408 – Why Do I Feel This Way

With **Steven** Bruce and **Kelley** Waters

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Steven (00:02):

Today we're going to look at patient's beliefs and their understanding of their own health. My guest is osteopath Kelly Waters Kelly. Good afternoon.

Kelley (01:07):

Good afternoon.

Steven (01:08):

I dunno, I can't remember how we got you on the show in the first place. Obviously it's partly because of your book

Kelley (01:13):

I think we were talking Yeah, exactly that,

Steven (01:15):

Which is “Why do I feel like this?” published last year, self published last year, I believe. you are an osteopath and you've written this for whom? For patients or for practitioners or for both?

Kelley (01:27):

I think I may have originally have written it for me in as much as I, after being in practice, well feels like a long time I got to a place where I just thought, I'm getting to this stage where I kind of feel like, I dunno what I know, what is it I do every day? What is the unique sort of, what's the special source if you like? What's the bit that I do? And I actually think I wrote it for me partly also because I think authors are my heroes and that's something I've always wanted to do as right. So I did it, but also I've aimed it at patients in as much as I've written it, so it's short. So it's something you could sit down and read a cup of tea in an afternoon. It's in generally in layman's terms, so it's not medicalized to death.

Steven (02:13):

Well actually, you talk an awful lot in the book about the body's operating system, don't you? So you're putting it in terms of virtually everybody now will understand

Kelley (02:20):

Yeah, exactly. And some practitioners who have read it. So I had a lot of help along the way of practitioners who read it for me along the way and the edits, and they've said, actually, do you know what? I really did find it really helpful because it just put things in a simple succinct fashion. So I think it's written mainly for people who want to just have an overview of the subject matter on each chapter, but not delve too deeply into it so they don't get stuck in one area and maybe get almost distracted from the overall view of it, which is to understand ourselves better really.

Kelley (02:54):

If you do want to go into deeper areas, then there's references, et cetera, send you on your way.

Steven (03:01):

You said you've been in practice for a long time. You graduated in

Kelley (03:05):

19 99

Steven (03:07):

From the ESA.

Kelley (03:08):

Yeah.

Steven (03:09):

What's the course been for you? You've been a sole practitioner all that time?

Kelley (03:12):

So I came out and worked in various other practices as an associate and then set up my own and have worked with colleagues over the years. It's grown and developed. So I was initially on my own and then have now got a multidisciplinary practice, so range or osteo physios, acupuncture, podiatry, mast massage, et cetera. So There's a few of us now.

Steven (03:34):

It's funny how few osteopaths I speak to who have chiropractors in their clinic and it's strange how few chiropractors Have osteopaths.

Kelley (03:40):

Yeah, that's true. That is true.

Steven (03:41):

And I'm not entirely sure why that should be because I think there's a role for both in the same clinic. I think when we've considered it in my own clinic, it's been, well, how do we explain to patients what the difference is when they phone up and say, I need someone to treat me for this or this

Steven (03:58):

Anyway, let's get back to your book then. And obviously I've read the book and to me it seems like it's a way of communicating stuff with a patient, as you say, in layman's terms, which might help augment what you are doing in the clinic or one of your practitioners is doing in the clinic when they're poking and prodding and yanking them around. If I can put it in such simple terms! how did you divide the book up? What are the aspects that you are looking at

Kelley (04:24):

Specifically? So I divided it into some explanations around what we as humans, the things that can trip us up really. So our tendencies, our kind of natural tendencies, how we're predisposed to react a certain way to life, to stress, to our stress responses. Things like negativity bias, confirmation bias, those things that will lead us down a certain path and that we perhaps, if we're aware of, we can mitigate slightly.

Steven (04:55):

Obviously I suspect most people will have an idea of what negativity bias and confirmation bias are. How does that relate to the patient's experience In Healthcare terms?

Kelley (05:04):

So let's say with pain, with a chronic pain pattern where someone says, I have now defined myself with this identity as having this pain. So I get headaches, I always get headaches. I am a headache patient, I'm a headache sufferer. So they will come in and have that identity and often look for evidence in life to confirm that they're right. So we all like to be right. It's part of our security and safety system. So actually creating that identity for themselves and then looking at, well, okay, I didn't actually have a headache this morning. I told myself I would have a headache this morning. I am looking for evidence that I'm going to get one. Oh, it's stormy outside. I always get a headache when it's stormy. So it's just looking at making sure that they're aware even of that tendency so that it doesn't control them and it's not the master of them really. So it's just trying to make them understand that they could think differently and it's not their fault that they think like that they're not being hyper contracts. It's not that they're bad, there's nothing to be ashamed of. It's actually just a human tendency. It's a natural human behaviour if you like.

Steven (06:08):

Yeah. And in doing this, how much research did you do and to make sure that what you say is true,

Kelley (06:15):

That's

Steven (06:15):

True as we can be in Medicine.

