for hormonal structures as well. But it's what we touch. It's our, it's our, our experience, if you like, of of our sensation in the world and it's piece of tissue that we very, very rarely get to see. And so that's my amongst things and when we start talking about going through that to get to the so ass and we've ignored all the structures that are underneath our hands in the first place simply because we didn't learn them because the book didn't show us. There's something going wrong here.

Steven:

But that's surely not to say that we can't influence the psoas by poking hard enough.

Julian:

It's an interesting discussion. But the end result doesn't justice necessarily justify the means. And also we assume that the, the function that we're assigned, the size is correct and that all the other stuff that's between our hands and the, so ass doesn't have any influence. Well, you know, you've got 16, 15 or 16 layers of abdominal tissue between here and sort of four inches down assuming that somebody is ready to be slim. So why would you think that mobilizing this, which is external oblique Rex is a dominance transverse of dominance, internal oblique, and all those other structures wrapping themselves around into thoracolumbar fascia on likely to have more of an effect on extension rotation, hip flexion then pounding away through another 18 inches to get to a size. It's just biologically implausible.

Steven:

So what when, when someone comes to you and says, I've been told I have a tight psoas, what's your response?

Julian:

Mmm, well, functionally what does that mean?

Steven:

Well, I guess it means that somebody has done a Thomas test or something similar and it says this doesn't go as far as I think it ought to go, or it doesn't go as far as the other side. And therefore there's got to be some, so involvement or depending on, I've done the test, other muscles try on, what they're trying to do is they're trying to even out the two sides or achieve a range of motion, which they think is healthy.

Julian:

Hmm. I think this is the issue that we end up with with, with things like differential diagnosis for, for, for Thomas tests on Southwest. You know, if you look for something hard enough you'll find it and there's all, there's a hundred papers out there that will talk to you about, so as functioned because they're looking at psoas function but they're not looking at size function in relation to internal standard bleed. So this is, this is my question. I find size relatively dull as a muscle in terms of if you compare it to say a piece of beef, you know, a shin of beef is, is hardworking you, you've got to cook it down. It's got lots of sinew and lots of structures in there that make it a tough muscle. You know, a fella isn't, it's a very lean muscle.

Julian:

You can eat it raw or so where there's lots of function going on is where I'm interested in as far as size is concerned. I think size is a lot more functional when it gets further up into up into, around that junction of Teton where you've got diaphragm coming to it. And I think it's probably a prime lymphatic driver for the human fall and probably more important as a lymphatic functional structure than anything. So I don't buy the, the, the, the model of Sovos as a, as a tightening on one side. I don't buy tightening of size as a functional issue because my issue with the client is, well, what does

that mean to you? Tell me what you know, what do you, what are you doing when you notice it the most? So, so I slating and, and focusing on one muscle is without being ever able to touch that muscle is something that I, I find extremely bizarre when we look at the concept of us is the first law of natural cures, which is the body be treated as a whole without referral to name disease or therefore by extension named structure.

Julian:

It just doesn't add up for me. I don't, I don't get it.

Steven:

I guess many, many practitioners would say, well, yes, but I'm not just doing so acid, whatever muscle it might be. I am working with others as well. But it helps to focus on the name because I know that there's something in there which causes the body to do this. And I'm trying to influence it. I've got some questions for you

Julian:

Then let's talk about what else is the relationships, and this is what missing Steven, is we're missing the relationships of things when we start to drill down onto individual muscles because we're missing, you know, what else is in there? And when we start to join those things up and get proper joined up anatomical thinking, that's when it starts to get really interesting. But so as by itself is,

Steven:

So what's a, what lenders, you're joined up thinking as you mentioned the abdominals as well. I mean, if you wanted to join it up, how would you explain that process?

