Exercise, Science and Keeping It Simple - Ref 152JE - Draft Transcript

with Joanne Elphinstone

18th March 2021

TRANSCRIPT

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Steven Bruce
Today I've got Joanne Elphinstone. Joining me from Cardiff. And again, we're going to be talking about communication. In particular, we're going to be talking about how we communicate with our patient's brain. And Joanne will explain what she means by that in just a second. Joanne, great to have you Good to have you with us again,

Joanne Elphinstone
Let's thank you so much for inviting me back, Steven.

Steven Bruce
It's looking very lovely in junglee. Where you are in Cardiff, my experience of Wales is that it's always raining. But the real,

Joanne Elphinstone
It's so true, but I miss my home, I obviously haven't been able to get back to Australia for a long time. So, I'm trying to create a little bit of jungle back here that can make me feel

Steven Bruce
I'm looking around your trees for a little koala somewhere, but haven't spotted him yet. Oh, you're a physiotherapist. You've written this book called the power and the grace, which I have recommended before to our viewers, because he's so beautifully presented and very well written. You come highly recommended by Thomas Myers, who of course, is the director of anatomy trains with which I'm sure many of the audience will be familiar. and elsewhere. Tell us a little bit about this book. And you know, what sort of book is it? Why is it important?

Joanne Elphinstone
Great? Well, it's first of all, just having Tom Meyers contribute to it was beyond my wildest dreams and expectations. I'm very, very grateful to both him and Elizabeth Larkin, both of whom are just such extraordinary practitioners who have given so much to us. But the book I wrote, it was something I've wanted to do for some time, because in my teaching, what I see is people come in with lots of knowledge and lots of information. But when we try to integrate it all, and then we try to make it meaningful for a real human being in front of us, in all a wonder in complexity, that's when it starts to get difficult. And so, what I wanted to do was write a book that was not germanized. It's written in the way that I would communicate with anybody. But it's recognizing that we have all of our science. And certainly, I'm going to talk about biomechanics, and fascia, and structural things like that. But it's about how we make all that meaningful. Because movement is it's personal. And it's emotional. And we were our thoughts and feelings and intentions in a posture, where it in the way we express ourselves in our movement. And that actually isn't really very often recognized. When we come to the patient who's in front of us, all of a sudden, it becomes about exercises. And so, with this book, what I wanted to do is find a way for people to be able to see the links, find out or why is it when someone's in this emotional state, what happens with the posture and when that happens, what happens to the mechanics, and then what happens then to the way they move, so that

we can actually see these relationships, and it doesn't have to be complicated. We just have to accept that we integrated human beings. And we can't necessarily be just divided into our parts when it comes to meaningfully rehabilitating somebody.

Steven Bruce
But you said that we're going to take a little look at one part of the book today, would you the chapter in the book that's relevant to what we're probably going to talk about? And of course, depending on your questions, I don't know what we'll be talking about today. But that chapter is called moving the brain. And I think I suppose I've always worried about my own practice in that, you know, I could tell people my opinion on how they should stand or what exercises they should do, but actually getting them to both accepted and do it is quite a different matter. So, there's that you're going to tell us about that in a minute. And also, I suspect, you'll probably tell us the difference between movement and exercise.

Joanne Elphinstone
Absolutely. Because I know a lot of people who come and say, Oh, yes, well, you know, I'm a physiotherapist. I'm an osteopath. Yes, I know about movement. And what it actually comes down to is that they know a lot of exercises. But in terms of what the brain thinks exercise and movement, it's not the same thing. And it's not meaningful in the same way. And it isn't necessarily relevant because exercises can be, they are good things. No problem with that. But we have to understand that what they're mainly doing is creating potential in the body. So, we create potential by maybe having more strength, or more mobility, something like that. But I often say it's a lot like learning a language, you can learn vocabulary, and then you go on holiday to whatever country it is and find that you can't make a sentence. You know, I went to Spain, well, thinking, I've studied some Spanish and then when I got there, I realized I could only have a conversation with a two-year-old and not even a really good one, because I understood the vocabulary. But I haven't been able to put it into sentences in a meaningful way. And we're very much the same with exercises. The exercise can create potential doesn't necessarily mean it's going to make any difference to the movement.

Steven Bruce
Well, here's one for you. This this question from Alex came in before we even started talking. And Alex says, how good is the plank as a one only exercise for people who never have the time in inverted commas?