Kelley (06:16):

Yeah, I think a lot in as much as I am constantly reading, researching the text that obviously stated in the book, but also I am a constant podcast listener and just looking into the current experts and what is being said and what is repeated and what is gaining traction through research, but also is something that someone else is taking and deep diving into and then being able to lift that information and make it something that's simple to explain

Kelley (06:50):

I Think is the key. So sometimes there'll be amazing things. I've read that I think that's a fantastic explanation of something, but I know if I refer a patient to that book, they'll read the first chapter and think, no, I can't dive into this. It's too heavy. Often patients will say that it's too heavy for me to read, and so I wanted to create something that gave them a taste of it. If they then found it really interesting, they could go off to the reference point, but it was written simply enough that they could get a grip on it really.

Steven (07:18):

But one of the things about the book, which is a great advantage I would suspect, is that most of the chapters are very short,

Steven (07:25):

These ones got my pencil marks all over them. Here we are. There's one, it's four or five pages long, and as you say, simple terms. So nice, easy bite-sized chunks for patients to grasp.

Sarah sends in a question asking how you go about communicating a patient's negativity bias to them. Obviously you don't just say you are not a headache person. Do you have phrases or terminology that you use?

Kelley (07:48):

Yeah, I often talk to patients in terms of something called the script in their head. So I often try and separate them from that script, give them the opportunity to think, okay, I'm the person who sits above my script and then my script's running in my mind and say to them, just look at the thinking. If you can describe a thought to me, if I can say to you, oh, I was

nervous coming in today, then I'm describing my thinking, not especially, but then we know each other. But if I can describe my thinking, then I'm not the actual thought. That's the slightly interesting concept to think, so what am I? So then it's the case of saying, well, maybe you are the thing that's observing the thought, and if you can observe the thought, we can start to challenge and question the thought. So that's probably the place I would start with them is to say, okay, so let's just think of a script that's running in your head. We've all got them. We've been handed them since birth and they've come along in culture, in family and friends in education that we're given these scripts. We've got to make sure we're checking whether they're true or not or whether they're just a soundtrack that we're now running. And so I often try and put it into metaphors or an explanation like that that gives someone a chance to go, oh, okay, hang on. If I can separate myself from the thought, I can challenge whether it is serving me or not.

Steven (09:01):

You illustrate that first point I think in the book when you say how much easier it is for us to solve someone else's problems than it is to solve our own. And we probably all realise that it's helpful to have it pointed out to us,

Steven (09:12):

As you say, when it's your own thoughts and your own perception of yourself, it's hard to take an objective, a helicopter view of what's going on.

Kelley (09:19):

It really is. And I think as practitioners, we are in a great position where we can give perspective to things. I think we do that in any way, whether it's a mechanical issue or symptom picture, we might say, okay, what I'm hearing is that you've got your left hip sore and it hurts when you walk up the stairs and I'm hearing this. And you can put a perspective and a kind of story around something with someone. But I think also being able to do that from their mindset, from their belief systems, from their mental emotional picture of saying, hang on a minute, let's just step back and look at this. And patients, I find anyway, my patients and I guess attracts, so we've got to factor that in, but my patients really respond to it and open up and actually come alive in a way of kind of going, oh, okay, this is interesting. And people generally like to talk about themselves. So actually just saying, go on, tell me more about why you think like that. And as I'm articulating a hip, it's not that we're sort of interrogating.

Steven (10:11):

Well, I was going to say, how long are your appointments? Because the more you talk to patients, for many people, the longer the appointment has to be. So how long do you spend with Your patients?

Kelley (10:18):

I run a 40 minute for a follow-up patient, but it's probably about half an hour actually in the room with the patient with about a 10 minute, it's a overlay from Covid times when we were giving ourselves time in between.

Steven (10:30):

It's quite useful to write your notes actually.

Kelley (10:32):

It Really is. And maybe grab a drink, you never know. But yeah, in about half an hour, I think that quite often I will get the questioning going and get the conversation going and then get them onto the couch and get the treatment going at the same time. So I guess it requires a certain level of multitasking, but instead of just saying, how was your holiday and do you think that your pain's worse at night or in the morning? It's just sort of maybe delving a little bit deeper into that, but being very careful that to differentiate that between actually going into an area that perhaps isn't your qualification or isn't your training. I mean I've done wellbeing coaching as well as a training, but I would always know that level of where, okay, this is interesting, we've opened this thought up, but now I think what I will do with you is maybe advise that you would go onto someone else if that's opened, something that we need to look at in more depth. Yeah.

Steven (11:27):

Is there a danger, I mean in saying to, you wouldn't say to a patient, you've got negativity bias, you wouldn’t use that terminology. Is there a danger though in communicating that you are getting the patient to blame themselves for what's going on?

Kelley (11:40):

There could be. Yeah, there could be. I think it's important when we're talking about it, to always be talking about it from curiosity and creativity that you're saying, isn't this interesting that we think like this? So I will never sit and say, come on, say it. Come on, Steven, what's going on with you? I will often say, yeah, we do that as humans, don't we? And I might not disclose loads about my personal life, but I would say, yes, I get that. I do that as well. And so taking the shame or the sense of embarrassment or we think we're the only ones, we always think that as humans, but the reality is most people are thinking the similar things that you are thinking. And so actually to say that, to tell your own story a little bit and to bring that human side I think can really disarm or not disarm can bring down those levels of potential shame and blame around it.