Julian:

If we look at, for example, what I have this, this, this thing that I call function junctions. So, so where lots of things are happening. So, for example around the groin, around the around sort of coming off the edge of the groin, you've got sort of the anterior superior iliac spine, you've got Sartorius, you've got size coming down underneath as far as NSO and Sartorius rectus femoris, vastus, lateralis and you've got all this fashion, there's joined them up. So it's a, it's a remarkable area to work on where there's lots of stuff coming into it, going through it, going around it, going under it. And the same thing goes on as far as say with, with, with, so ice is concerned, let's look at how many different structures are going in so many different directions directly underneath our fingers underneath our hands, which would enable us to be able to help change direction. Even think about the relationship of the system as Dorsey, as it wraps itself, the fascia itself of wraps itself around external Blake is remarkable. We just don't look at that. We open our anatomy book and we find a muscle. There's a big strong muscle and we we buy into that. You can only have a problem if you've got a name for it. You know, I've never had anybody talk about an operator, internist syndrome because nobody's studied, have tried to internist.

Steven:

So if you're saying, well, we've got to, we've got to consider all these different tissues going in many, many different directions. What's your approach to actually achieving a therapeutic outcome? Because you can't go in all those directions. And I would imagine,

Julian:

No, I mean this is, this is the difference, isn't it? And so, so from, from a Boeing perspective you know, I spend a lot of my time out of the room and so my, my therapeutic outcome is defined by the markers, by the, the subjective and objective markers. And that's why I'm constantly beating the living daylights out of my students to, to go through their soap. I've put a free webinar on, you know, subjective objective assessment and an action and plan to find out, well, you know, what is your subjective markers? Because it's only the client telling you what their clinical outcomes are that makes a difference. And so we have to get good measurements on that. And probably I'm going to raw. This is my sacred cows. Does it matter what we do? You know, does it matter whether we're doing osteopathy or chiropractic or is it that we are doing what the certificate on our wall tells us we're doing and that's what we are investing in and what our clients are investing in. And so therefore that's what our outcomes are determined. And it's, I don't know, this is, you know, I'm not even sure what we do anymore.

Steven:

It's one of those things that I'm constantly come back and share on these shows actually, is that I'm not that the name or the title of our degrees or diplomas matters too much, but where research is concerned up until very recently, most research has been concerned about how you influence this one thing in changing this outcome. Whereas if you took a bunch of physiotherapists, chiropractors, osteopaths, bone therapists, and said, right, we're going to throw a randomized number of patients at you and we'll just see what the outcome is. We don't care what you do in the treatment room. We're just trying to find out what helps the patients that would be much more helpful.

Julian:

I think it's, I think is, again, it's a case of what you look for. And because, because we've gone down, particularly with osteopathy and chiropractic over the last few years, we've been regulated and we've gone down that clinical model. We started off with a clinical, anatomical perspective of naming parts and therefore assigning functions that parts without examining the relationships of them. We don't have a bomb at biomechanical perspective within our our medical model anymore. So the temptation has been to go down that medical model. And you know, it doesn't really work. It defies logic. It defies the laws of physics. And so, so looking at individualized structures and then finding what they're doing, I don't think it's helpful. So our research has been clinicalize and anatomic realized if you like. And so that's what we're ending up doing. The effects of X on X two to give us that.

Julian:

And so, you know, in touch, she's left out of that. I was reading an article this morning it's in the guardian about a woman who's had several miscarriages and she's talking about the concept of miscarriage and the investigations that have gone on in terms of blood tests and genetic testing. But all the times that I've spoken about was going to do a project with somebody in Wales. Eventually we're writing it up. There's no mechanical aspects. Has what's the history of somebody's pain or

dysfunctional mechanical or physical dysfunction that they might've had? Is that a factor? It may be. It may not be, but it's not really been looked at.

Steven:

I got some observations from our audience and questions. Marion Jones asks what you think of Stecco, which I don't know anything about. So for you.

Julian:

Oh I love colour stack. I think Carlos Beko is a genius and I think the work that the stucco's have done on fascia and their ability is just phenomenal. The work that's been put out I don't fully understand that. So I, I've come, I've sort of taken that step back. That's a lot of science that's gone there. And you know, the Snipes and the stack goes, are really drilling down into the science and the on the cellular structures. And for me, I'm not, that's not how my brain works. And I, I am sort of got a bit of a science going on here and I, I, I love some of that stuff, but it's not where I'm going. So I want to try and do is translate a little bit of that but also bring it into a functional approach that can be understood by manual therapists.