Joanne Elphinstone
I get asked about the plank really frequent? It's a really great question. Because when there's millions of people planking all over the place, aren't they all over the world? And this comes down to what is the purpose for the exercise? What are you hoping to achieve from it? So, if I want to work with somebody who runs, for example, and I know that for running, I need really great counter body rotation, which means that my abdominals need to work at a relatively low enough threshold to allow for the motion to happen. But that these muscles, the more superficial muscles can work he centrically and concentrically. And then I look at the plank, and I go, so which of those issues Am I addressing with the plank? And the answer is none of them. But if I'm working with a discus thrower, and they have to be able to keep their whole body

consistently in the same relationship, the muscles are not changing length, in order to be able to get a quick rotation, then it would be really relevant. So, you know, what I'm trying to do through my work. And with gems, you know, those are the clinical courses we teach is that the people to learn to clinically reason, exercise and movement in the same way that they would clinically reason any of their other manual therapy techniques, is normally at the university, we're given a very strong educational, clinically reasoning, our manual therapy. But often we don't have the same level of clinical reasoning for our movement well. So, I would say the same thing, like with planks with a bridging exercise with the glutes. And you're like, Okay, so what is it doing is doing inner range and concentric gluteal activation? And what are you hoping the patient's going to do better? Well, they really want to, they want to be able to squat down, which is a centric moving into outer range. So, does one necessarily lead to something better than the other? No, not necessarily. You've taught the brain to do something here. And you've taught the muscles there. And it's quite specific, but it doesn't necessarily mean it's going to carry over into other activities or the functional activities. So, I'd say thanks. Okay. But from a clinical point of view, it's not something that I would see as being super relevant very often.

Steven Bruce
So, Alex's question was about whether it was a good throwaway exercise. And he didn't say that, as a one-off exercise for people who don't have the time in their own opinion, is your opinion that you should let's have a different exercise for different people, which is their one and only exercise, if that's all they're going to do? Or can we educate them to realize they need to be more?

Joanne Elphinstone
Well, again, you know, where I am with it is not, it's coming back to this whole idea of is it exercise? Or is it movement? Now, what are we doing it for? You know, you the ability to hold a plank position, for as many minutes as you're going to do doesn't necessarily mean anything? Like, is it going to make your back better? Probably not? Is it going to make you move better? Probably not. Does it make you feel a bit better about yourself? Maybe? So, yeah, for me, if I was going to give something, I wouldn't be giving that I was going to give one thing, it might be something completely different. To be honest, it was going to give one thing, make a difference in someone's posture, core stability, back pain, everything. I'm going to teach them how to breathe properly. Oh, that's getting back to a topic which we've covered so many times over the whole lockdown, period, breathing for pain relief, breathing, for calming the mind down breathing for all sorts of things. It's breathing for musculoskeletal effect. Yeah, and so you know, I'm seeing so many people, it's not just about the, the, the emotional side of things with the breath. It's also about the biomechanical aspects of, of the breath. And, you know, we're just seeing so many people, especially treating, I mean, I'm doing a lot of my treatment remotely now. And in a way, it's been advantages because people have been a bit more willing to settle and just actually think, okay, we're doing this now because there isn't a choice of just getting up on the plane. And it's been so interesting to see like real neck problems, real back problems, you know, things that normally would get treated and, and we we get this diaphragm working in a way that it's actually starting to change what's happening to the spine. And GE, the symptoms get better.

Steven Bruce

What's your starting point for treating teaching people to breathe properly?

