



Emotions, Stress, Posture and Patients

with Anne Jensen

20th April 2021

TRANSCRIPT

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Steven Bruce

This evening's talk was built to be about emotion, posture and the patient. And of course, that is what it's going to be about. I've got a fascinating guest with me to talk to us about that. I have Dr. Anne Jensen, Anne is a chiropractor. She's a New Yorker who did her chiropractic training in New York, but now practices in Australia where it is currently just after 4:30 in the morning. And she also did her PhD at Oxford University in the UK. Her interests are varied, she's a clinical researcher, she's done a lot with sports, but she is also very interested in clinical psychology. And she is responsible for developing a technique which she calls HeartSpeak. And we'll be hearing a little bit more about that. It might sound a little bit new age and I hope she'll forgive me for saying that. But it is based very soundly on neuroscience. Anne, it's fantastic to have you with us. I'm so sorry we've got you up at 4:30 in the morning to do it. But I'm looking forward to hearing what you've got to say, how are things out there?

Anne Jensen

Yeah, they're great here. It's nice and nice and warm, beautiful 28 degrees. So it's good.

Steven Bruce

Even at four in the morning?

Anne Jensen

Well, maybe 23.

Steven Bruce

Look, I gave a bit of a brief overview into your background there. I mean, I think you qualified in chiropractic quite a long time ago, didn't you? So what's your journey been into where you are now?

Anne Jensen

So I practised in, I left New York, when I graduated from New York I went to Australia directly and went to a small little town and practised there for a few years and then moved to a bigger town and then got interested in, well, how the mind affects the body, how the body affects the mind, started a master's degree in psychology, then got accepted to Oxford. So of course, you go when you are accepted. So I left North Queensland in 2005 and returned in 2018.

Steven Bruce

Am I right in thinking that your PhD is in evidence-based care?

Anne Jensen

That's right, evidence-based health care, yes.

Steven Bruce

Yeah. Okay. I mean, one of the strengths I think of getting you on the show is, and we have a lot of presenters, a lot of speakers like this, is that you aren't just somebody who does the academic stuff about evidence-based medicine, evidence based healthcare, but you actually put this into practice in your own clinic. So you can talk to us about how we might use the things that you've discovered over this little journey of yours. I'm interested by those pictures behind you. What are they?

Anne Jensen

Well, it's hard to do this.

Steven Bruce

Yeah.

Anne Jensen

These are my Oxford degrees. Three. And then behind that, directly behind me are the HeartSpeak card pictures, which we can talk about.

Steven Bruce

Well, I recognise one of them from your website, so my thought, yeah, that's an interesting hell of a mix of them there. I'm sure we'll come on to that. So talk to us. What is HeartSpeak?

Anne Jensen

HeartSpeak is a stress reduction process, a way that I can teach you how to use feelings with purpose. With HeartSpeak we can help people with physical pain but also mental emotional pain, turn those feelings, self-sabotaging harmful feelings into self-empowering ones, to use them with purpose.

Steven Bruce

Okay, we get a lot of people talking about the power of the mind on one's physical wellbeing, on musculoskeletal pain and so on or the sense of pain. You got any examples of how your technique might differ from other people's or, I know in your training program, you say that HeartSpeak is not only effective, but it's fast and long lasting, which, you know, is something we're all striving for with our patients.

Anne Jensen

Right? Yeah, chronic pain is one of the most effective things we can address with HeartSpeak. What's fascinating is when the pain goes up the spinal cord and into the brain stem, from there the neuron synapse with primarily, first the emotional centres of the brain, the amygdala and hippocampus, so it can impact not only your physical state, but your mental, emotional state. But also on the other side of things, if you're depressed, if your mental capacity isn't as firing on all cylinders, you can actually feel pain more than if you were happy.

Steven Bruce

Yeah. What's the neuroscience behind that? Because what you've described what seems like a plausible theory, but is there some research that proves that there's that connection in both directions?

Anne Jensen

Well, when I put this together, I used primarily the work from Joelle LeDoux. He's a fear researcher from New York University. And I can describe how HeartSpeak works using his words, but he wasn't describing HeartSpeak. But this is what he said. He said that when an event becomes important enough in our lives, the memory of event gets stored into long term memory. And there are two kinds of long-term memory *audio problems* facts. This is what happened, I was seven, I fell off my bicycle, I broke my arm, went to hospital, facts. And then there's implicit memory, which are the feelings behind the facts. Now, when we

need that memory again, we bring it from long term memory into working memory. And then when we're done with that again, we put it back into long term memory. But something really interesting happens on the way back in, is that we have an opportunity to change it slightly. We do it naturally. I mean, every time you recall something and store it again, next time we recall it without recalling the original memory, the one we just, we just store in back. So we can do that over and over again. And the memories are not the actual facts of the memory, but the feelings of the memory can be altered, shifted, softened. And that's what we do.

Steven Bruce

Are you going to talk us through how we might put that into practice without giving away everything about HeartSpeak, perhaps.

Anne Jensen

Yes, but I do want to tell you some also really interesting things about the two types of memory, implicit and explicit memory, which are really important. You know, I spent over 10 years in England at Oxford and I did a lot of clinical work as well, I was invited to do sessions with other chiropractors and clinics, so I got to really know, I think, British and I love you guys, and I really miss you guys. But I also know that you're very logically minded, you're very, I don't use the term left and right brain so much as logical mind or feeling mind. And I think it's really important for you to know that you have two minds, you also have a feeling mind, which, believe it or not drives behaviour more than the logical mind. So if we can all learn to honour that, we can be much happier and much less stressed. Um, but can I just talk about the difference between the two types of memory?

Steven Bruce

Oh, please do, please do.

Anne Jensen

Great. So the explicit memory is mediated by the hippocampus in the brain and the hippocampus is fully formed around the age of three. So that's why we don't remember facts much before the age of three. And it is also, with explicit memory, stress, when we're stressed, our explicit memory or the facts we remember disintegrates, gets less accurate. And also with time, it also disintegrates. And implicit memory on the other hand, is mediated by the amygdala. Now the amygdala, do you know when the amygdala is formed in our brains?

Steven Bruce

I got a feeling you're going to tell me.

Anne Jensen

Yeah, it's the fear centre. It's also the seat of emotion, but it does other things as well. The amygdala, we had amygdaloid cells from day one in the world. So you know, when we're conceived, you know, two cells become one cell, then one cell is two cells, four, eight, etcetera. By the end of 24 hours, we have cells that become our amygdala. So we can be making implicit memories and emotions from the very first day in the womb. So this is why they're extremely important to pay attention to. Implicit memories also, the amygdala, with the implicit memories, with stress, implicit memories increase with time, get worse. This

is why people with PTSD often don't get better with time. In fact, things escalate over time and also with stress, it also escalates. So this is the difference between implicit and explicit memories. This is why it is very difficult to address problems that involve feelings. For example, phobias and PTSD and even feeling depressed or down, it's very difficult to talk them out, because that's using the logical mind. If we can address these feelings using the feeling mind, we are much more successful. And that's what we do with HeartSpeak.