Julian:

You know, because again, there's that disconnect that the fascial world is going down that, that route. And there's a lot of science and a lot of justification about what we're doing within the science. And so, so from that perspective, I'm in all of those people. That's incredible what they're doing from a, from a functional physio, physical perspective. I'm not, I don't quite understand the, the manual approach that they come at. But that's not to say that it's not right, but I'm, I'm sort of trying to translate some of that science into a little bit more of an approach that a lot more day to day therapist can understand and have some kind of application for. I think sometimes there's a disconnect between the science and what does that mean to us as manual therapist. And that's really what I want with my dissection classes is for therapists to go away and because of what they've seen to have a visual understanding of what they're touching and to be able to help people direct you the moment they step out of that, that's actually in that

Steven:

Apparently we've got quite a lot of osteopaths and chiropractors jumping up and down at the my window wanting to point out that right from day one we're taught that the body functions as a whole and we don't focus on individual muscles. Is, is that something which you would recognize in the osteopaths and chiropractors that you've come across? What do you think? Yes.

Julian:

Theory as in theory, I would recognize that 100% and, and please don't be offended, I'm not dissing chiropractic or osteopathy as a profession in any way, shape or form. I'm, I'm saying that, that I'm questioning the way that we teach anatomy and the politics and the religion that has got us to here. So yes, osteopaths are taught that. And we're all taught that within our field of, of, of natural therapy. In fact, it was Malcolm STEM some, the name might ring a bell for some people that, that, that [inaudible] I think there's first law of natural cure the body be treated as a whole without referral to main disease. The trouble is is that the anatomy has been the anatomy and my, my, my

perspective is that you will ever get an anatomical your OpenStack, I'm sorry, stucco Netter or grants or Grazer and you will get this regionalized anatomy. So although we're being taught from a manual therapy perspective, from an osteopathic perspective, that the body be treated as a whole, the anatomy doesn't match that.

Steven:

Right. Okay. Matches sense. I've learned two new words from this question. Matt says, says, has said all manual therapy for him works by improving [inaudible] thereby improving an individual's effort, mentation, irrespective of the actual treatment. Do you have an opinion on that?

Julian:

Yeah, absolutely. But if he's going to follow that by two to its core orientation, is that actually, are they actually words [inaudible]

Steven:

I mean though, don't we?

Julian:

We know what I mean. So when we're talking about program sets of touch, we're talking about increasing, you know, garbage in, garbage out. And so where, where do we go for that? That that tissue that we just looked at is, is skin superficial fascia. Again, I would urge caution in terms of that. And as much as that superficial fascia again doesn't exist, it's part of the deep fascia connection and part of the Epimedium endomysium perimysium layers that go down and get smaller. So we are looking at the whole way that we touch and respond to that touch. And remember, we have to remember that pain is an output. So everything therefore is an input interpretation. Spinothalamic pathways behaviors are a massive part. You know, I spent half of my life with clients going, you know what, you're not in as much pain as you think you are and you're more fear than you are pain. And I think anybody that's been in this business for long enough realizes that behaviors are a massive driver of our pain and how we respond. So I fundamentally agree that manual therapy is about a getting fluids moving and to, to maintain and improve fluid movements, all of the systems of our body, all about moving fluid and be improving that communication between our systems, you know, autonomic enteric central nervous systems and creating a balance between those.

Steven:

So, yeah, and that leads me on to the obvious points in which people are crying out for is are you going to demonstrate how we should have a very comfortable poop?

Julian:

Well, I've given you the video that, so I didn't know

Steven:

Place that on a website until afterwards for people to

Julian:

Absolutely. Yeah. So it's up there. It's on YouTube as well. So, you know, one of these things in terms of the decisions we make as humans, whether it be to sort of, you know, increase our, our booze or whether to whether to not exercise or whether to go and do two dimensional exercises in the gym. One of the big decisions we made was to, was to take the natural function of our, of our human defecation and, and, and make angles out of it that, that don't make any sense, you know, so how would we go on what your child, when you're potty training, it's squats, you know, it has got a nap in it, squats to per, it's an instinctive response. And we beat that instinct out. We potty trained somebody and then, well, yeah, they're a big, big child now they can go to the toilet. And so now we, we, we take that pelvis and instead of tilting it, so the rectum is pointing down, we who round the corner and we change all the pressures that we would normally have. So you know, you deprecate twice a day, you drive your fluids around the human form and you push all, all the lymphatic on the lymph nodes in those certain areas are, are driven forward. And that's where our science is working as well. I believe.