Joanne Elphinstone
Okay, well I can't remember what the last time I was with you I did in a space with you, which is a way of being very non-judgmental about breathing. So, the first thing that I find, I see a lot of patients who are distressed by breathing exercises, they can't do them, because they don't have a pattern to work with. And so, they're trying to count because everyone says you could cash accounting for this much and count out but that much and they can't do it. And they get more distressed. And so, what we start off with is saying, All right, you're just one big container. Yeah. And we're going to change the shape of your container. And we're going to find out where does the Aygo because it's going to go somewhere different, depending. So, it's not that it's right or it's wrong. We're just interested in finding out what is happening at the moment. And when you see all the baggage, I get people saying, you know, say okay, so where's the breath going? So, I'm trying to make it go down here? Because that's where it should go. I'm like, No, no, no, no, I'm not interested in where you think it should go. I just want to know where it is going. And then we can work from there. And then more baggage comes from all the breathing tuition that's gone on. So, if we start from a place where we just learn that the breath can go somewhere different depending on where the body shape is, and then settle again, often it's changed just from doing that. And often people find that they can then start to regulate the timing of their breathing. Because we've come away from all the effort, and the trying, and the baggage, and the I can't do it. You know, I've met so many people over this period, who've even before COVID came, I have people who've had respiratory issues, they've had like a trauma of scuba diving, or there's all sorts of things. As soon as you start talking about breathing, it all goes pear shaped. But if I come back into the body, and away from the breathing, and just think about changing on I'll change, for example, if we take someone into just a SAG, you know, what, where does the breath go now? And the take it up the other way? Let's take it over here, where does it go? It goes somewhere different. And as we do that, and this really kind of cuts into the key about what we're going to talk about here is we take it out of the cognitive. And we start actually embodying and becoming experienced with sensing what is happening in the body, instead of trying to make something happen. Now minds, there's a massive distinction between these two things. And that's I think, where that's kind of the key for, you know, where I'm trying to take the teaching here is say there's a huge difference between talking to the brain and talking to the mind. And the mind tries to do mind over matter, and everything gets locked up. And if we bypass that, by saying we're not doing right or wrong, we're just doing exploration and curiosity right now. So that means I'm going to ask, where do you think you might notice something moving, going to put your hand in different places and find out it where something's moving. And then that can often lead them into being able to sense it from the inside out. And now, something really huge is happening, because we're changing the brain. They're learning how to sense themselves. And then once we have that, then anything else we do from there on is going to be so much easier. Now we're talking to the brain now, and taking them out of this cognitive place.

Steven Bruce
You make it sound as though it's probably quite easy, Joe? And

Joanne Elphinstone

Well, actually, it is, it's actually more of a problem deconditioning ourselves from the way we've been trained.

Steven Bruce
You can deconditioning ourselves as practitioners or deconditioning our patients,

Joanne Elphinstone
as practitioners, we've been programmed to teach usually, or to interact in a certain kind of way. And it's been so cognitively dominant. And it's really interesting, because I read an article recently, and it was interesting about how in medicine, we tend to make pain, the subject, and the patient is the object. And you think actually, it's true. And then the patient comes in and we teach them to make their body the object. They're not in their body at all, then they're taught to make their body do something to get control of it. And so, they're becoming more and more disembodied, as the process goes on. And actually, the biggest issue for us is coming out of instruction mode, and putting ourselves more into guide mode. Our job is to help to guide someone through the experience of being able to inhabit themselves and understand themselves again, and the inherent logic that is in their bodies. That's really good. frantic giving commands, you know how to do this right? And then they get taught to give themselves commands. And so yes, if we can actually invite ourselves out of that, and the way to do that is to learn to a first of all, stop talking. Give me I was a given minimal, I get the bare bones of instruction for something for people, get them going, and then I'll start asking them questions about it. But I need to make them easy questions, because people don't know what you want. And that makes them stressed. I used to, once upon a time go and see a particular kind of therapist net. And she'd be doing some body work and saying and saying What does and what does she need? And I'm like, I have no idea what you're talking about. What do you want me to say? You know, I didn't know what she wanted. So, with a patient, we, we get really direct with it. So, let's close the perimeter there. What do you notice, in this part of your body? As you do that? with us? I don't know. Because people often don't actually know how to feel. They've got the circuitry. But they don't necessarily know how to drive it. They'll say, I don't know. Okay, that's a set a defensive position, because, you know, this is a difficult situation for them to be in that I feel safe yet. And I'll say, all I want to know, is this anything change. So just notice, now, I don't know where the pressure is under your foot. And we're going to do this thing, and I just want you to tell me doesn't change? Does it go anywhere else? And that makes it quite an easy question to answer. Because they don't have to give me any details to start off with, they just have to tell me that they've noticed the change. And then I am going to use self-efficacy research. I'm going to reward that discovery. So Oh, that's great. That's perfect. Let's do that again. You really noticed that change? Oh, yeah, you do. Okay. So, anything else that you notice about that? And then that gives them the chance to step in and go? Well, it seems to go more towards the front than the back. Oh, that's, that's really interesting. So, I wonder if we changed it this way. And you did it that way? What would happen then just to that area? And so, you're now in process with them. And they're actually doing the work

Steven Bruce

for your center? And you said, where does the pressure go? And under your foot? Is it more here or more there? And then you reward that? But how do you interpret what is good for the patient? What is going to help whatever the problem is they wanted you to fix?