Steven Bruce

Okay, so are you talking here that the implicit memories, is this the sort of thing that drives fear avoidance, pain avoidance behaviour, for example? And I also, I do wonder, I suspect there isn't an easy answer for this, you know, why does some people suffer from PTSD having been exposed to the same circumstances as other people who don't, and that must apply, I imagine to people with pain avoidance problems.

Anne Jensen

Well, it can start from in the womb or even early in life, when we're exposed to stress, or our mothers are exposed to stress, it could set up those fight or flight pathways very early. And the earlier these pathways are set up, the more resilient they are. However, it doesn't mean we can't change them. It's just trickier.

Steven Bruce

So I suppose one of the questions that will inevitably arise here is if you are seeing a patient who describes a certain pattern of pain and whatever else, how do you work out whether it is straightforward pain or chronic pain, which doesn't have an implicit memory base or whether it is the implicit memory you have to address or do you just assume that it always is?

Anne Jensen

It's a great question. Now, it has a fun story to it because it uses muscle testing. Now, before, you know, the sceptics in the room, say wait, wait, wait, muscle testing. I was one of the sceptics. When I was very first introduced to muscle testing back in New York Chiropractic College, I attended the applied kinesiology class, that was a club, rather, and they tried to show us how to muscle test and I absolutely could not do it. So I walked out and I didn't revisit muscle testing again, for 15,16 years.

Steven Bruce

Just to be clear, when you say muscle testing, you're talking about applied kinesiology, you're not talking about, you know, testing muscle strength. Expansion away. Yeah.

Anne Jensen

Yes. So the applied kinesiology style of muscle testing, and I believe that there's three, we can talk about, this is a whole other talk I can give because when I got to Oxford, I wanted to do a research that my PhD on the effectiveness with HeartSpeak on people who were depressed. So during my first talk, like the first year you're doing your DPhil, is all about designing your methods, talking to people, talking to the experts in the field, seeing what they've done, seeing what others have done, designing your methods. So there's a lot of reading, a lot of investigation, a lot of seeing what is already out there. When I was designing my methods of this randomised trial with HeartSpeak and depression, during my first talk in Oxford, I

demonstrated HearSpeak, which uses muscle testing. And a statistician in the back of the room, by the way, you have to understand that my DPhil was in the department of Primary Care Health Sciences, my colleagues, my advisors were hardcore medical researchers, some very famous researchers, very knowledgeable, very influential researchers, my colleagues, the cohort, the DPhil students around me were surgeons and dermatologists and psychiatrists and nurses and medical people. And here I am, wanting to do, study something fringy with depression, so it was, to their credit, they had an open mind. So I'm giving my talk. And I'm demonstrating HearSpeak, which uses muscle testing, the statistician in the back of the room stood up and said, hey, hang on, can you just please stop talking? Because if you don't stop talking, I'm going to leave. Well, my supervisor who was a GP and great, she said, you know, this is not validated. She's doing exactly what she needs to do in exactly the right place. And we carried on from there. And then I think it was in my, it must have been my third year, because I had data, I was presenting my data, the first data I got from my first study, oh, and as a result of that first talk, they said, okay, you have to show us that muscle testing works before we let you do a big randomised trial on HeartSpeak. So that of course took a life of its own. And I wound up putting the HearSpeak trial aside and did a series of diagnostic test accuracy studies on whether or not muscle testing works the way I use it, in HearSpeak, in other kinesiology techniques. And a lot of input from a lot of very influential researchers, clinical researchers, we developed a very rigorous protocol to study, and we designed diagnostic test accuracy studies. Now, the statistics I got for my piloting and the beginning part of my first study, were so impressive that that statistician in the back of the room actually wanted to then become my secondary supervisor, because he wanted to be involved.

Steven Bruce

So let's try these trials, then. I mean, one of the many criticisms about most research into what we do is that the trials are underpowered, that they don't end up being statistically significant. How did you go about yours? I mean, presumably, there were multiple testers it wasn't just you doing the muscle testing. So, you know, whether there was an inter examiner sort of reliability in this as well as a power from the cohort that you actually examined.

Anne Jensen

Yes. When I was looking at what research has been done before I realise that one of the weaknesses of many of the studies is they handpick their practitioners, they handpick their muscle testers. And I think that would give me perhaps a sort of biased outcome. Now, and I wanted to make my research as unflappable as possible. And what I did is, you may or may not be aware, but people out there in the world, clinical world, use muscle testing, to detect pretty much anything, anything from, I use it for detecting stress and differentiating between emotions, but people can detect allergies and, you know, if something's a toxin, or if there's organ dysfunction, or pretty much anything under the sun. And we had to decide very carefully, we had to determine what we were going to use muscle testing to detect. And the debate went on for probably over a year. And we decided to detect a lie. That wasn't a decision we made lightly. We made my supervisors my supervisors and I discussed this over many, many months. And the reason we decided to use muscle testing to detect a lie, meaning, this is the paradigm we use, is if a patient spoke a true statement, their arm would stay strong. And if a patient spoke a false statement, the muscle strength would give and it would seem weak. One of the reasons I chose that is because that's a paradigm, one of the paradigms I use in practice, it also is used by probably a million people around the world. And it also has a gold standard, when you assess a new test and muscle testing would

be a new test. We have to compare its results to a gold standard. And if we chose the truth, which we note which we can know to be true, we can create a true situation, so the patient speaks the truth. And we know it's a truth, that's a gold standard. So that was a big strength of these series of studies.

Steven Bruce

Was that study published in one other journal?

Anne Jensen

Yes, I wound up doing actually six diagnostic test accuracy studies. In the first study, I had 48 practitioners testing 48 naive patients. And the second study replicated the first study because the results were so impressive. They didn't believe they were true. So my department asked me to replicate it. So the first paper I published was the first two studies. And we wanted to publish it in an open access journal, meaning that anyone can go online and download it. So we chose the BMC Journal Complementary and Alternative Medicine, which was one of the best alternative journals at that time and I think it still is. And when I submitted it, it took 18 months for the paper to become accepted. And that's a little long, usually it's certainly within a year, often closer to six months to get a paper accepted. We went through two editors, one editor quit, did not want to edit my paper. And also six reviewers. Usually there's two or three. We had a few reviewers quit as well.

Steven Bruce

Why do you think that was? Is this just innate prejudice?

