

Exercise, Science and Keeping It Simple - Ref 152JE

with Joanne Elphinston

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TRANSCRIPT

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Steven Bruce

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

Joanne Elphinston

Well thank you so much for inviting me back, Steven. It's looking very lovely and jungly where you are in Cardiff, my experience of Wales is that it's always raining, but there we are. It's so true, but I miss my home, I obviously haven't been able to get back to Australia for a long time. So, I'm trying to create a little bit of jungle back here that can make me feel at home.

Steven Bruce

I'm looking around your trees for a little koala somewhere, but haven't spotted any yet. You're a physiotherapist, you've written this book called *The Power and the Grace*, which I have recommended before to our viewers, because it is so beautifully presented and very well written. You come highly recommended by Thomas Myers, who of course is the director of *Anatomy Trains* with which I'm sure many of the audience will be familiar and elsewhere. Tell us a little bit about this book. What sort of book is it and why is it important?

Joanne Elphinston

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

Steven Bruce

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

Joanne Elphinston

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

Steven Bruce

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

Joanne Elphinston

I get asked about the plank really frequently, it's a really great question. Because when there's millions of people planking all over the place, aren't they, all over the world? And this comes down to what is the purpose for the exercise? What are you hoping to achieve from it? So, if I want to work with somebody who runs, for example, and I know that for running, I need really great counter body rotation, which means that my abdominals need to work at a relatively low enough threshold to allow for the motion to happen, but that these muscles, the more superficial muscles, can work eccentrically and concentrically. And then I look at the plank, and I go, so which of those issues am I addressing with the plank? And the answer is none of them. But if I'm working with a discus thrower, and they have to be able to keep their whole body consistently in the same relationship, the muscles are not changing length, in order to be able to get a quick rotation, then it would be really relevant. So, you know, what I'm trying to do through my work and with Jems or the clinical courses we teach is that for people to learn to clinically reason exercise and movement in the same way that they would clinically reason any of their other manual therapy techniques. Normally at university, we're given a very strong educational, clinically reasoning our manual therapy. But often we don't

have the same level of clinical reasoning for our movement. So, I would say the same thing, like with planks, with a bridging exercise for the glutes. And you're like, okay, so what is it doing, it's doing inner range and concentric gluteal activation. And what are you hoping the patient's going to do better? Well, they really want to, they want to be able to squat down, which is eccentric, moving into outer range. So, does one necessarily lead to something better than the other? No, not necessarily. You've taught the brain to do something here. And you've taught the muscles there. And it's quite specific, but it doesn't necessarily mean it's going to carry over into other activities, other functional activities. So, I'd say, thanks, okay. But from a clinical point of view, it's not something that I would see as being super relevant very often.

Steven Bruce

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

Joanne Elphinston

Well, again, you know, where I am with it is not, it's coming back to this whole idea of is it exercise or is it movement? Now, what are we doing it for? You know, the ability to hold a plank position, for as many minutes as you're going to do doesn't necessarily mean anything. Like, is it going to make your back better? Probably not. Is it going to make you move better? Probably not. Does it make you feel a bit better about yourself? Maybe? So, yeah, for me, if I was going to give something, I wouldn't be giving that, if I was going to give one thing, it might be something completely different. To be honest, if I was going to give one thing, make a difference in someone's posture, core stability, back pain, everything, I'm going to teach them how to breathe properly.

Steven Bruce

Oh, that's getting back to a topic which we've covered so many times over the whole lockdown period, breathing for pain relief, breathing for calming the mind down, breathing for all sorts of things.

Joanne Elphinston

It's breathing for musculoskeletal effect. So, you know, I'm seeing so many people, it's not just about the emotional side of things with the breath. It's also about the biomechanical aspects of the breath. And we're just seeing so many people, especially treating, I mean, I'm doing a lot of my treatment remotely now. And in a way, it's been advantageous because people have been a bit more willing to settle and just actually think, okay, we're doing this now because there isn't a choice of just getting up on the plinth. And it's been so interesting to see like real neck problems, real back problems, you know, things that normally would get treated and we get this diaphragm working in a way that it's actually starting to change what's happening to the spine. And gee, the symptoms get better.

Steven Bruce

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

Joanne Elphinston

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

Steven Bruce

You make it sound as though it's probably quite easy, Joanne.

Joanne Elphinston

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

Steven Bruce

Deconditioning ourselves as practitioners or deconditioning our patients?

Joanne Elphinston

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

Steven Bruce

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

Joanne Elphinston

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

Steven Bruce

Could I perhaps ask you to put that into the context of a hypothetical patient? That is a real patient because Jess, thank you for the patient, Jess has said that she's got a patient who has a spinal fusion T10 to L1 and she would love some advice on fusion patients generally, but in terms of how she might approach dealing with a patient like that. So, what would you do?

Joanne Elphinston

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

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

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

Steven Bruce

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

Joanne Elphinston

Well, he did ask whether I was getting my broom stick out. Very rude, but not entirely inaccurate.