Joanne Elphinstone
Okay, well, this, this is really important. There's no such thing as good or bad. There's only things that the brain is offering as a possibility. But you want to do this here have a possible solution, that's not the one. Okay, then maybe we need to look for another one. But before we start looking for what might be a more effective solution to the particular movement problem that you're talking about. First, we have to get the system on the move. So, it's not binary, it's not like this is the way you were doing it. And this is the way I want you to do it is really binary. And reality movement is variable, we have lots of possibilities. So, the first thing is getting it on the move, and getting them able to actually sense themselves. So, for example, one of the most basic things is helping someone to understand what it is to actually stand on their leg. Now you think that'd be obvious, wouldn't you wouldn't even stand up. So surely, we're standing on our leg. But so many people are standing behind their leg or standing in front of their leg, they're not actually standing where gravity is on a stacked structure, where they really feel connected to the ground. And so, you can do all these little exercises if you like. But if you can't sense yourself, it's going nowhere. So, the actual This is the big thing about it's actually more about us that has to change than about the patient, we give up our kind of attachment to seeing a correct outcome. And we actually look at what is best for the patient. What's best for the patient is that they learned to sense themselves, understand what they're experiencing, and also understand that they have a possibility of choice.

Steven Bruce
Could I perhaps ask you to put that into the context of a hypothetical patient? That is a real patient because Jess, thank you for the patient justice said that she's got a patient who has a spinal fusion t 1012. One, and she would love some advice on fusion patients generally, but in terms of how she might approach dealing with a patient like that. So, what would you do?

Joanne Elphinstone
Well, I don't have I mean, obviously, I don't know. But what stage this patient is, so I've got no idea how she's presenting. But let's have some hypotheticals. Yeah. My first hypothetical will be that her diaphragm doesn't know what to do. And if a diaphragm doesn't know what to do, then her deep abdominals are not going to know what to do. And neither is a pelvic floor. Okay, that's just how it goes these things play with each other. She's had a fusion, she's obviously had quite compelling back pain that has led her to that step. So, this has obviously been going on for some time. So, my first my first port of call with this person, and actually I had someone just last night, we looked at the posture. And we could see that, you know, there's a lot of upper body upper spine rigidity, and the lower body wasn't very active. And there's no point in asking her to put her body anywhere else, because it will be contrived, it will be high effort, and she's trying to be trying to hold herself there, it's pointless. So, we lay her down, support her head, knees bent, one hand on the chest, one hand on the belly, and all I'm going to ask is to both of them move, when you breathe in. And both of them move, when you breathe out. It's a very simplified thing that I call a quick check breath.