Steven (12:33):

Again, it's a difficult tightrope to walk that one because we are expressly told that we mustn't get too friendly with our patients. And I'm not going back to Tuesday night. I'm not talking about sexual friendliness. It's not Tuesday night with you.

Kelley (12:50):

Let's Just clarify that if you could!

Steven (12:51):

We are told we have to maintain boundaries and keep a distance from our patients, but actually to break down those barriers, it's very helpful to share a bit about yourself, isn't it? Yeah. Do you find that your patients are buying the book?

Kelley (13:06):

Yes.

Steven (13:07):

Right? Do you encourage them to do that?

Kelley (13:10):

I am not very good at that bit, so I don't do much of that other than it is in the clinic. It is visible. I probably need to make it more visible. I did a mail shot, I braved it in the mail shot and mail shotted our list and just said, I've written it. And that did generates patients buying the book and then it's in the clinic and people quite often walk off into reception and say, oh, I'm going to grab your book on my way out. And they do actually, my other practitioners in the practice promote the book sometimes. So that's really nice.

Steven (13:43):

Always better promotion when someone else does it.

Kelley (13:45):

Someone else does it. Yeah, I think it's not my skillset. I need to probably think about that a little bit more. It has sold a bit on Amazon and it's a tool. The times when I will recommend it to a patient is if I say, this is the stuff I've written in the book, and I'm saying that sort of not from a sales pitch, but literally just actually I've written it all down. Quite a few patients will say, oh, I wish he'd written all this down. And then I will say, oh, actually I have. Here you go. So it's a mixture really.

Steven (14:18):

Right. Okay. Stu has said that this reminds him of the Sedona method. Have you heard of the Sedona

Kelley (14:23):

Method? I've heard of it. I'm not very well versed in it, but yeah. Right.

Steven (14:27):

Okay. Well maybe Stu could tell us more about that, unless it's what you are discussing here,

Kelley (14:29):

And I'll look it up

Steven (14:30):

And Mark says, I like the idea of using treatment time to chat about things that are relevant to the patient's recovery. It's very easy to use that time for chatting about things less relevant that perhaps prevents us from sticking to the 30 minute appointments that or 40 minute that you have. Yes. And my wife, Claire's always telling me what great conversations she has with patients over the treatment table, but she is a bit of a chatterbox, is Claire, but they'll be about music or politics or all sorts of things, but there's an awful of useful stuff we can do there as well as you've said in talking about the obstacles to treatment, and I stopped you after you talked about negativity, negativity and confirmation bias. So what else does the book cover?

Kelley (15:10):

I think one of the things that, just referring to, what was it? Stu? Stu, yes. Yeah. I think one of the things that I'm trying to get across with it is that in the treatment room, a patient quite often, and I see this time and time again with patients, they don't join the dots necessarily because they haven't got the training to do so and the knowledge to do so. And so they will sometimes come in and say, this happened. My low back's "gone". It went. And I'll say, did you do anything happened? What were the triggers? What's aetiology? And they might say, no, no, nothing at all. Nothing at all. I mean, three weeks ago I was moving house, but that's fine. It wasn't then I lifted a box then, but my back was fine. Now it's "gone". I don't understand why part of the not understanding why is the glue that's holding the problem in place. So we all know about well taught and neurological pathways and pain pathways. And so sometimes saying what else has been going on in life and how is life generally and what's happening? And so you moved, okay, so what was going with the move? Is that a happy move? Was that a positive thing for you and what's going on? And then they say, well, at the same time, the dog died. And actually that was when my son left for university.

(16:19):

Just simply saying, wow, that's a lot, isn't it? To have been going through at the time. I wonder if just general stress levels were up, I wonder whether your system was feeling less robust. We all know about stress fatigue in terms of how we cope well in acute situations. Then afterwards we go like that. So explaining this as a concept, it's kind of like you are human. You've got these settings in your system, they haven't been updated for hundreds of thousands of years, so you're predisposed to have a certain setting, and this is you being a human, this is you doing what humans do and this is how it may have contributed to your pain and why you may have gone acute at this point. And so just bringing that awareness to them, I find sometimes it's almost like you can feel them sort of melt the glue, melts that glue. That was the lack of understanding of the context of why their problems happening at this

point in their life actually melts a bit. And then I feel that the physical therapy gets in on another level.

Steven (17:10):

Yeah, this is one of our struggles as osteopaths and chiropractors, isn't it? When we come to justify what we do that without wishing to pretend that we are counsellors or different therapists that we are not. A lot of the benefits of what we do perhaps comes from our willingness, eagerness even to talk about things like this, to talk about the other contributing factors to health. And we've got the time to do it, which a GP generally doesn't have.

Kelley (17:38):

And we can bring things, sorry to interrupt you. We can bring forward, I think sometimes just saying, how did you get on at that appointment with your elderly parents two weeks ago that you were talking about? Just bringing that back again is that actually you are also ticking those boxes of a patient feeling known and feeling heard and feeling understood, and actually that someone has met them on that level. And so again, that you are bringing them in the right direction for healing. You are in that truly holistic sense. You're bringing them on that journey because you are helping and promoting them to engage with everything.

Steven (18:13):

So what's the feedback that you've had from patients about the book?