Steven:

So you know, the standard design of Thomas crappers is he, and he designed the system, I think Disney, but the laboratory is that you're sitting upright much as I am now, although I suspect most people don't see it outright. You're telling us that's a bad thing to do.

Julian:

I'm saying certainly in terms of, in terms of polling, I'm going to, I'm going to demonstrate it now if I can get up and I can get up and test. So, so the idea of that we had the Squatty potty, it was the marketing genius that designed that over the years. And the Squatty potty is fine, but it doesn't give you loads. So if I go into a squat to deprecate, I now change the position of my SSI, my pelvis, and my NSI joint. I change my intra dominal pressures. I load through my knees and my hips have full fractions through my knees, my hips, my ankles. I'm putting weight onto my hips as well. I'm driving through my groin. Whereas a collection of lymph nodes, I'm massaging my ascending Colonel, my descending coat on, and I'm creating this natural downward pressure, which is going to allow my fecal matter to drop out.

Julian:

So this is the position that we would design. The human form is designed to delegate in and we stand up and off we go. Now if we understand that the lay down of connective tissue, in order to maintain, it's its ability to move, it has to be hydrated. You have to have fluid coming into it and going through it. Now once you stop doing that, you create a change. And so your connective tissue gets laid down more. You create more connective tissue fibers. In this instance, collagen, we call that stiffness. And after a while you end up being able to say, well, I can't squat. Well, the two words missing from that are, I can't squat anymore because at some stage I could squat and I stopped being able to, and the reason I stopped being able to is because I stopped doing it. So you know, if you want to, if you want to keep using it, you keep, you have to keep doing it.

Julian:

So think about hip replacements, knee replacements, diverticulitis, Crohn's disease, lymphatic systems, you know, all these things would have a contribution for our ability to continue to mobilize our joints. And I'm just saying that pooping is one of them, right? Quite an important thing. Well, yeah, I mean it's a great design. If you think about it, if you don't, if you don't, if you don't poo, you know you die. So you've got to do that twice a day. You probably, if you're doing your property and after a while, if you don't happen, then you're just going to die. So it's a natural thing that we have to do. So it's a, it's a part of our natural process and we've taken ourselves out of that natural process and we don't drive our fluids around him. You know, what's our fluid? Well, it's our immune system. Our immune system is dependent on us having good lymphatic clearance through our system. Don't forget that our, our, you know, all our lymphatic systems are joining in with our fats as well. It's coming up through the thoracic duct and draining straight away into our heart. So again, where's our big area of all, in fact, the drainage, but it's at the cistern, a cistern, which is where our lymph drains into. So as is their QL, is their diaphragms there accident? I don't think so. This is a big driver for our, for our lymphatic drainage. So that's where we're loading through our sort of [inaudible] area. It's a big area.

Steven:

And the fascial component in that,

Julian:

Well, the fascial component is the fascia of all those structures I've just talked about. So the end of the fascia, the curve of the diaphragm, of the top of the size the top of QL. And also, depending on who you read, now, star, stacker and blaming, say there's only two layers of thoracolumbar fascia, but so the third layer is histologically different, but basically the third layer of thoracolumbar fascia is coming up into there as well. So the, the seating point if you like, of CISE and QL is the anterior layer of authored layer of throttle and fascia. So if you took it from a string perspective, then you'd say, well this is where you'd also have load coming through this as well, but it's the centre of rotation. So or rotational centre would be into this point. And across the top of that is also going to be our celiac trunk and the what's that thing? The of the bank, sorry, the pancreas is in there as well. So it's a massive area of, of nerve, of lymphatic, of functional drainage. And the whole thing is bound up in very, very thick fascial components spreading out with this. A star in the middle of it.