And most people will be able to tell you, oh, this, this one moves, and that one doesn't? Well, they both go up. And then once it gets to come back down again. Now, that's high-quality information for the patient, because I'll just be there supporting them to say, Well, is there anything you can do about that. And I'm going to give some time, and not bought in too much with all these words that we feel compelled to fill the space with when we're clinicians. And what happens is, things start to sort themselves out. And one of the things I talk about in the book is just using the idea of an internal balloon, we move that balloon down the body, finding out what can it expand, balloons don't just go one way. So, if you're going to feel yourself inflating upwards, there's all these other possibilities, particularly in the case of this patient, being able to actually expand backwards. And we'll move that down. And by the end of that, we then stood back up again, looked at the posture, totally different. She's on her feet, the lower abdominals are contracting, the upper body is relaxed. What have we done, we've just got equal that we've balanced things out in the torso, we've given the diaphragm to have an opportunity to be both a postural and respiratory muscle because we see that it's both? And then we've got some way to go from there. The world's your oyster. This person needs to know, I mean, I might do something very simple. For example, can you lift one arm up? That's a really interesting thing in two directions. So, let's take one of the points that I was going to talk about later, but we'll talk about it now. The idea of lifting the arms, for example, if I was standing, I can do it sitting. We could all do it too. If I was to invite somebody to take their arms above their head. What often people will see in the patient is that this this, the trunk will go, yeah, so perhaps, perhaps you might see this kind of thing happen. Or you might see the pelvis. Tip the other way he is all these things that can happen. And we immediately start getting involved in all of this. Instead of first of all asking, Well, what does the brain think this is? Here's the thing up to this point. This is clearly an up direction, isn't it? There's an upward trajectory. But past this, it's going backwards, isn't it? It's the backward direction. So, the brakes done something extraordinarily clever. It's gone. Okay, so this is going backwards. So, I need to counterbalance. That's really clever. So, we look at it as a mistake. But actually, it's very intelligent. So, if you don't want that to happen, then we need to clarify for the brain. Well, what direction do you want to go in? Well, the Direction is Up. Where's up will ups here I'm pointing towards the ceiling. That's a completely different thing. Then we have a few people who don't realize that their arms are attached to their pelvis with a piece of string. So, they start going with the arms it's going up that the pelvis is going to now conventionally we might tell someone to keep their pelvis somewhere and not move it in, it tends to not work very well. But if I just say Listen, this is piece of string, you didn't realize it was there, but I need to cut the string. So, let's just cut the string let the arms float. And to their enormous surprise, their pelvis doesn't go with them. So, this is these are examples of talking to the brain, appreciating the brain and instead of saying all these are all the things going wrong, understanding why the body might be making those choices and Speaking to it in its own language, rather than speaking into it in the language of what I would call NT movement. So, it's another concept that would come up later. But it's interesting how often in conventional exercise and rehabilitation, we're telling someone to go stop. So, we're saying, like, why did you do this movement? But make sure you don't move that. And the brains now got a processing conflict. Are we going or are we not going? Is it some movement? Or is it a not movement? You know, and it happens all the time. Yeah. So if I that's my book, and that I was going to use for another demonstration later. If I want to turn my shoulders and I find that the person's pelvis and knees are going to, I could tell him to keep them still. But all they will do is become more tense, and then movement will be worse. But as I said to them, well, could we just leave, can we leave it behind,

just put your hand, leave it behind, and we'll take, we'll take this one for a walk. It changes everything. If you think you know, people at home, if you think about keeping your pelvis still and then try to turn, you'll find that you can't move. But again, if you just put your hand in reception and leave you behind, and I'm going to go for a walk over here, then suddenly, the movement becomes available. So it's, I mean, obviously, there's this so much, so I just need to move this because it was a nice Christmas present for my husband. And it's, it's very nice, and I don't want to roll my chair over it. Okay, so

Steven Bruce
I'm just guessing that there isn't a broom head on the other end of that. Joanne?

Joanne Elphinstone
Well, if you did ask, but I was getting my brain. very weak, but not totally inaccurate.

Steven Bruce
of you, you're in mid flow. But one thing occurred to me when you begin this is that your patient who is supine, and you're asking them to feel their diaphragm and their chest? Surely the first question the patient is going to ask of you is well, what's correct? You say, Well, could we change that? Well, the patient wants to know what they should be doing, don't they?

Joanne Elphinstone
And this is where we, again, it's bad deprogramming, isn't it? Because the first conversation I have with people about breathing is there isn't one correct way to breathe in it really is context dependent and position dependent. And that's why I started them off putting their bodies in different positions to show them that there's lots of possibilities. And so, as we're lying there, we just want to know that we'll do we have the options to expand in all of these different directions. So, there's options all available to you, rather than locking it down. And saying, this is the one true path. I'm just like, I just simply want to see that if you were a container, from your neck down to your pill be at the bottom of your pelvic your one big container. When you breathe in, I want to see that the whole container can fill up. Not just a little part of the container here. Because this is the other thing that's happened is people have been cut in half, you know, people telling me Oh, well, I know I have to breathe from my belly. And then I have to go to my chest. And then it has to go the other way. And oh my god, haven't we just made a dog's breakfast out of breathing. Because you know, at the end of the day, diaphragm descend, pressures changing in the abdomen pressures, changing the thorax, it's all involved. So, I just teach them to find the whole container, rather than worrying about what's right or wrong.

Steven Bruce
Luckily, I've got a whole load of questions. Can I run through some of those? We had this plan that you were going to talk about something but as always, we're getting lots of questions in 45 minutes is a very short time for the first the first one is from Claire, who kind of anticipate what I just said. And so Stephen, if you ever give me a stick for Christmas, she wouldn't be happy to.