Anne Jensen

Yeah. Yes, exactly. Over the seven years, I studied muscle testing at Oxford I had gotten quite a lot of, I would call it hate mail from people that told me I shouldn't be studying this. They were mostly people that use muscle testing in practice. They accuse me of not knowing what I was doing that I was going to damage the profession. I got yelled at, I got sworn at, I got harassed and I got heckled when I spoke. So it's been an interesting ride. But nevertheless, the results stand for themselves. And now the paper was accepted for publication in 2016, I came out in 2016, end of 2016. And since then, I think there were four other papers published. We have one more yet to publish. But it is the precision paper. As you mentioned before, there's intra examiner reliability and inter examiner reliability that is assessing precision rather than accuracy. For a test to become valid, to be considered valid, it needs to be both accurate and precise, accurate meaning, can this test detect what it's meant to detect? Precise meaning can it do it consistently?

Steven Bruce

Yeah, we've got lots of questions coming in here. And maybe I should say one of these straightaway because Marianne, I saw Marianne sent the question in originally, but several people have asked, what exactly is applied kinesiology? How does that work? Or are you going to come on to that in a little while?

Anne Jensen

I am going to, I can talk about muscle testing. Now through my research, and through my data collection and seeing what people were doing out there I've come to realise that there are actually three types of ways people test muscles. One of them is the one that we all use as chiropractors, osteopaths, physios,

we test muscle to determine muscle strength, rated on a zero to five scale. I call that orthopedic neurological testing. And we usually test any muscle on the body, orthopedic neurological testing. Then there's applied kinesiology style of muscle testing, which was, I want to say created but there was probably people testing muscles before George Goodheart, but George Goodheart formalised it into a technique he called applied kinesiology. Now kinesiology is a word that means the study of motion, which is unfortunate because we're really not interested in how the muscle moves but more how it responds. So, George Goodheart's muscle testing, that they do and applied kinesiology which I call applied kinesiology style of muscle testing also tests any muscle in the body. It also, it does not test for muscle strength, but it tests for things other than strength, such as organ dysfunction, nervous system deficiencies, neurovascular, neuro lymphatic, things like that, problems. If an outsider would look at the orthopedic style, and the applied kinesiology style, it would look exactly the same. However, applied kinesiology style is binary, meaning it only has two outcomes. It's either strong or weak. Then there's actually a third type of muscle testing, which I've come to call muscle response testing, which uses an indicator muscle, one muscle, which tests over and over and over again, as the target condition changes. So now I'm testing for stress. Now I'm testing to see if this supplement's useful for this patient. Now I'm testing to see if the livers functioning. And this is the type of muscle testing that HeartSpeak uses. So this is my studies. I use muscle response testing.

Steven Bruce

Just a second ago, you indicated, you know, are you telling a lie and use the strength of the shoulder as a marker there? To me, and probably to many others, it's, there's a reasonable pathway when a patient knows the answer to the question, how their muscle might react differently if they say yes or no, to somebody who saw the truth or lie. It's harder to grasp how a patient could possibly know whether it's the liver or the pancreas or the gallbladder or whatever that's wrong, and how they would then, how that would affect the strength of the muscle.

Anne Jensen

Right? Exactly. In my research, I wanted to blind the patients. But we at that time could not work out a way to keep the patients blind. So we use naive patients, we recruited only patients that had no experience with muscle testing, therefore, they did not know if their muscles should stay strong or go weak. We did track on it. And we asked them at the end, this is during the first study, which is the biggest study, we asked them if they detected a pattern with what their statements, between the statements, and what the muscle did, the arm did and about 10 to 15% guessed, which isn't a lot. So yeah. And one of the biggest questions that practitioners asked me while I was going around data collecting, was, how does muscle testing work? And in fact, when I was in my viva, and by the way, for my viva I had as an examiner, the director for the Centre for Evidence Based Medicine, his name is Dr. Carl Heneghan.

Steven Bruce

Yes.

Anne Jensen

And he, I knew he was tough. I knew it'd be tough, but I also know he'd be fair and open minded, so I wasn't too worried. At the end of my three hour plus viva, we were wrapping things up and he leaned over and he goes, well, how does muscle testing work anyway? And my advisors, schooled me, anything

off topic, always answer, that wasn't my research question. So I did. So to Carl's question, how does muscle testing work? I said, well, that wasn't my research question. And he was happy with that. And we moved on. And the truth is, he was the only one in seven, this was eight years now at Oxford to ask me that question. Really? Yeah. He was the only one at Oxford, the only one of all the researchers and scientists and medical professionals that asked me that. They want to know if something works, an intervention or test works, how well it works and doesn't cause harm. They should be asking questions more often now. But they're not.

Steven Bruce

Well, I suppose a lot of people are asking about how applied kinesiology works. And yeah, and I think that will be something which will puzzle us for a long time to be honest, because, again, I can't quite grasp how you can ask someone, you know, I don't know what the question would be, does this supplement benefit you and get an answer from that which is meaningful?

Anne Jensen

Yeah. So what I do in HeartSpeak is, I've come to appreciate muscle testing. And I test, I try and detect stress with my muscle test. Now, a lie is a stress. So in essence, my research at Oxford was detecting stress through a lie. I've really steered away from asking questions. I've really just focused on detecting stress. Now, for instance, in Heartspeak, we have a whole, I don't have it here, but we have a whole list of emotions that we muscle test for. And the paradigm that I use is if the muscle goes weak on, say, fear, that's where the stress is. So I don't know how muscle testing works. It's not a question for a clinical researcher like myself. There are many different theories. And I do not engage, I don't care. I want to know how well it works and that it doesn't cause harm.

Steven Bruce

And I'm guessing that last question is quite easy to answer, is that it must be quite difficult for muscle testing to cause harm, or is there a possibility?

Anne Jensen

Absolutely, there is. And this is an argument that my colleagues, in my department at Oxford, complained to me about was that if someone goes down the route of complementary alternative medicines, whether they get chiropractic, osteopathy, acupuncture, or kinesiology or any of these...

Steven Bruce

It's harmed by omission rather than caused by directly by the muscle testing. Yes, yeah.

Anne Jensen

Exactly. They are preventing themselves from getting proper medical care.

Steven Bruce

Yeah, I see what you mean there. This question came in from Lawrence a little while ago. And it's actually, I think it's quite a key one. He says muscle testing is rather a yes or no question system. And to get the right yes, you need to ask the right question. What happens if you don't know the right question to ask?

Anne Jensen

That's why I stick to stress, Lawrence. Yeah, I see the rabbit hole that questions bring. And yes and no, because I do not, you really want my, should I give you my theory on how muscle testing works? Well, it's not how it's more, I use the paradigm in my practice and in my life that we work, we function from two minds, there's probably more minds, but two primary minds, the thinking mind and the feeling mind. The thinking mind tries to make sense of the world around you, tries to categorise, tries to explain things, describe them. And this is the mind that we're trained in from when we're children, we develop it, we hone it. The feeling mind just feels. It perceives stimuli and then reacts in ways that it has learned from in the past. And one of the reactions is our emotions to feelings. So you get, you know, someone, you go into a shop and that person, you get a reaction, but you've never seen that person before. That person probably reminds you from another person. So I think what muscle testing is doing is letting the feeling mind speak without interference from the logical mind. That's my theory if I were to give one.