Steven:

Thank you. Caroline has sent in a question. Caroline sent me a very nice email this morning. So I think Caroline, for that she says, do you take emotional factors into consideration as well as biomechanics when you're treating?

Julian:

Yeah, absolutely. I mean this is, this is the area and this is what I do, which is emotional stiffness. And so if, if you spend, if you look at somebody,

Steven:

Sorry, that sounds like a very difficult term to define in a way that would satisfied the conventional medical world or scientific world.

Julian:

Well, yeah, I mean I'm, I mean my example is this is that is we understand that we understand the concept of mechanotransduction. We understand the concept of training. If I'm going to go and train for javelin throwing or trombone playing or weightlifting, then I'm going to have to train on my body shape is going to change as well. Now, if I spent my time being angry or stressed, if you look to somebody in a very angry posture position and their go to is that position or a depressive position and they spend their time going into that position. Well, it's not unreasonable to suggest that their postural position is representative of their emotional state. So I would refer to that as, you know, the kind of emotional stiffness. How is somebody immediately going to, where is they go to position and what's coming first?

Julian:

Is it an emotional driver of that or is it a physical driver of that? You know, if I asked somebody to cross their legs and then cross their other leg, well one leg is easier to cross over than the other. Why? Because we do that more than we do the other. So if I'm spending my time in a depressive position or an angry position, is that my go-to? It's an interesting question and we can look at people and go, you know, this is what's happening. Breath will be affected by that as well.

Steven:

Have you got thoughts on the 10 Segretti modal pools? Asked a question about that.

Julian:

Yeah. it's, it's, it's great. I mean, the idea of tension you know, biotene Segretti I, you know, I like Graham scars model. And yeah, I mean, I think that the idea of remembering that connective tissue that the fascia is a, is an inert structure. That it's the cells that laid it down. So most connective tissues or connective tissues are by definition mostly inner. And they are non-cellular by makeup. Predominantly. There are cells in them but they're not, that's not their key factors. So they create space and it's this space and this fluid mechanism driving through it. That's interesting. I don't quite understand what else there is to say about it. But I know a lot of people go onto it. 10 secretary models are great and, and I think there are really nice way of explaining, you know, structures as far as the human form is concerned. As another example, again, there's a, there's a big field into there. When I've looked into it and I've read a couple of books, I think they say the same thing. So I, so I don't know what else to say. I think grand scars book is great. Love it. Of Matt. Not sure what else. The same really.

Steven:

Okay. A number of people have asked a bit more for a bit more detail about your approach to actually treating. Some people have said the structures we've talked about, but I'm guessing from what you've been saying, that you don't treat structures, you treat a problem named Brown outcome.

Julian:

Yeah, I mean, I, I think, I think problem solving is, is a great one. And I, and I, I will bow to many people who are much better in terms of diagnosis than, than me. But I've very, very rarely found over the years that, that a pain is to the level that anybody says or thinks that it is. And that that fear and behavior, big driver behind that emotional perspectives as well. But also in terms of I don't prescribe to the idea that one structure that is very unlikely, the one structure is going to be doing the job of, of, of creating the dysfunction problem that we see. So whether it's gluteus Maximus or hamstrings, because again, having looked at the anatomy of it, it's, it's, it's, it's impossible. So so every single, we can't have isolated muscle movement. For example, you know, we move our arm up and down and something else moves down inside our, our hip, our abdomen.

Julian:

So all we consider in those relationships when we look at the function of the individuals. So I would go about from the perspective of, of, of certainly trying find a starting point. That's a really, really important point. Trying to find a starting point, but as much as possible also to think about what might be influencing that. You know, in any client walks in the room and gives us a story, we're only going to get 20% of the story and it's like walking into the middle of a game of chess. We just don't know what's happened to them in the last 10 years, 15, 20 years and they don't either. So it's inspired guesswork. But yeah, certainly they keep coming back and, or they don't keep coming back. That's the point. But they keep referring and the pains go away and we still seem to get the results. And one of my jobs, fortunate, unfortunate, it's to Mark as students when they're coming up to exam levels and they're doing quite remarkable things without quite realizing what they're doing. So something's happening.