Joanne Elphinstone
Listen, I'd rather have a stick than a vacuum cleaner.

Steven Bruce
Yes, yeah. I personally, I'd rather have a power tool of some sort. But Nick, Nick says is your approach largely from functional exercises and movements designed for that person?

Joanne Elphinstone
I'm just trying to get clarity on the question. So again, for me,

Steven Bruce
it's your approach to treating patients largely from functional exercises and movements designed for that individual.

Joanne Elphinstone
Okay, so there's basically a fundamental movement building blocks that are common to us all. And, you know, individuals will come in with difficulties in some of these. But there's, it's not that it's all just, you know, it's all random or infinite. So, for example, we all need to be able to drop and raise our center of gravity. Some of us need to do that to be able to sit in our chair, and some of us need to be able to do it. Just Squat down to a box. Some of us need to do it just to shock absorb when we run, but it's all the same. It's all what we call vertical force management. And we all need to be able to propel ourselves forward, if you want to walk, that's propulsion. It's a completely different state of affairs, to be able to accept weight, unilaterally, that's what we would call support. In gyms, we will have that in common. While most of us have it in common. Obviously, there's some variation there, too. So, I mean, there's this, there's lots of these lots of, you know, these categories, you can definitely put things in for what I would call functional force management. It's how we create forces and how we control them. And that's what we do from the moment we wake up to the moment we go to bed, when we breathe, we're creating a force, and we have to learn how to absorb that force. So that's the most fundamental. And so sometimes people think of forces as big things. But actually, we have to create it, to do the little things too. So functional force management is understanding what is how does someone create a movement, how they control it, and it depends on then on their function. So, this is where the individualization comes in. If I was to work with somebody who's, you know, it's easy to use sports examples, because you can see the the differences, someone who's coming with a wrist problem, and they're a tennis player may be coming with a completely different set of principles, property and properties to someone who's a violinist with a wrist problem, they both got wrist problems. But the tennis player has to understand how to create the energy, the force from the powerful legs, and then through progressive rotation, move it through the kinetic chain, and then funnel it out into his hand. And if you can't do that, then often what he does is over uses the upper limb and we end up with this problem, the violinist clearly is not the same thing. They need to actually be able to be grounded, either through their legs or on their on their pelvis, depending whether they're standing or sitting and what they do, and to have a central axis and supportive torso, to then support those upper limbs to then support this complex task that they have to do. So, they're two risk patients, but they will be treated based on different functional force

management principles. Otherwise, we're not going to fix them if we just apply a risk to treatment. And this is what we see. Because most of my patients are all people who've had a lot of treatment and it hasn't gone well. Normally, because they've had whatever the evidence base is around that particular part of the body. But one of the big things we always ask is, why is this structure under pressure?

Joanne Elphinstone
Why should it be in this situation? Just not enough to say, Oh, it's been overloaded, they've used it too much. You know, I love it. When runners say to me, Well, I've been told I've got an overuse injury and my left Achilles, but my right Achilles is run the same distance as my left Achilles. So How come I've only got on one leg? Well, that's a really sensible question isn't. It requires us to think a bit harder about just blindly talking about an overuse injury, necessarily, why is it under pressure. And that's when it gets really interesting. Because we're not just applying the same path exercises to people, we're actually going up actually, you know, you go along, and you don't rotate your upper body to the left. And so when you hit the ground, then you tend to tip into the frontal plane instead of into the transverse plane. And when you tip into the frontal plane, it puts more load on that leg, which means you've got longer context time on that leg, which means you have to push harder off that leg to stick and that's how you follow the train.

Steven Bruce
That's a fascinating biomechanical train of thought that's going on there, which, yeah, will appeal to a lot of people. In fact, we've had a call commenting earlier on from somebody at the Bolton osteopathic clinic who says you're talking great sense, and that we're obsessed with functional strengthening and often weakens, excusing, excuse me weaning people off pointless exercises that their own personal trainers might have given them is one of our challenges. Jolene has sent in a question about pelvic floor she says she does a lot of work with diaphragms already, so she completely agrees with everything you're saying. But apart from the standard pelvic floor exercises, what can we do for the pelvic floor and why? Okay, summed up into a nice tight one minute.