Steven Bruce

Okay. I mean, you've said that your testing is designed to illustrate whether there is any stress in your patients. But isn't it also, how do you work out what is causing that stress in order to address it, or is that not a problem?

Anne Jensen

Yes, absolutely. In fact, one of the things I teach in my muscle testing course is how to address symptoms using muscle testing. First you detect if there's a stress and then you detect what type of stress it is, whether it's a physical stress, chemical stress, mental emotional stress or some other type of stress. And then if, say, the muscle test, told you that it was a physical stress, then you can do some more testing to determine what the source of that physical stress is. I have a tendency not to worry about the source talk so much as to rather I worry about how to either remove or lessen the stress. Because, like Hans Selye said, who coined the term stress and the way we use it today. Before Hans Selye, we used stress as in material science, how much stress can this material take? Yeah, but it's the same thing. How much stress can we take, before we blow a gasket, before we collapse and we only have a certain amount of stress that we can take, I can liken it to a bucket, we put all the stress in there, whether it's physical stress, mental, emotional stress, chemical stress. And when our buckets are relatively empty, we can handle a lot. But when our buckets are toward the top, easier then to start expressing symptoms.

Steven Bruce

Presumably the bucket has a small hole in it somewhere. So the stress can gradually diminish over time.

Anne Jensen

Yeah, there's ways to empty your bucket for sure. And I use the muscle testing to figure out how to empty your bucket basically.

Steven Bruce

Okay. Hopefully, we can get to the detail of that in a minute. But Hannah asked a question a little while ago. She says she's really interested in what you do, and wonders if there are any good quality systematic reviews that you'd recommend on the reliability of muscle testing. And any papers that you'd recommend

on the efficacy of muscle testing, and what you use as an outcome measure. And maybe the references you can share with us afterwards, and I can send those out separately.

Anne Jensen

Yeah, so the last question is easy to answer, the outcome measure is actual truth. We compare the actual truth to the results of the muscle test. And we calculated accuracy by the percent correct. Meaning, how many did the practitioner get right.

Steven Bruce

Okay, what sort of question would you ask?

Anne Jensen

Okay, good question. So, we had a computer screen, the test patient in the studies had computer screens in front of them. And on the computer screen was shown simple every day, pictures of everyday things, an apple, a tree, a dog, a fence, a car. And they were given instruction in an earpiece, the computer told them what to say in relation to the picture. So say they were looking at a picture of an apple. And they were told to say either a true statement, which would be, say, I see an apple, or a false statements, say, I see a dog. And it wasn't tricky, it was either definitely true or definitely false. And when they were given that instruction, they put their arm up. And they would say, looking at the computer screen, they would say, I see an apple and then the practitioner would test. If the muscles stayed strong, the practitioner would enter an S on the keyboard, if it went weak, it was a W and then we entered into no more dialogue than that.

Steven Bruce

Okay, presumably you got a couple of true statements to start with. So you've got a baseline of strength.

Anne Jensen

Well, they could do test statements prior to that and most of them did. So of course, we need a baseline. And then once they were ready and got the difference between a true and a false, a strong and a weak, then we started the actual testing. In the first study they did 16 muscle tests, broken up into blocks of 10. Now, this was a really crucial part of the studies, is we had blocks of 10 muscle tests. And then during the pilot, we just had them rest. But one of the researchers at Oxford of my department suggested that we compare it to actual just lying, trying to detect a lie through visual auditory kinesthetic ways. So we had 10 muscle tests, 10 guesses, 10 muscle tests, 10 guesses and they'd had 60 muscle tests and 60 guesses and then we calculated the percent correct and we found in that first study, we got 69% accurate, which is, we compared to guessing accuracy, which was 49% correct. 20% difference. Now, when I saw the 69, when I calculated it, when I saw my statistical package sped up 69% I was absolutely heartbroken. I'm like, 69%, that was terrible. What are we doing, you know, I was expecting it to be 80, 85. So, but then my supervisor, my statistician supervisor saw the difference between the 69% and the 49%. 49% is chance, which is what you'd expect for guessing. So that was, we know we were on the on the mark there. 20% difference in a diagnostic test accuracy study, he said was amazing. So he said, keep going, carry on.

Steven Bruce

It still means there's a significant number of people who muscle testing would not work for, either practitioners or patients, one or the other.

Anne Jensen

I can interpret that as some patients are more easy to test than others.

Steven Bruce

Right. Okay. Yeah. The other big question here is that, it's quite a leap of faith to say that because this works in a patient who is looking at a screen with an image which is either correct or not with a buzzy little voice in their ear saying, say it's an apple or say it's a dog, and then translating that to healthcare.

Anne Jensen

Yes, absolutely. So when you're assessing a new diagnostic test, the first step to do is to determine if it's accurate and precise. Then we go on to clinical utility trials, which are randomised trials to determine if a process, a system that uses muscle testing is more useful, has better patient outcomes than a system that does not use muscle testing. For example, if you are a practitioner that prescribes supplements, we could design a study where we can use a muscle testing practitioner to dispense supplements and compare it to just a normal nutritionist who doesn't use muscle testing to see which patients got better. So that would be clinical utility, those are the studies we need to do next.

Steven Bruce

Okay. Kathy has asked why, if you were so skeptical about the merit of applied kinesiology, that you turned to it as the chosen method for testing for stress.

Anne Jensen

That was a long process. I didn't revisit muscle testing, like as I said, for at least 15 years. And I found myself at a seminar, at a workshop, weekend workshop that, they use muscle testing in the process. Now, I did not know that when I signed up for the workshop. So it was highly recommended to me by a few people. So I did attend. And I gave it another shot, and I still struggled with it, until you keep practising it, until you get confidence in it. And then it seems to flow better. So at the point when I applied to Oxford, I was actually using muscle testing on a daily basis in my practice. And this was 2002, three, four years later. And I wanted to know, as a practitioner, I wanted to know, I was seeing amazing results. People were getting better and staying better. Whereas if they, before I used muscle testing, they kept coming back every six months with the same complaints. But they stopped those patterns when I started using muscle testing. So I was like, huh, is what I'm actually, the results I'm getting actually the process or is it something else? So I started to do research in my practice. And I honestly didn't know what I was doing. I was doing it poorly which was really frustrating for me. So that's how I got to Oxford. I wanted to do good clinical research. And Oxford is the fountainhead really.

Steven Bruce

Robin's asked whether, if we don't have a model for how this works, you know, we can't sort of postulate a physical, biological, chemical mechanism for it working. How can we justify treatment based on muscle testing on applied kinesiology particularly if a complaint is raised against us?