Kelley (18:16):

That it is simple to read that they do understand it, and a few of them have very kindly said, it's something that I refer, I can refer back to and that they've given to other people. I hadn't particularly aimed it at teenagers, but quite a few of my patients have said, I've given it to my teenage daughter to give my teenage son. And because it's short, because it's not a great, I mean, kids sadly don't like to read. A lot of children, don't read as much nowadays, and they're obviously looking at digital means of information gathering, but they've actually sat down and curl up in an afternoon and read it, which has been great. So it's made me think about what I could do with it in that respect and whether I can podcast it, whether I could do other things that would make it more accessible actually. But generally the feedback's been really positive and they've said, people who know me have said, yeah, I can hear you in it. I can hear your voice in it, which I think that's a good thing.

Steven (19:11):

This is a question - It's difficult to answer honestly, but also possibly difficult to know the answer to. Do you think that as a result of reading the book, it has helped with their health, their recovery from whatever it is they've come to see you for?

Kelley (19:24):

Yeah, and I think it's because it means they can apply two things. I think they can apply some self-agency then

(19:30):

And some self-compassion actually, which are key, aren't they? To any recovery and getting some context around what's going on for them so they can say, oh, okay, now I understand why I'm doing that. Now I understand why I'm resisting this or not doing the exercise I should be doing. I've actually realised I'm exhausted and I need to apply some compassion and just help myself through. And particularly the chapter on anxiety and pain and the chapter on grief refer to that concept that, for example, post, there's that idea of actual recovery time. There's allowing yourself the kind of time to wallow in something, allowing yourself to process and not be rushed out of the state of being.

Steven (20:12):

Yeah, I think it's something that you said, it's something I think you quoted in there, words to the effect of that there's only one way to get over grief and that's to grief. There's no simple Switch for this.

Steven (20:24):

But I suspect that there's a component in a patient's recovery where they will have their own beliefs about whether they should be allowed to grieve. You talk, I think in the book about when your father died and how it affected you. I remember when my mother died, I was a serving military officer. You don't cry. Stiff upper lip, all that bollocks. And I probably would've benefited from having somebody I could feel comfortable with letting go with,

Steven (20:55):

And

This isn't about me, but this is about how many patients might not realise that they're Allowed

Kelley (20:59):

That's such a common thing, isn't it? We hear that with patients all the time, that they're keeping that stiff upper lip that they're holding it all back

Kelley (21:06):

Actually then their symptom picture, whether that's the fibromyalgia picture or something else going on, that all of that's being Accelerated And exaggerated and amplified, and sometimes simply saying what you are saying, which is you are in grief, aren't you are in grief, and you have a right to be in grief, and it may show its own way with you. It doesn't have to be wailing and gnashing of teeth, but actually this is grief. So that exhaustion you're feeling, that could be grief. It's just giving them permission to even think about it, isn't it? And

Steven (21:34):

Helping 'em to understand that everyone does it. It's normal, as you say.

Kelley (21:38):

it's Normalising.

Steven (21:39):

Think we are unique, we are different in some way, but actually virtually everything we do is being done by millions of other people. Stu came back with some more about Sedona. He says, patients say, I am sad instead of I feel sad. The Sedona method is about the power of letting go of negative emotions might be worth having a show about Sedona method at some stage. It's the first I've heard of it. mark says, with so many of us recommending patients to learn more about pain, for example, watching the NOI videos or the famous Aussie Pain guys Brown snake bite video. Gosh, no, the name's gone out of my mind.

Steven (22:15):

NOI, isn't it? It's the Pain Institute. It come back to us. Understanding Pain is the name of the book, I think. So the Brown Snake video, is this book a way to help patients understand their mental state and pain that's easier to read than noy? Yes, of course it is much easier to read than,

Kelley (22:33):

Yeah, I think it Is.

Steven (22:35):

Yeah, there are bright coloured snake images and things in the NOI books aren't there.

Kelley (22:40):

So this has just got some simple images. I suppose if I was criticising it, I would say there's a danger that it could be too simplistic. I don't know. It depends, as you say, it's about who the target audience is. I think if practitioners read it, they would be thinking of it in terms of yeah, yeah, yeah, I know this stuff, but okay, you're putting it in a way that I can easily articulate or you're putting it in a way that's really easy to understand. But I don't think a practitioner is going to read this book and think, wow, I didn't know that. I dunno whether you've read it, you think, you think, but generally speaking, I think it is really simplistically written. So yeah, I think it's a simple version.

Steven (23:20):

I don't think a practitioner is going to read it and think, wow, I didn't know that. But they might read it and think, wow, that's a really useful way of conveying this to a patient

Steven (23:30):

Helping them to understand what's going. We talk about endorphin and serotonin and oxytocin. Patients don't want to know about all that stuff. No, they just want to know about what is it that makes me feel the way I do? How can I influence it?

Steven (23:42):

Funnily enough, my memory has just come back and coincidentally, just as somebody's written it here, Lorimer Moseley as a fellow who wrote the book

Kelley (23:50):

You've still got It!

Steven (23:50):

Well, as long as somebody writes it on my notes here, yeah, that's fine. There's a toolbox in here, isn't there? There's a toolbox in there. So what's the toolbox contained?