Steven:

Something's happening somewhere. We had, we had a very interesting talk last week by Georgie Oldfield who was talking about the contribution of emotional stress in many of the chronic pain problems that she's seen well with people. I mean, look at it, if we weren't there for that broadcast, and Carrie who's also been our guest on a couple of occasions was asked a question. She says, is it true that fire fibroblasts are made in fashion?

Julian:

Is it true that fibroblasts are made in fascia? Fibroblasts are flight fibroblasts make fascia, right? Yeah. So fibroblasts are the cell that produced the fascia, fiberglass or the cell that are producing the cartilage and fibre. So, so it's the fibre blast that has to be triggered by generally somatotrophs. And so somatic trophies will be the front of a pituitary. There'll be saying to produce, for whatever reason, I'd be getting a signal to say produce connective tissue, produce collagen and the type of collagen and they produce will be dependent on the signal that they get. So tight thirds is associated with scarring and Taiwan with remodelling or is it the other way around? So, you know, loading building training, the pressure mechano transduction that we don't have in our hands are going to trigger the fibroblasts. A good example of that is phagocytosis, the, the inflammatory process in, in tissue repair triggers that the macrophages are triggering the fibre blast to produce the connective tissue that will heal them.

Julian:

So it's for fiber bras that produce the, the, the connective tissue rather than the fiberblast being in cash. And in addition, there's one element of that which is also very important, which is the fact that the fiber blast doesn't just produce the connective tissue, but it produces own fluid. It produces its own ground substance that becomes that essential part of the extracellular matrix, glucosamine and glycans that are probably more important than the cells that surround it. So, you know, it's like a big fruit salad. If you like, jelly fruit salad, the sort of bits of, of jelly, the bits of fruit floating around in the jelly is the jelly. That's the big deal as far as we are concerned as manual therapists. But it's the fiber loss that the main, the, the connective tissue rubbing the other way around and their own, their own particular substances and each, any cell. So a conduit blaster, fiber blaster and osteoblast will produce a slightly different variation of their own ground substance.

Steven:

Fantastic. Thank you. I'm really like this question because we've actually, we had a discussion which included this particular aspect of therapy before. What do you think of fascial release tools that it'll usually very expensive metal tools with different shapes and curves and edges to them? Yeah.

Julian:

Ah, so the instrument assisted tools I don't think you can, I don't believe that you can release fascia and I'm not sure where it's going to go when you release it. I don't think that there's any tool or manual therapy approach that you can have that's going to change or adjust fashions that are paper and Roberts rubbish like 2000 7:00 AM. Fascial plasticity, a new biological explanation that talks about the idea of, of the pressure that we would be required to, to change fascial distorted would probably rip it or tear it long before it happened. So what are we doing with those tools? When you saw the slide earlier on and superficial fascia, you got to get through that stuff before you get to any of the tissue that you talk about as being deep fascia. And there's a lot of behaviour in that stuff that I have questions about that a lot of the neuro biologists can't answer because it's, you know, so, so what are we doing with we, we, we making it feel good. We are moving fluids around. We're bringing Hyler onto the surface. Are we, are we releasing fascia? Well, as I said, I don't think I know what that means and we're not changing it. Fascia responds really slowly, you know, it's a 21 day process, you're going to have to take a while to get that fresh to achieve. So

Steven:

It says in 21 days, what will you achieve in changing?

Julian:

Well, you're laying down more collagen. So once we lay down collagen and all the time, but if you were to do something every day for 21 days, Dan Daniel Cohen and the book called the talent code talks about this idea of myelinating nerve endings. So if you want to sort of pick the trumpet up, you don't pick the trumpet up and play flight of the bumblebee, you know, you have to practice. And, and so the modern nation of nerve endings creates our, our, our memory, if you like. So in order for us to, to create a fast yield change or a fascial habit, we have to function differently for a period of time. And then we're going to lay down those connective tissues and the mind and around the nerve

endings in order to facilitate that change. But it doesn't happen quickly. It happened outside of the session and there's not a lot happens in the session room. So you know,

Steven:

It's fine. So the opposite end of the spectrum from a Letterman's theory about stretching muscles, which is that you can stretch them in the session, but it only lasts a short time. You're saying that actually with fascia, not much is going to happen in the session, but over a long period of time you can make a difference.