Anne Jensen

Good question.

Steven Bruce

I embellished it a bit. It wasn't all Robin's work. Sorry, Robin.

Anne Jensen

So there has been complaints raised in England. And they've actually taken my studies, my papers to the, I want to say trial, what is it, a meeting? And they found in favour of, this one particular practitioner that I am thinking of.

Steven Bruce

Was this a chiropractic hearing or osteopathic or physiotherapy or chiropractic?

Anne Jensen

Chiropractic.

Steven Bruce

Right. So presumably we're talking it went to the Professional Conduct Committee to the general counsel. Yeah. Okay.

Anne Jensen

But you know, practitioners contact me quite frequently to ask for help in this regard. And they also asked me for help in getting their, especially kinesiologists, getting their systems recognised on a wider scale. So I know that it's been taken to the British Parliament, also, the Irish Parliament has taken my studies, people in Parliament have reviewed my studies. So we have a lot of work left to do. And I can't do it all. So happy to help, but I can't do it all.

Steven Bruce

Yeah, it's always worth bearing in mind, isn't it that there's an awful lot of stuff that goes on in conventional medicine for which we don't have simple, straightforward answers. But we feel so vulnerable in the complimentary therapies, because of course, there are some very high-powered people in conventional medicine who will do their utmost to beat us with any handy stick. Ian has sent in an observation about Dr. Tedd Koren, who uses what's called an occipital drop as an indicator. Are you familiar with that? He calls it the KST. I'm not sure what that means.

Anne Jensen

Koren's specific technique, yes. Right. There's all sorts of ways where people can use as indicators. I've heard of the occipital drop. I've heard of leg length, arm length, foot flare. People use pendulums, people use, really all sorts of things.

Steven Bruce

I mean, this isn't what we got you on to talk about, it's not your topic. But what is the KST? What does it mean? Koren specific technique. But I mean...

Anne Jensen

Yeah, I don't actually know because I'm not taking the course. But it's a technique that uses, an indicator to guide the course of care. But it would be really easy to assess the accuracy and precision of this, using the same methods that I used.

Steven Bruce

Okay. I suppose the key question here from Sue is, you know, how do you use it in clinic? What goes on? How could we use some of these techniques to help our own patients?

Anne Jensen

So it's a course, you'd have to take a course and there's many different courses out there that teach muscle testing. I do teach an introduction to muscle testing. I actually, I recorded it. And it's online and available. Also, I don't have my schedule in front of me, but I know I'm teaching a self muscle testing course, which is a type of muscle testing where you test yourself, for patients. So when I do sessions online, when I do HeartSpeak sessions online, I can't muscle test that person because they're somewhere else. So yeah.

Steven Bruce

And I should point out to people, I mean, we will put all this information together for everyone, but your website is HeartSpeak.com. And I know that your training events and also other material, including what's headlined or headed as emails is a long trail of blog posts in there about your work, isn't it?

Anne Jensen

Yes, I haven't in a few months, but I send out regular emails to the practitioners, HeartSpeak practitioners, with ideas on where to help, you know, what to clear and what to look for, and how to use HeartSpeak in certain situations. So I think those emails are on there. Yeah.

Steven Bruce

I think there still seems to be quite a bit of confusion in the people who are watching at the moment about how you're using HeartSpeak, because you said it focuses on stress only. And how, just how does that guide your treatment? Once you've determined there is or isn't stress.

Anne Jensen

So can we put muscle testing aside for now? Yeah, ok. Okay, so seeing that muscle testing works in the way I use it with HeartSpeak, we can show people, why don't we just show people how to experience? Yeah. So the best way to do that, because we're all sort of physical medicine practitioners in some regard. So if you would like to, give it a try, just everyone sit up nice and tall, turn your head as far to the right as possible. And as far to the left as possible, now I'm feeling that I can't turn to the left as far as I can to the right. Now everyone will feel some kind of, usually feel some kind of strain more on one side than the other. And so let's see if we can shift that using your feelings using each and everyone's feelings. So the intention I have is that whatever emotion comes up, and whatever we're going to do will help the group rather than specific individuals. So I'm going to ask everyone to, wherever they felt the strain, obviously now it's shifted, now it's over here, then that will happen. So I'm going to ask you to just put your hand, just touch on the part of your neck or upper back where you feel there's tension, or that's restricting

motion is really what we want. All right, now I'm going to use muscle testing to determine which feeling that we're going to use that's related to an emotion, which are the normal emotions, so fear, anger, sadness, so we're going to use some sadness, so you can take your hands away. And then we're going to put the neck aside for a moment. Now I'm going to ask everyone to feel sadness. Now. What most people that are new to this type of work do is they think of something that makes them sad, which is fine. But know that you don't need to do that, you can just, eventually you'll be able to just evoke sadness, without a memory or without a cognitive aspect. All right. So we also take postures, which I will, I would love to speak about at some point. The posture we're going to take, which will enhance your fixed experience of the feeling is your hands are going to go over your eyes and tuck your head forward. Like the normal posture when you're feeling sad. So just everyone try this, just stick your head forward. And just start breathing in and out. Breathe in and out. And feel your sadness. Keep doing that. Keep breathing. Keep feeling sad. You can feel sad about anything, everything, personal loss or grief. Loss of our current freedoms, whatever you feel sad about. Feel the pain, feel the heaviness. Keep breathing big breaths in and out. Alright, well take a big breath in. Now sit up with your eyes closed, shoulders back, head back, lightly open up your chest and look for a sense of peace in your heart space. Look for peace. That'll be in there too and sometimes it's difficult to find. But when you find it, it's like, there it is. There's peace and then drop into peace. Choose peace for this moment. Sit in peace. And then open your eyes. Turn your head right and left again. What did you notice?

Steven Bruce

I'd be interested to see the feedback from the people who are watching. Mine still crunches and grumbles as much as it did before.

Anne Jensen

Does it go any farther?

Steven Bruce

I'm not sure about that. I do not think it does. This isn't the answer you wanted, I'm sorry about that.

Anne Jensen

That's alright. Look, I spent, you know, 10 years at Oxford. I have been, you know, a lot of sceptics over my career. Nothing fazes me, but um, even, I wasn't even doing that clearing properly and I can turn farther now. So thank you.

Steven Bruce

So is that something you would do? Let's say it's an online appointment with a patient, you would do that with them. And as a result of it, you would say what, it's sadness, which is affecting the emotion in the neck or?

Anne Jensen

Okay, I can explain this. But let me explain how, how emotions are related to our bodies. Remember I said we bring up long term memories, we bring up not the explicit memory, but the implicit memory. And the reason we don't worry about the facts of a memory, the explicit part of the memory is because of the memory flexibility. Every time we store and recall, store and recall a memory, we can change it slightly.