Kelley (23:57):

So the toolbox, when I was writing each chapter, I kept coming across thoughts where I'd be like, oh, here's the issue. Oh, I've got a solution for that. What would I say to a patient about that? Well, what might I suggest if someone had a certain issue going on? Where would I send them? And so every time I came across that, I used to just shove it in a Word document and eventually I thought, oh, these are enough things that I'll just shove this all at the end. And this is a toolbox, and it's not written in really any order, but it's just ranging from the obvious stuff that we all talk about as practitioners, they're breathing and how important it is and how it can help. But also other just observations of what I've seen over 25, 30 years actually really helps people. So ring fencing time, all the things that we, so obvious stuff like exercise, movement, sleep, nutrition, all the obvious.

Steven (24:49):

You say obvious stuff. A lot of patients don't see it as obvious.

Kelley (24:52):

No. And sometimes I think just trying to say, look, this is simple. This is free, this, you can actually access this. It makes it much more, it's easier then for them to think I could do one or two of those things and build small steps. Because I think particularly when people are in stress fatigue and they've gone over the edge in that way where they're just wiped out. If you give them too much to do, it's just overwhelming. And actually all it does is builds a shame picture, which is master osteopath tried to help me. She tried to give me these things to do these 10 exercises and I haven't done them. It may even mean that they don't come back for that very reason because they don't want to admit they haven't done it, or it just means it's insurmountable. I can't do this. And it just fills up the tank on shame. And as we all know,

shame is a big danger for the human brain. So it's trying to say, look, this is an easy thing. You could try lie on your bed, breathe five times, see how that makes you feel.

Steven (25:47):

I mean, you state some fairly things which ought to be obvious, which are not. And I say they're not, because I say to myself, I want to go to bed at a certain time. So at that time, that's when I almost stopped doing what I was doing, which is usually at the computer, but then I find a whole lot of other things that just need to be done in the computer, the kitchen, or anywhere else. So I end up going to bed an hour later. But it must be quite hard with so many people these days to get them to adhere to that sort of discipline when everyone's got so much going on.

Kelley (26:18):

And actually, it's a really good point because in a way, a lot of the time with the tools, I don't think I'm necessarily saying, do this, you should do this, you must do this. You could do this. Actually a lot of the time in our treatment context in the room, what you're actually saying to someone is sleep's really important. And they might say, yeah, but I've got so much on and I'm up late and I'm helping the kids with homework and I'm doing this and I'm doing that, and the dog's been sick. And it's kind of like, yeah, and so therefore this is why you're feeling the way you're feeling. So it's not just about if you did this, you'd feel better. It's actually saying, let's just understand why you feel the way you do. You are not getting enough sleep and the reason you're not getting enough sleep, it's because life's too hectic.

(27:02):

Sleep's really important for the brain. It's contributing to your symptom picture right now this week, we can't change that. You've got to deal with the elderly parent or the sick dog or the child's homework, but just really naming it, cooling, it sounds really obvious, and I'm sure people are like, well, yeah, that's obvious. We say that all the time. But actually sometimes just saying that out loud, somebody will go, yeah, that's it. That's it. And again, there's that melting of the glue of the whole picture because it's like, oh, I can be compassionate, but I can see, and with some self-agency I can say, well, in a week's time, what I'm actually going to do is, and what they'll usually say is, yeah, what I'm going to do is I'm going to do 10 walks a week. And that's when we as practitioners will say, well, let's just woo, let's just rein it in.

(27:45):

And just, what about just seeing if you can get out in the garden, stand there for 10 minutes and listen to the birds, set yourself some small steps, and then you've taken the pressure out of it all and it suddenly becomes a curiosity, a creative thing, which is the antidote to an anxiety where you say, if you could get curious about it, what would a good day look like? And it's that kind of, okay, well good day would look like I went outside and I got some sun and I got some air for 10 minutes. Like, okay, set yourself five minutes. And actually their creativity, their curious mind where you've shifted them out of amygdala thinking where it's all kind of like, ah, stress response. And you shifted them into the curiosity brain and into that

side of the world, that side of thinking where they then go, oh, while I was in the garden, I then potted about and cleared up the leaves and that became half an hour. And so that's creative in curiosity rather than fear. Yeah.

Steven (28:36):

Yeah. And I wonder, it is made me think when whoever it is came up with it and said, you've got to eat five fruit and veg day, or someone said you've got to do 10,000 steps a day, whether that just creates another way for people to fail in looking after their healthcare because for a lot of people, they don't want to do that sort of thing.

Steven (28:56):

And actually the authorities behind it probably have no real evidence. They're just saying, this is probably good. Let's give people a target. But it might be a negative. It might have a negative effect.

Kelley (29:05):

And I think the digital platforms now, which can be so great, but also can, because there's always someone, if you start scrolling through Instagram, there's always someone who's saying five things you should be doing every day. And actually for me, that is an absolute, that's a stress trigger for me, someone telling me that. Whereas actually someone saying, what do you like doing? What did you like doing when you were a kid? What brought you joy then? And where could you bring a bit of that into your world? Even if you can't go rock climbing right now, but can you curate your Instagram feed so that you get loads of rock climbing videos? Actually just bringing it back to what your brain likes.