Steven Bruce

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

Joanne Elphinston

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

Steven Bruce

Lovely. I've got a whole load of questions. Can I run through some of those? We had this plan that you were going to talk about something but as always, we're getting lots of questions and 45 minutes is a very short time. The first one is from Claire, who kind of anticipated what I just said and says Steven, if you ever give me a stick for Christmas, she won't be happy at all.

Joanne Elphinston

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

Steven Bruce

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

Joanne Elphinston

I'm just trying to get clarity on the question. Say that again for me?

Steven Bruce

Is your approach to treating patients largely from functional exercises and movements designed for that individual?

Joanne Elphinston

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

a wrist treatment. And this is what we see, because most of my patients are all people who've had a lot of treatment and it hasn't gone well. Normally, because they've had whatever the evidence base is around that particular part of the body. But one of the big things we always ask is, why is this structure under pressure? Why should it be in this situation? Just not enough to say, Oh, it's been overloaded, they've used it too much. You know, I love it when runners say to me, well, I've been told I've got an overuse injury and my left achilles, but my right achilles has run the same distance as my left achilles. So how come I've only got it on one leg? Well, that's a really sensible question isn't it? It requires us to think a bit harder about just blindly talking about an overuse injury. He said like, why is it under pressure? And that's when it gets really interesting. Because we're not just applying the same pat exercises to people, we're actually going oh, actually, you know, you go along, and you don't rotate your upper body to the left. And so, when you hit the ground, then you tend to tip into the frontal plane instead of into the transverse plane. And when you tip into the frontal plane, it puts more load on that leg, which means you've got longer context time on that leg, which means you have to push harder off that leg to take a step and that's how you follow the train.

Steven Bruce

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

Joanne Elphinston

One minute. Okay. Yeah, so this is interesting too, because, you know, for so long we were looking at hypotonic or weak pelvic floors, but now I'm seeing in both men and women, the hypertonic overactive pelvic floor which is bringing just as many problems as the reverse, and often what happens is that they're given more pelvic floor strengthening and actually what we need to restore the elasticity of the structure. So, I might choose, for example, to take my balloon breathing down into the pelvis. And I'm going to say, right, so we're going to expand this balloon, the first thing that's going to happen, it's going to push the plates on the side of your pelvis, that balloon is going to expand and just create a bit more space between those plates. Now, obviously, the bones are not actually moving, what we're asking for is a relaxation response. And I might come down and say, right, do you know where you're sitting bones are, find your sitting bones, we're going to take a balloon down here. And we're going to blow up a balloon, and we're just going to create a bit of space between your sitting bones, we'll see how that goes. Or it might be that we show them what the coccyx looks like, it's just like, that's your tail, okay, and so you can have a happy dog or a not happy dog situation here. Because if we tuck our tail under, you know, with too much pelvic floor, then we've got a bit of a difficulty. So, what we're going to do is we're going to breathe, and we're going to let our little tail float up. And I remember doing this with a professional squash player with really chronic patellar tendinopathies. And he just couldn't squat. And he really struggled with his pelvic position. And so, what would happen is we would go down, he had a very, very lordotic, lumbar spine, lots of erector spinae tension, he'd go down

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

Steven Bruce

Indeed. Tracy asked whether you have any experience of patients posts caesarian section who have breathing issues.

Joanne Elphinston

Oh, yeah, absolutely. And again, I'm going to start there. And also, there's a lot of women I've seen whose caesarians were some time ago. And they're still struggling to get that connection. Or they've learned how to do it with various forms of core stability, but it's actually a more superficial contraction, they haven't actually restored that very deep, low threshold contraction. And again, often we can't start with that until we've actually got the diaphragm working. And often what you'll see is that you'll get a lot of tension in the thorax, because they're trying to hold it together from somewhere. So, it gives us the opportunity to relax that and start to rebalance again. The other thing I do a lot is the sensory input for these people because it's so interesting. And again, can I say it's not just c-sections, it's also women who, they may have given birth but remember your women who have had miscarriages Can I just say they're the forgotten group here and they could have just the same loss of proprioceptive connection and internal connection to their abdominal wall as anyone else. So, you know, we do a lot of you know tummy rubbing and you know, just letting the brain know, this is where we are here and it's okay. And you'll find that for some people that is okay. And then for others we'll find that there is an emotional block there. That we need to be very careful to process with them because they can't go there. And there can be, I was working with a lady the other day, that whole area below the waist was associated with shame.

Steven Bruce

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

Joanne Elphinston

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

Steven Bruce

Joanne, we're out of time.

Joanne Elphinston

It goes very quickly.

Steven Bruce

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

Joanne Elphinston

You can get it on both. It's fine, but I usually say to people just jump on to Handspring's website. They've got lots have wonderful books on there as well.

Steven Bruce

If there's a chance to look inside it will almost certainly convince you that it's a book worth having. So, there we are. Joanne thanks for joining us again. It's been a delight as always.

Joanne Elphinston

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

Steven Bruce

We might send some of them through to you and tax you to answer them after the show.

Joanne Elphinston

I'll look at that.

Steven Bruce

Joanne's agreed to do that. Thanks again, Joanne.