So it is well known that memories are inaccurate, both explicit and implicit memories are inaccurate. And that's why we don't worry about the facts, we just worry about the feeling. So when I asked you to feel sad, I asked you to, it was actually bringing up an implicit memory, we don't really know why we're sad. And that's okay. We just keep feeling sad. And the interesting thing here is we do not know where long term memory storage is. We know how it's mediated in the brain, but we do not know where long term memory storage is. And there is a leading theory that it's stored in the fascia, a lot of people, a lot of us have had experience of either ourselves getting a massage or in a yoga class and we all of a sudden get emotional. That's the release of a memory in our fascia.

Steven Bruce

I wonder how that theory would play out with your research colleagues in Oxford?

Anne Jensen

Yeah, well, there is more and more research in the fascia world, there's actually a whole symposium now on fascia, what it is and how it works.

Steven Bruce

Quite coincidentally, we have a fellow talking about fascia on Thursday lunchtime. We'll be talking about the science of fascia, and I will bring that question up with him, then. We've got a number of other questions here. People still asking about what is HeartSpeak specifically, Lawrence has made the observation that all therapies have a model of how they work. But then something comes along which challenges and doesn't fit the model. Just as the case with osteopathy, we might say it comes back to the inherent healing process of the person and what's required to help that process. And I have to say, I mean, I'm with what you said there. I mean, some extent if you find something that works, it doesn't really matter that you understand how it works or whether your theory is correct, does it?

Anne Jensen

No, in fact, that's one of the biggest lessons I learned at Oxford. Kind of, I don't know about osteopath, chiropractors are always, the biggest research agenda is, how does chiropractic work? And my department at Oxford does not care. The people that do the clinical research are informed policymakers, they don't care how it works, they just want to know if it works. How well it works, does it cause harm? And I think if we kind of put the how it works question aside and focus on the question, the research questions that will inform choices, I think we will, I think people will start listening.

Steven Bruce

Mags has asked, she says she's experienced muscle testing a couple of times but was never convinced that the weak responses were not just her not being ready for the test at the time. Her question is, do you think that that 69% accuracy in some way reflects what she experienced?

Anne Jensen

Well, we use all naive patients, so they had had no experience with muscle testing in the first study, in the big study and then we also, in later studies, we use non naive patients, and the muscle testing accuracies were similar.

Steven Bruce

Okay. Sorry, I was slightly distracted then because a comment is coming to me with a big red flag on it, which says that in a very poor assessment of the results from our audience during your test a little while ago, it shows that the team watching us on Vimeo mostly didn't get better but the Facebook team did so Claire's asking whether it could be social media related. She's taking the mickey of course. Jackie says, why did you pick sad, why didn't we use something else?

Anne Jensen

That's the mood the muscle testing told me where to go.

Steven Bruce

Okay. Pipp says, does touching the part of the body concerned before feeling the emotion have a specific function?

Anne Jensen

It's bringing your mind body's attention to the part of the body that we're interested in. I'm basically asking your body, hey, is there stress here? And then I muscle test.

Steven Bruce

Okay, I see. Yeah. Okay, so yeah, I must admit that when I found that little part on my neck, I wasn't convinced I'd found the right part where the stress was arising in my neck. But hey, I'm on air. So I had to do it live. I got a question for you. I mean, years and years and years ago, I do a bit of gait analysis. And one of the things that we were shown on a gait analysis course was if you, you do a strength test on a person's outstretched arms, without any sort of preparation, you'll find that they're however strong. If you then put their feet into subtalar neutral while they're standing, you get a much stronger response. And the people demonstrating this to me said, well, this is a justification for giving people orthotics. I've never believed that, I just think it shows that if you change something here, you can change that response in the body. And it was very clear, it happened almost every single time. Again, I don't think it's a justification for prescribing orthotics. I just thought it was quite fun to show that changing something in the ankles can make the body do something or behave differently somewhere else. What do you think?

Anne Jensen

Yeah, I think anything can cause anything, I think we're all connected in ways we will never know. Truly. So. Yeah, how does it work? I don't know. But I've seen it done. And, you know, if you want to do a research study, I'll help you design it.

Steven Bruce

Okay, thank you.

Anne Jensen

You know, actually, I should also, back before COVID, I had been in contact with Foot Levelers Orthotics to do this exact research study to see if the muscle test in our orthotics would, and we'll see if it could detect the need for orthotics and also, to see if the more expensive orthotics, which the practitioner would actually get more money for, had an influence.

Steven Bruce

So many, there are so many confounding factors in that, aren't there. How much does how much you pay for the intervention affect your outcome? Does the practitioner's enthusiasm for selling something profitable affect the outcome? And in any case, with orthotics, how do you actually measure that outcome? Because it could be a long-term benefit, but anyway, let's not go down that rabbit hole. Alex says he wonders if that range of motion would change if you just tried to achieve the sense of peace that you were talking about without all the other stuff?

Anne Jensen

Yeah, do it and let me know.

Steven Bruce

Yeah. But it has to be, Alex, it has to be a proper randomised control study with a meaningful cohort. Hannah says, how do we know the change in the neck is, the range of motion is not simply from positional release from holding the head down.

Anne Jensen

Let's do some more interesting, let's do some more work with posture and feelings. Shall we?

Steven Bruce

Okay.

Anne Jensen

All right. So, how I got into the feeling world in general is I've always been a feeler ever since I was a little kid, I was feeling things. Feelings to me were more important than what actually people said. So I really paid attention to how my body and how I held my body impacted my feelings. So before we start this, I realised that I've been feeling all my life but I realised that some of you probably aren't feeling, haven't been asked to feel. So just be patient with yourself about this. So take a nice seat, nice posture. And I'm going to ask you to sit up nice and tall, really open up your posture, shoulders back, palms up and open, head back, chest out. This is a really open posture and sit here for a moment. And when you're sitting here, look for the feeling of love in your heart space, the big love, not associated with a particular person or situation. Just love and see how easy that is. Alright, and then relax and then we're going to take a closed posture so that was an open posture and a closed posture is you're going to slouch, hunch, come into a ball, a tight ball, come really forward, forward, forward. And in this posture, look for the feeling of fear. When you're still in that posture, go to a neutral feeling. Put fear aside and then look for love. Oh, keep down there. Yeah. Keep down there and then look for love. Notice and then sit up nice and tall in your open posture again. Shoulders back, head back, open up. And in this posture, let's look for a feeling of fear here. What have you noticed?

Steven Bruce

Me?

Anne Jensen

Yes?

Steven Bruce

I hesitate to answer because Claire would say, my wife would say I'm the most unfeeling person in the world. But I find it quite difficult to find, I find it very difficult to find a sensation of fear.

Anne Jensen

Yes. In both postures or in?

Steven Bruce

More so in the second one, more so in the second one, definitely.

Anne Jensen

Okay, great. And what about love?