Steven (29:48):

Somebody just sent a message, I've got a very good idea who sent this in, but they've said, Steven, it's now 30 fruit and veg day, keep up. But it does change, doesn't it? And I found myself this morning looking for something. I think it was something in relation to your book. I was looking it up on the internet. I was thinking, I don't believe that. And I started looking through all the different entries and I found you can find 6, 7, 8 more entries about the same topic, all giving you different figures, and it's going to become worse and worse with the advent of AI generated nonsense on the internet, isn't It?

Speaker 4 (30:22):

Yeah, for sure.

Steven (30:23):

Sarah says how nice it is to think of curiosity as a healthy thing. She likes that, and I like that expression of yours melting the glue as well. I don't remember it from the book, but

Kelley (30:31):

no,I should have put it in the book. Melting The glue

Steven (30:33):

It's quite a nice image too, I mean, melting away all sorts of things. Jennifer says, what is a negative emotion? Surely every emotion has its purpose,

Kelley (30:43):

A negative emotion. I would think of a negative emotion being something that is holding you back from what is a natural thing, which is forward motion and moving into what you want to be doing. So if something's maintaining you in a position that is not serving you, that would be negative. But I think obviously she's absolutely right that emotions, if I feel anger and it's because someone's attacking me, that's a really useful emotion. So negative being something that's holding, I mean negative as being something that's holding us

(31:18):

Into a state of being that's not serving us anymore. And it may have served us previously. I mean certainly in childhood there were many things that we gather as habits and beliefs and ideals and behaviours that served us well and may actually have saved our lives in childhood, or certainly the childhood amygdala would've thought it was saving its life. So we've all got habits and behaviours that we used in childhood to get by, and then in adulthood it's looking at those and saying, is that serving me to be thinking like that? Or is that reaction I have a current reaction, or is it just an old trigger, an old pathway that's not serving me anymore? And having the self-agency to be able to do something about that often starts at the place of someone being able to describe it, to start with being curious about themselves.

(32:02):

Why do you think you feel like that or what's going on about that? Then why did that come up then for you making it a conversation like we're having now of just curious interest. Tell me more. What do you think about that? Rather than, you are broken and I'm going to fix you, which is if I wanted to say what I'm not trying to do, it's that that's something I don't believe. So it's trying to say to a patient, you're not broken. You're just carrying this whole weight of adaptions that you've learned that some of which are not serving you anymore. So let's just make sure we're not carrying things we don't need to anymore.

Steven (32:35):

I was thinking about what Jennifer said there about, she says, don't all emotions serve a purpose? I'm not sure I agree with Jennifer on that. I mean, they all have an effect, but I'm not sure what the purpose of grief is. Wouldn't it be nice if we didn't have to Grieve? Yes, it has an effect, but maybe I'm just arguing pedantic semantics here.

Owl says, I'm going to come quite clean here and say, I wasn't expecting to learn much from this show, but you've given me some really nice tips on how to say things to help patients

move forward, change their thinking, and keep it simple without pretending to be a qualified talking therapist. Thank you. I think he's just after a free copy of the Book, don't you?

Kelley (33:11):

Oh, he can have one. That's such a nice thing to say, isn't it nice?

Steven (33:16):

Yeah, really Nice. Well, somebody here has said, what training did you do

Kelley (33:22):

As an osteopath or coaching?

Steven (33:23):

Well, they haven't specified, I think given that you are talking about the psychological components of wellbeing in the book, have you specially trained in psychology, psychotherapy?

Kelley (33:35):

No. So I went straight into osteo from A levels years, so I trained early on, and so I did the normal osteopathy course at the ESO and then which obviously took an amount of cranial into it as well, functional medicine into it. And then in covid when we had to stop working, I thought, oh my goodness, what if I can never get my hands on anyone ever again? And so I did a wellbeing coaching course then and then since then I've done other coaching type wellbeing coaching type stuff as well. So to supplement that. So that's my, yeah, I'm not a counsellor and I haven't done psychotherapy.

Steven (34:21):

No. And nothing in your book suggests that you are pretending to be a counsellor or that you think you have counselling skills, you are just communicating some well-researched information about what contributes to wellbeing, I think, and the important thing about it's how to get that across to your patients.

Ambo says, I really like this whole concept and discussion over melting the glue that's holding us in a situation or health or health illness response. Curiosity is also something I'm going to try with family and patient interactions. Thank you so much. People are coming in early with their praise for your approach, which is good.

In your toolkit, you talk about hobbies and there was an interesting aspect of hobbies, which I'd never considered before. What do you think of hobbies for wellbeing?

Kelley (35:08):

I think they are brilliant for wellbeing, and I see a correlation between the patients who've got an interest, a hobby, and their wellness. I think hobbies bring community, and we are tribal beings.