Julian:

Yeah, I mean, I mean in terms of his, I love Iowa. I mean I hate the man. He drives me mad, but when I'm in his, in his classes, but I'm terrifically fond of him and he makes me, tries me mentally, it makes me think, and I read his stuff and I have to argue with them. And every time I try and argue with him, he just destroys me. So it's great. So but, but yeah, and, and he talks about stretching muscles, but the amount of muscle we can stretch, Whoa, is just tiny. And then, and as we say, why, what are we doing? Well, you know, we are, when we're stretching, we are in Yuring ourselves to, for some reason we need to function in that way. But once we stop functioning that way, we come back. You know, we don't really need that pliability.

Steven:

Which of course ladies, what ladies? What I will say is, isn't it he, he's not arguing against you in that, in that particular area.

Julian:

No, no, absolutely. I mean, he's persuaded me completely. It's completely changed my, my way of thinking. And I've got his books and I quote him quite regularly in terms of the idea of, you know, and I, the first thing I did when I went back out was to going back to my sports guys and going away and I started from stretching and do it differently and the results were phenomenal with them. So I'm, I'm not, you know, I'm totally on board with completely as far as that's concerned. As far as fascia is concerned. If you want to increase your flexibility, then you're going to have to have the connective tissue that's going to allow you to do that. But even then the, the length of muscle that you're going to have, you know, stretching doesn't make you taller, you know, just so it just makes you more flexible and are your muscles actually that much longer? And the answer is no, they're not. In terms of, in terms of actual volume, there's, there's no more or less sarcomeres than there were in the first place. Somethings happen. And really when you look into it, really nobody quite understands the physiology of why flexibility increases and changes. But it's probably within the, the, the context of connective tissue more so than muscle.

Steven:

Julian, we're already over time. I got one last question which will only take you a second to answer. I'm sure Mariah's has said. What do you think about trigger points? Do they exist?

Julian:

I never seen one had a long chat with Yan Donahoe a couple of years ago in Colorado. We found some stuff in our superficial fascia, never seen one in a muscle, not exactly sure what they are. And, and after two hours or three day, five, four days with Yan, I'm still not, still not entirely convinced something's going on there.

Steven:

Yeah. And of course I think is one of the arch critics of the trigger point theory, isn't he?

Julian:

Yeah. Yeah. I mean, just considering he's been editing the travail and Simmons book he, he's one of these guys that that is, is fundamentally questioning his own field and what he does. And I absolutely admire that. I think, you know, anybody that, I don't think he's a critic of it because he uses it and he uses dry needling. He understands the trigger point, but he really calls BS on some of the theory behind it. So I really admire that. I think he's really sort of stirring up is it's not just throwing up a hornet's nest, but staring up a hornet's nest and standing there waiting for the waiting for the result of it. So I admire that approach.

Steven:

Well we've done a number of sessions with Simeon, Nia Lasha who works a lot with trigger points and he's been working with dr Bob go in in the States who apparently they have conducted some research now, which is about to be published, which I am assured absolutely proves the existence of trigger points. We'll wait and see.

Julian:

I mean I'm open to anything else. Do you know if you asked me the same question tomorrow? I, I'm not, it's not, I'm not an expert in the, in the, in the field. I, you just read it and you look for me when, when I bring people into a dissection room, I ask you, I'm not the anatomist. I'm not going to tell you what's right or wrong. I'm going to ask you to look at the donor and the donor is your witness. You know, the donor is that person that on that day w w that died, here is their body. This is what they are. So how will it look for, for the evidence and bring those sacred Holy, Holy cows in and see whether they stand up to scrutiny as far as your donor is concerned. And if they do, then great. But generally speaking, they leave a lot of questions and answers. They need more questions answered than they may answer. So, you know, that's, that's the thing we have to really consider ourselves. And as Gil says, it's always what I would end with is hold onto your practice daily. Do what you do, but your theory is, is probably not what you think it is. And so don't hold on to that too strongly, cause you might, you might wind up saying

Steven:

That's probably a very fitting statement on wasteland. Yep.