Joanne Elphinstone
Okay. Yeah, so this is interesting too, because, you know, for so long we were looking at at hypotonic or weak pelvic floors, but now I'm seeing in both men and women, the hypertonic overactive pelvic floor which is bringing Just as many problems as the as the reverse, and often what happens is that they're given more pelvic floor strengthening. And actually, what we need to restore the elasticity of the structure. So, I might choose, for example, to take my balloon breathing down into the pelvis. And I'm going to say, right, so we're going to expand this balloon, the first thing that's going to happen, it's going to push the plates on the side of your pelvis, that balloon is going to expand and just create a bit more space between those plates. Now, obviously, the bones are not actually moving, what we're asking for is a relaxation response. And I might come down and say, right, you know, where you're sitting bones are fine, just sitting bones for what, we're going to take a balloon down here. And we're going to blow up a balloon, and we're just going to create a bit of space between your sitting bones, we'll see how that goes. Or it might be that we show them the caulk six looks like it's just like, that's your tail, okay, and so you can have a happy dog, and not happy dog situation here. Because if we tuck our tail under, you know, with too much pelvic floor, then we've got a

bit of a difficulty. So, what we're going to do is we're going to breathe, and we're going to let our little tail float up. And I remember doing this with a professional squash player with really chronic patellar, patellar tendinopathy. And he just couldn't swapped. And he, he really struggled with his pelvic position. And so, what would happen is we would go down, he had a very, very lordotic, lumbar spine, lots of electrospinning attention, he'd go down to a certain point to get stuck, and we say, Okay, let's breathe a happy dog here. And so, he'd breathe, and you'd relax as pelvic floor posterior pelvic floor, and then you say, his great surprise, he would drop further. And we would keep doing this until he got all the way down, then he looked up at me. And he said, this has been most unexpected. He'd never even been there before. But it was actually this incredible tension in his posterior pelvic floor, that was actually stopping him from being able to get down. So one of the first things I would say is when we're doing our diaphragmatic work, and I'm going to put a big call out for this, because I've actually been seeing quite a lot of women struggling with prolapse problems and so forth. And they've gone and they've had a lot of treatment. And none of them have had any work on their breathing pattern. And when we're talking about prolapse, as we're talking about the pressure game aren't wait weren't like, where is the pressure going? Yeah. And so, if we haven't looked at what's happening with the diaphragm, then we've missed a huge part of their rehab. So getting that elasticity, and many of these women have got the sense that they have to hold it all up and together, like they're slamming, and I endorse shot. And I can totally understand why they would feel like they need to do that. But then we don't have an elastic responsive pelvic floor. So, it can't do what it needs to do if you cough or sneeze, because it can't actually release to be able to contract again. And that goes for everywhere in the body. You can only contract something as well as you can release it. And the pelvic floor is no exception to this. So yeah, there's a few things anyway, around because there's so much we could talk about with the pelvic floor. But just remembering that it's not just women it's meant to

Steven Bruce
do. Tracy asked whether you have any experience with patients posts as arion section, you have breathing issues. Oh, yeah,

Joanne Elphinstone
absolutely. And again, I'm going to start there. And also, there's a lot of women, I've seen his Missourians work some time ago. And they're still struggling to get that connection. Or they've learned how to do it with various forms, of course stability, but it's actually a more superficial contraction, they haven't actually restored that very deep, low threshold contraction. And again, often we can't start with that until we've actually got the diaphragm working. And often what you'll see is that you'll get a lot of tension in the in the thorax, because they're trying to hold it together from somewhere. So, it gives us the opportunity to relax that and start to rebalance again. The other thing to do a lot is the sensory input for these people because it's so interesting. And again, can I say it's not just c sections, it's also women who like they may have given birth but remember your women who have had miscarriages Can I just say they're the Forgotten group here and they could have just the same loss of prep receptive connection and internal connection to their abdominal wall as anyone else. So, you know what we do a lot of you know Tommy robbing and you know, just letting them brain know this is where we are here and it's okay. And you'll find that for some people that is okay. And then for others will find that there is an emotional block there. That we need to be very

careful to process with them because they actually they can't go there. And it's places it's there can be I was working with the lady the other day, that whole area below the waist was associated with Shane, really, you know,

Steven Bruce
communication with the patient? How did you learn that? Because it's not the sort of question you would ask directly, you might say, am I allowed to touch you here? How? What was her response? How did you how did you get that information back from her?