(35:26):

And we like people to what we like. So there's also that thing of I am really fascinated in let's say beekeeping. That's not my thing. And if you go, me too. We just love that. We love that. So I think for community, for connectivity, shared interest commitment, it usually involves doing something of some kind. It can involve sitting behind a desk, but it largely will involve some sort of movement, some involvement and travel and knowledge, deepening knowledge. And again, we come back to this curiosity concept and creativity. So creativity does tend to act as an antidote to anxiety. And if with some of my patients who are just really struggling and they're really overloaded, sometimes just say to them, look, just what do you really love? And they'll be like, I just really love a tidy Tupperware, a tidy cupboard. It's like, okay, if that's it, sit in front of your cupboard today and just sort those things out and make, and the visual thing of I like the tidiness, I like the neatness. That's a creative act. It doesn't have to be art. So anything that gets their brain gearing into creativity and hobbies, do that.

Steven (36:40):

Yeah, we're going to get another comment in a moment because my wife is going to send something in saying, ya see, I told you Tupperware was important. I hate the fact that She collects every plastic pot known to man,

Kelley (36:50):

I'm with her, so let's not argue.

Steven (36:54):

Okay. So what about if your hobby happens to be roleplaying games? Now I don't play roleplay games, but that means being glued to either headset or goggles or a computer screen

Kelley (37:04):

like gaming,

Steven (37:06):

But maybe you are playing with a community, but they're all virtual, is there's presumably a downside to that as Well.

Kelley (37:12):

I think there is, but I'm really careful not to be too negative about that because I have seen, or certainly my own teenagers, my own children, but also with patient teenage patient children who are gamers that for certain people and quite often I would say yeah, I think they are probably sometimes maybe on a neurodiversity as well, that they have found a community

through that that they would not be finding every day in life. Now, in an ideal world, we'd have found them a community, we would have more youth groups and more. They would be doing all those good things. But in place of that, sometimes the gaming can actually bring a sense of community connection with friends. They talk in a way they wouldn't talk face-to-face. So it depends on the game. I became a bit of an expert in the different games and there are some games that are much better than others for this. And the only comment I make with my teenage patients who are heavy gamers is to talk about what game they're playing and just say, look, there's certain aspects of that game that really don't do great things to your neurology.

(38:12):

Such as, I would say Minecraft for example, has had quite a good research around the fact that it is really a positive creativity thing for the brain. I'm

Steven (38:23):

Nodding as though I know what Minecraft entails.

Kelley (38:25):

It's creative, they're creating worlds

(38:28):

And it tends to be less about stalking somebody on a street and shooting them. There's obvious example. But yeah, I think the only thing I would say about someone who's maybe finding that hobby online is are you offsetting the sedentary element of that by getting outside and seeing the sun? So I would probably just nag them a bit and say, I just want you to promise me you're going to get outside every day and making sure that perhaps we encourage that looking at those pillars of getting some fresh air, getting outside perhaps connecting with nature. Does that mean you sit there all day and don't drink any water, get a really good water bottle and have it next to your thing? So it's just if that's what you are doing, if that's who you are, let's make sure we build some support around it. Yeah.

Steven (39:14):

Here's a bit of a tangent. Do you tell patients how much water they should drink per day?

Kelley (39:18):

I tell 'em to drink more than they think. Yeah, more than you think. Yeah. And some patients will say, well, what if I dissolve everything in my body and I don't have any minerals left? And we then start to do a bit more research. But I think generally speaking, the average bear isn't drinking enough water, I think I would say. Yeah. So just putting hydration is one of one my five things I would say always. And I would often say when we're talking about that ungluing thing that's sort of melting the glue that whatever the question I will always say, oh, water is probably the answer. So that feeling of I'm frazzled, I'm exhausted, or maybe I've

been sitting under bright lights or I had a busy day or whatever and I think, and I can't cape and oh, I don't like so-and-so and oh, I think I'll get a divorce. That kind of way escalates. That stress escalates.

Steven (40:02):

You come in here and you're complaining about my lights, so sorry,

Kelley (40:04):

But where you suddenly go from naught to a hundred because you are literally just dehydrated and you go off and my thing to my, I would say, go and have a drink of water and then five minutes later you're kind of like, oh, actually yeah, I think I can handle this.

Steven (40:17):

I read an interesting piece of research recently which said that there were lots of people who say, this is the amount of water you should have per day. And their conclusion from the studying the evidence, from doing what they called reviews, proper reviews of the evidence was that drink when you're thirsty is the answer. But I wonder if just as you suggested there, a lot of people disguise the fact that they're thirsty to themselves because they're busy doing something else,

Steven (40:44):

And so they Forget that they're thirsty

Kelley (40:46):

Think there's also something, don't quote me on this, I think there's also something about the thirst that's the wrong thing to say, but I think there's also something about the thirst centre in the brain and how actually there's a modification that if you don't drink enough, it doesn't necessarily tell you're thirsty in the way because from an evolutional point of view, there was evidence that you didn't have water available to you at that point. So I don't think you can trust whether you're thirsty, but I think if you are feeling a state that you don't want to feel a glass of water will probably improve it.