Steven Bruce

You have met my labradors, have you? I can experience that though; I can feel that. Yeah.

Anne Jensen

Was there a difference in how you experienced love with your different postures?

Steven Bruce

I think so, yeah. I mean, it seems like common sense almost. Sitting upright and open feels a much more responsive way to feel love. Did I get the answer right, because that's very important to me.

Anne Jensen

Yeah. So in HeartSpeak we use postures to enhance feelings. Therefore, when we want to experience feelings like love and joy and peace, we're open and invite it in. And when we want to experience the harmful feelings, the fear, the anger, the, well, not so much anger, but disgust and all that, we're in a closed posture. So, I've done this little experiment with people all around the world, 1000s of people now. And by far, the majority of people say that they can experience love easier in an open posture. And it's harder to experience fear in an open posture, easier to experience fear in the closed posture. Now, what does that mean for practitioners? Well, look at your teenagers, the teenager, adolescents in your practices, or kids even, they are always slouched. And they're looking at devices and then they're all depressed. And you know, I don't know about in the UK, but in Australia, the suicide rate among teenagers in the past 12 months has been unbelievable. Like, I don't even know the statistics, but so much higher than in the past years. So if we can just, this is, you know, I'm a chiropractor, I'm used to, telling people to sit up, you know, have good posture for physical reasons, but also, there's mental emotional reasons as well. And because I have an interest in it, I've done some research on kids at school with posture. And they found that kids with better posture at school got better grades, not because they were smarter, they looked at their IQ, they weren't smarter, but they look smarter that the teachers thought they were smarter, so they got better grades and they followed these kids. And they found that they had more friends, they were more popular. And when they left school, they got better jobs and made more money.

Steven Bruce

Interesting, is that do you think the effect of their posture on other people, you look better in an interview, if you've got good posture, rather than being hunched over, you look better to your potential friends, if you're like that and maybe your teacher making more eye contact with you treats you in a different way, it's not so internal here, it's the other person's response.

Anne Jensen

Yeah, but we can manipulate it, we can use it to our advantage.

Steven Bruce

Yeah. Okay. Kim wants to know how the things that you've described work in regard to back pain, for example.

Anne Jensen

Well, so one of the reasons I've got into the mind part of this mind body complex is that when I first started adjusting people, I noticed that when people were under stress, their physical symptoms were more intense. And when things were going smoothly in people's lives, they didn't seem to be as troubled physically either. And one of the things that really frustrated me is by, I was adjusting people with back pain, sometimes week after week, certainly month after month with the same areas of the spine, same exact segments of the spine, I'm adjusting each time. And that was frustrating. Why do I need to adjust this every single time. And if you go back to chiropractic philosophy, a vertebra will sublunate because of three types of stress, physical stress, chemical stress, mental emotional stress, that's from DD Palmer, for your chiropractors out there. And so I say, well, if we're only addressing physical stress with our patients, we're missing the boat a bit. So I started to look at ways I could help my patients with chemical stress and mental emotional stress. We didn't have a lot of ways at that time to help people with mental emotional stress. So, started to explore different ways and sure enough, even, yes, I work as a chiropractor as well, part time, but I also do a lot of HeartSpeak. And if someone isn't improving with chiropractic adjustments, then I'm going to check them for other stress.

Steven Bruce

There's a fascinating question come up here about the stress that you just tried to put us into, I don't know who asked the question. But they've asked whether there are any ethical issues about inducing fear or any sort of stress in a patient?

Anne Jensen

Yeah. So I speak at all kinds of conferences. And whenever I speak at a psychology conference is always a question of re-traumatizing a trauma patient, is it going to be causing them harm if we get them to feel a feeling? Two things, first, we've been tracking adverse events on our HearSpeak website for four years. And HeartSpeak's only six years old. So for the majority of our time, we've been tracking adverse events, there has not been one adverse event reported in those four years. And I'm not saying there might not be an adverse event. I'm saying that one hasn't been reported. So I'm not saying it's completely safe. I'm saying that so far, we're pretty good. And the other thing is, let's take someone with PTSD, who has had a trauma in their lives. I am not asking, I will never ask that person to remember the trauma, that's going to be over there, you know, hanging out. We know it's there. We know the person's been traumatized.

But let's just focus on what's happening over here. What's happening now. Oh, you have back pain. Oh, and that back pain is related to fear. Oh, then I walked them through the HeartSpeak process, that fear might or may not be related to the trauma, regardless, the back pain goes away. And the trauma, big trauma, pile of trauma, gets less. It's like, how do you eat an elephant? One bite at a time. We just take one feeling and deal with one feeling at a time, then we're done with that feeling. Okay, what's next? What's safe to feel next. Okay and then we're going to deal with this feeling. So it's taking the trauma in micro doses and dealing with one small feeling at a time and we let the patients drive. And they only experience the feelings as much as they feel comfortable, especially with trauma people, that have been abused or traumatised. Yeah.

Steven Bruce

We've had apparently lots of comments about the emotions people felt when they were in those different postures. Claire tells me she can't pass them all over because there's too many. But it's interesting to know that the process has definitely had an effect on what people were feeling, which is good. Anne, is it, would it be useful for us to share that bullet pointed list of the HeartSpeak process? Justin, could you put that up on the screen, please? Justin will bring that up. Would you like to talk us through that?

Anne Jensen

Yeah, yeah. So this is what we call the HeartSpeak tools. And over the years, I've been collecting little things that you could do in the moment when you're struggling. The open postures, what we did, if you're going into an interview or something or going into a meeting that you need to actually not be reactive. Keep your posture open. So that's, that's a classic one. And these aren't mine, particularly. But these are the ones I found over my lifetime, ones that I use. By the way, also these are not going. So when we are in the emotional response, we're usually triggered into becoming emotional, there's something going to trigger, a stimulus is going to trigger the response. And it's usually very consistent, every time we experienced that trigger, we're going to have that emotional response. That's a pattern we usually learn it when we're little. The HeartSpeak tools, do not soften triggers, the HeartSpeak process will. But the hard speak tools are certainly useful if you're struggling in the moment to feel better. So Justin, can you put the list back up and I'll walk people through it?

Steven Bruce

Just give him a second, it'll come up, come up in a moment.