Joanne Elphinstone
Okay, so this patient I was working with remotely. So, and also, you know, I, I'm careful with my touch, you know, I like to communicate with my hands, but not quite as handy as maybe I might have been earlier in my career, to give people the respectful space for them to have their relationship with their body, rather than me getting involved in that too soon. So, for her, the first thing you see is something in the face. That doesn't look engaged. You enter the house interesting. Okay, so I'll tell you what, let's just do a bit of like smoothing the body, and we'll just find out where are you? Where does it feel? Okay, you know, find me a happy place anywhere, anyplace. So maybe it's your left elbow? Is that happy? We can say Happy? Yep. Is it still happy here? Yep. still happy here. Maybe it's a different feeling here. So let's, let's put a name on that. We'll find out what their so what happens when we come here? And then what happens below that? Nothing. There's nothing there. Okay, so I tell you what, let's, let's find out where the barrier is. I mean, this is going into a completely different area that requires a lot more respect and time to talk about. But what I will say is respecting that, that you can see when someone's not comfortable. We start finding out what is okay for her actually ended up we did some dancing around. We didn't do touching. We didn't do focusing on trying to contract anything. We just got up and worked out, could we just dance around a little bit in her and she was a bit like, oh, it feels a bit strange. I'm not used to doing that. And I'm, and I'm quite happy to make a fool of myself or anybody. I've been in public parks jumping along at gorillas all sorts. And I'm there kind of just seeing if I could just take my hips from side to side, and would you like to join me and, and we started to just move the lower body. And but the next time I saw her, it was really interesting, because again, it was a remote appointment. And her husband kind of wanted it. And he said, Yeah, I have a dancing wife now. And I was so happy about that. Because actually what it meant was, she started to feel like it's okay to be in my body. And it was actually the next session that she was able to say, I realized that I felt a bit ashamed around this area. And an eye clock that I don't go into it in any great depth. That's not my field as a scope of practice element there. But what I am going to say is, you know, where I was at now, is there anything? Is there anything else we could do with that one lady, we decided we're going to go in there and paint, paint the walls. We want to paint the walls with she's like, Red Velvet, maybe? I go Yeah, I'm liking that. Okay, let's do that. And so, we're just trying to build an internal relationship with a body part that at the table for quite some time. So, when really getting into the dance now, between what is happening, neuromuscular Li what is happening structurally, what is happening emotionally, what's happening in the brain in a way that is often completely unconscious. And it takes us full circle, really to back to the beginning, when you asked me about the book and talking about the fact that it's it is movement, his

emotional bodies are emotional. And we're now having to pay attention to that aspect of the patient and not just what's that muscle doing.

Steven Bruce
So, when we're at a time,

Joanne Elphinstone
It goes quickly,

Steven Bruce
quickly. I'm really sorry about that, because I don't know if we covered anything that you intended to cover in this, which means the handout I had prepared is probably totally irrelevant for everybody. Ricky, Ricky, you were Next on the list with the question, but I'm sorry, we are out of time. Caroline, salami, Olivia, Emma, all those others who sent in questions, I do apologize. But we can only cover so much in 45 minutes. I kind of mentioned the book again, the power and the grace. I will be sending out an email later on when we'll put together a handout from this but I'll also put in Joanne's offer 15% of the book, and we I don't like selling people's products, you know unless they're really, really good. And I just love this book. I think it's really brilliant. So, take a look at it at least I think it's available for Amazon is only through handspring you can

Joanne Elphinstone
get on both. It's fine, but he says people just jump on to handsprings website. They've got lots have wonderful books on there as well. So

Steven Bruce
it was a chance to look inside it will it will almost certainly convinced you there's a book worth having so So there we are. So, and thanks for joining us again. It's been it's been a delight as always.

Joanne Elphinstone
It's been wonderful to be here David. I mean if anybody wants to do learn more about this kind of thing if they just jump onto our gyms movement Facebook page, it this the number of questions that seem like they're still to come maybe I need to start thinking about doing something like a Facebook Live so I can answer some more questions for you guys.

Steven Bruce
Send some of them through to you and and tax you to answer them after the show.

Joanne Elphinstone
We'll look at that.

Steven Bruce

Jerry Jones agreed to do that. Thanks again, doing