Steven (41:19):

One of the things in the book, which I thought would probably be instinctively appealing to patients was there's a bit, I think it's in the toolkit where you say, make use of daylight, reinforce your circadian rhythms and so on. And very often that's immediately it seems obvious to get out there when it's daylight. But I suspect a lot of people, they work late into the night or they sit up late into the night and they get up late in the morning. Important,

Kelley (41:44):

Really important. I think more and more so research at the moment showing that if you can get out first thing, and it doesn't have to be because I think we all look at the weather, especially at the moment and think, well, it's grey and say, what's the point? I can't get any sun. It's not coming through. But actually the truth is you're going to get the sunlight coming to you and even, yeah, so you might not

Steven (42:03):

Be getting vitamin D,

Kelley (42:05):

You are triggering the bits of the brain. You want to be triggering and you're also probably, unless you are, well probably you're going to be triggering that. You're going to hear birdsong and there's brilliant research going on about how effective birdsong is. So for the human brain and some great studies going on there. So if you can get out, get up, brush your teeth and go and stand outside your door for five minutes, that's all it takes. And I think it's that small step, isn't it that you started the day right and you're setting yourself up for success at night. Then

Steven (42:35):

I have a lengthy commute from my house to this studio of about 200 metres, and most mornings when I come in, there's this bloody noisy robin up in the bush somewhere and it's just absolutely delightful. It's amazing how much it changes your mood when you hear this bugger shouting at the world.

Kelley (42:49):

It really does, consciously and subconsciously. So there's lots of evidence around, from an evolutionary point of view, if we heard birds song generally, it meant there were no predators. And so we have this idea, the brain tends to chill out a bit when it hears birds,

Steven (43:03):

Primate, the computer names them or they name themselves. Primate says Drink when you're thirsty doesn't work for us older folks, colour of urine output can be a more reliable guide.

Kelley (43:13):

Yeah, absolutely. Really good

Steven (43:13):

Definitely if it starts going very dark colour, you need to start thinking about it. And Vince says, I often recommend that busy, troubled by life patients escape into the realms of the detectorists and the gentle delights and curiosities of friendships slowing down of time, being in nature, et cetera. We are coming gradually to the end of the show. So how long did it take

you to write your book here? Which it is a small book, but that is quite a bit of effort to put that

Kelley (43:45):

Together, isn't it? Yeah, I was surprised at myself for sticking at it amidst the busyness of life, but I really enjoyed it. I think for me, actually, I was walking the walk in that I did, it was a creative thing that really helped me at the time. It probably took about a year in total of just because I was writing around the edges of life. I was writing 11 at night or when I could around family, around work, around the practice.

Steven (44:09):

So I think A lot of people have said the therapeutic bit is actually writing the book.

Kelley (44:13):

It really was. And it was

Steven (44:14):

Not stressful while you were doing it?

Kelley (44:16):

No, the only stress for me was the ending where my sort of OCD and perfectionist nature meant that I couldn't, I realised self-publishing, I couldn't create what I really wanted to create, covered all that stuff, and I had to do that kind of that'll do and let it go and my poor husband had to literally say, prise it out and say let it go because I could keep going. So there were stressful bits to it, but it was on the whole a really, really positive thing to do and I'm pleased to have done it and I dunno what it might lead to, but I think for me it's a sort of a thing now that I can use maybe in the future, even if I haven't got time right now to be doing stuff, I'd love to create some teaching material around it and I'd love to podcast around it and things like that.

Steven (45:00):

Yeah, the whole business of self-publishing is quite fraught, isn't it as well. I mean, just one of the big issues is getting that ISBN number that you've got on the back as I understand It.

Kelley (45:10):

Yeah, I had great help with an editor who was brilliant. Yeah,

Steven (45:14):

Michelle, well, I was going to come on to this. Susie has said, what a great show and sounds like a really useful book. She's going to get some for the clinic, but I was going to say, for those people who don't want to spend a year and trying to sweat over producing something

which is already out there, this is a sales pitch, would this be a useful thing for me to have in my clinic to offer to have for patients to look at and decide on whether they want to buy it?

Kelley (45:35):

Yeah, I mean maybe from the point of view of having it, I've got a few obviously for sale, but I've also just put a few where we put magazines and things like that, and quite often they say I quite like it. They don't necessarily know it's me, but I quite often see the patient when they're waiting for another practitioner flicking through it, and that's quite nice to have because it just means that they might go, oh, anxiety and pain chapter or grief chapter and have a little read. But also, yeah, I think it's a tool, isn't it? So if you are a practitioner who thinks this is information that at this point don't feel really confident diving into, but someone else has done the work around, then yeah, I think it's a tool that you could say to your patient, do you know what that stuff I was referring to has been written by a colleague of mine? And you can read about it in more depth.

Steven (46:16):

And of course, from your own perspective, it can't be bad for business that you can say that you are the author of a book, a self-help book for patients and so on. Last comment about the healthcare issue, Sally says lots of info is out there on how morning daylight sets cortisol levels for the entire day, which

Steven (46:31):

Maybe That's detail you don't want to go into for patients, but it's telling 'em to get out there and enjoy the morning sunlight is a useful, someone else has asked whether you could do a course.

Kelley (46:40):

That's what I'm hoping to do. I would love to do that. And in fact, a link I think that I may have given you, I think I gave to Neil, it is to the website page for this, which I've just done a page on the website for the book, and if anyone's interested in that and leaves an email, then if there was enough interest in it, maybe I could try and create something. I would love to do that. I love the idea of teaching it as a concept.