Anne Jensen

All right. So open posture we spoke about, belly breathing in yogic and meditative communities, meditation communities, we know that belly breathing will drop us out of sympathetic response into a more of a parasympathetic response. So it calms our sympathetic nervous system down, that's well established. And it's something that you can just do even though you're not, people don't even have to know you're doing this, start belly breathing to feel better. And simply putting a true smile on your face will actually lift your mood. However, there is a caveat to this. There is research to also show that a false smile will depress your mood, it will worsen things. So a true smile, you actually have to smile with your whole face, your eyes, just light your face up. It actually takes practice, it's probably the hardest one to actually do effectively. Alright, we can go back to the list. Feeling curious is a feeling, if, for example, I give this one to people that have had, like, they get really stressed out if their boyfriends don't text them

back straight away. You know, instead of running that pattern of like, ah, just feel curious. I wonder and it's just a feeling. I wonder. Firmly padding your torso and limbs is the next one. And what that will do is, it'll just bring you back into the present moment. So if you're feeling out of sorts, if you're feeling a bit panicky, just start patting yourself. That brings you back to the present, because when we're anxious we're usually worried about the future, if we're depressed, we usually worried about the past. So you can bring yourself back to present. Okay, and then yawning changes your state, the next two, imagine yourself 10 feet tall and your invisibility cloak I give to kids who are bullied. These are amazing, energetic ways to help kids in your community that are feeling, are bullied. The other two, ask yourself, am I safe right now? That's a good one. Just keep repeating that. You don't even have to get an answer. Just the question. Am I safe right now? Am I safe right now? Am I safe right now. And the last one I would love to do with people. Do we have time.

Steven Bruce

Yeah, we have. We've got nine minutes left.

Anne Jensen

Ok great. You can use the expand tool for physical pain or mental emotional pain. So if you're watching this, choose either a physical pain you have a moment or a painful memory. And this is again changing your state in the present. Sit with the pain, the mental emotional and physical pain, sit with the pain and rate it on a zero to 10 scale. 10 is the biggest ever pain ever, zero there's none. Close your eyes and start expanding your consciousness to include the whole room you're in. Expand to include the whole building, out to the street, to the whole neighbourhood, keep expanding, then to the whole town or village, the whole city, the whole region, the whole country, the whole continent, keep going to the whole planet, pass the moon, keep expanding your consciousness past every planet in the solar system. And then to the whole galaxy. And then to the whole universe, expand to the farthest star in the universe, past all the stars known and unknown. And just enjoy it out there for a moment. And then turn your attention to the either the physical pain or the mental, the painful memory. Sit with that for a moment and rate it again, zero to 10. How does it feel?

Steven Bruce

Mine went down. Definitely, I can tell you this is a really uncomfortable chair to sit on, especially when you're half twisted towards a screen like this. So I definitely had a pain in my back to focus on. Yeah, so that worked for me.

Anne Jensen

Excellent. Yeah. So and again, it's not going to soften the trigger that triggered the pain or the painful memory. But it will make you feel better for some time.

Steven Bruce

Just going back to the concept you've talked about overall, Ian sent in a question a little while ago asking whether feeling mind, letting go of emotions, whether that is part of something called the Sedona Method, which I don't know anything about.

Anne Jensen

Someone else has asked me that about recently. And I've noticed in the last five or six years, particularly that there are quite a few emotional release processes that have popped up in different parts of the world. I don't know what the Sedona Method is. But yeah.

Steven Bruce

Okay. Wendy's asked when you're doing your muscle testing, what pressure do you exert, because presumably, everybody's different when it comes to the amount of pressure they can put up with?

Anne Jensen

Yeah, it's, I use as light as possible.

Steven Bruce

To some extent, it doesn't matter, it's the response you get from the patients to whatever pressure it is, isn't it rather than any specific pressure?

Anne Jensen

When I teach, I stress the importance of being able to distinguish between a strong muscle and a weak muscle. And as long as you can distinguish when a muscle stays strong or goes weak, that's enough pressure, and it's not very much at all.

Steven Bruce

Is there a danger in us trying to incorporate what you've said that, you know, we're straying into the realms of psychology here. And that's not what we're trained to do, you are, of course, but you know, is it outside our expertise?

Anne Jensen

It's a grey area. And, you know, I'm in two minds about that. Because I always think that if you're not addressing the source of patients' problems, you're really doing them a disservice. In fact, back pain is a great example. You know, with back pain, there's always emotional components to it, stress components to it, always. Whether it's causing them or caused by them. Now, if you're not addressing that, the research shows that you're actually not only doing them a disservice, you're actually causing harm. That's what the research shows.

Steven Bruce

Yeah, I suppose one could argue and hopefully it won't happen. But one could argue that if that is an essential part of the treatment, then we need someone who is expert in that psychological component to contribute, rather than trying to do it on an amateurish basis as we might be also.

Anne Jensen

Yes, and that just makes me feel like I have so much work left to do. I have to do that research study that I put aside during my DPhil on depression and HeartSpeak, there's just so much we have to do.

Steven Bruce

Final question, perhaps, Kathy says, do you deal with the adverse feelings that you've identified through physical therapy? And she says, for example, manipulation, or are you using talking therapy to address them.

Anne Jensen

We don't talk, we just feel. So in HeartSpeak, we just feel but, we also teach how to use feelings in a physical sense as well, I teach a course called HeartSpeak light for bodywork, and HeartSpeak for yoga, where we, for example, with HeartSpeak for yoga during specific postures, you introduce a feeling, whether it's fear or sadness, which will actually help people open up, especially in the hips, you know, women, we all have these tight hips. You can use feelings to actually open that up during the posture. And trigger points too, are often little nodules of feeling.

Steven Bruce

Yeah, well, I mean, we've done a long series of programs about treating trigger points with Simeon Neal Asher, which if you're interested in, you know, you can find on the recordings page of the website. And yes, he's very often stressed the components of emotion and trigger points and the benefits of touch generally, which is always interesting. Anne, it's been a rapid run through what you've done. Is that, just very, very quickly, is there research into the outcomes for HeartSpeak itself, specifically, rather than muscle testing?

Anne Jensen

Not yet. I do have studies designed and I'm just now in a position to actually get them through an ethics board and start doing them again, start researching again. But in this climate, it's very difficult to recruit.

Steven Bruce

Yeah. Yeah. And as we all know, research is very difficult in our field generally, because we're not backed by huge amounts of money from pharmaceutical companies. Anne, thank you so much for joining us. And it's now what, must be five o'clock or six o'clock in Australia. Six o'clock. So it's a nice, healthy morning for you over there. I hope we can talk to you again sometime in the future, because I'd love to hear particularly if you're going to get some research results from HeartSpeak itself.

Anne Jensen

I'd love to share my research on muscle testing at some point, the actual research.

Steven Bruce

Yeah, please. Well, I mean, what I'd like to do is I'd like to send out the document you just saw on screen, the bullet point list there. But also if I can get some research references from Anne, then I shall put those out into an email to you again tomorrow as well. So perhaps we can talk about that a little bit later on. Yeah, meanwhile, I mean, that's it for today. I hope you've enjoyed that. I get the sense that there's some very healthy skepticism in the audience as much as anything else. But here we have someone who has a doctorate in evidence based clinical healthcare, telling you that there is significant evidence behind the techniques that she's talked about. And I hope that's provoked a little bit of thought amongst the audience.