Academy of PHYSICAL MEDICINE

Movement as Therapy

With Joanne Elphinston

28th April 2020

TRANSCRIPT

Please note, this is not a verbatim transcript:

- *Some elements (repetition or time-sensitive material for example) may have been removed*
- *In some cases, related material may have been grouped out of chronological sequence.*
- *The text may have been altered slightly for clarity.*
- *Capitalisation and punctuation may be erratic…*
- *There may be errors in transcription. If something appears odd, please refer to the recording itself (and let us know, so that we can correct the text!)*

Steven Steven:

We are still discouraged from doing face to face consultations where we can't. And today I've got Joanne Elphinston joining me to talk about a number of things that we can do by online consultation but also stuff that will be very useful when back in clinic. Joanne, welcome to the Academy again.

Joanne:

Ah, it's lovely to be back Steven. Thank you.

Steven:

It's a long time ago wasn't it? And that was a proper one in the studio when actually you were doing techniques using one of my team as your model.

Joanne:

Absolutely. And I believe we had to get you moving to

Steven:

Well, yes. I'm always a challenge. I haven't actually introduced you to the many hundreds of people who are watching this time who won't have seen you before,

but you 're physiotherapist by qualification. You've worked at a very elite level with musicians, with Olympic athletes and others. You're the author of two books, including your latest book. We talked about the other one in the last broadcast, which was Science, Sports and Performance Movement,

Joanne:

Stability, Sport and Performance Movement.

Steven:

Um and then this one.We'll talk about that again in a minute. And you lecture and you do all sorts of stuff and and you were absolutely brilliant last time. So you're going to come back in today and talk to us about movement and hopefully we're going to get some sort of a differentiation between movement as opposed to exercise in terms of rehabilitating our patient. Is that fair?

Joanne:

Absolutely. Okay. Well, I thought because most of us now I've had to move our practices and you know, without being able to be face to face with our patients, we have new challenges and many of you have invested a great deal of your time and your experience developing your manual therapy skills. But of course now that's pretty much off the table unless you're teaching people how to do their own, which I have been doing. And they've been enjoying it very much. However with manual therapy now shifting to the side, we have to look at what are the skills we can bring in to still be treating our patients and the two that I want to bring forward today are movement as a treatment and assessment modality and communication, because never has that been more important as it is now. What I thought I'd do is actually talk about a real patient that I've seen and treated him remotely. New patient. So I've done the initial assessment online and I've treated him online and while we're doing that, then we can have a little play with some of the movements that I used and the reasoning process that I used so that you can also get the feeling of some new things in your body as well.

Steven:

Okay. That sounds good. And I think communications is particularly pertinent to the chiropractors and osteopaths who are watching today because of course that is very much a requirement of their CPD qualifications. We both have to cover communication.

Joanne:

Just to set that up then, what I'm going to invite you to consider is that, for the session that you do with a patient online, that we think about it more of a lesson than a treatment and that puts you in the right brain space for communication. Because if we take for example, a couple of distinctions, exercises are not the same thing as movement and people actually don't realize that. And so if you look at a classic

patient treatment where they might get some manual therapy and get some exercises, that is not the same thing as we're talking about here. So that's the very first thing we need to consider, movement exercises. But also when you instruct somebody and you don't see what you're expecting or you're wanting, it's very easy for us to fall into this idea of correcting them.

Joanne:

Okay. So often what we do is we offer a correction when in fact what we need to do is be much clearer about what we're looking for or we need to find an alternative route or alternative kind of cue that speaks to that person's unique nervous system in a way that's meaningful. So what rings a bell for one person is not what rings a bell to the other, but often we use the same cues and then the same corrections, they don't need correcting, they just need a different perspective. So that's again, utterly pertinent when we're working remotely.

Steven:

Okay. So exercise inevitably does involve movement. So is it a particularly subtle distinction you're making here?

Joanne:

No, not really. And I think when we walk through this patient, I think it will become evident what the difference is, because this patient has had other practitioners work with him up until now and he's, received exercises and that's not wrong, but exercises-

Joanne:

Sometimes we're hoping that they will transfer into the person's movement and if the person's movement and the way that they're using themselves is actually one of the causative factors, then really what we're doing is kind of throwing stuff at the wall and hoping something sticks rather than getting to the point. So, if we wander through this patient together, we'll revisit that at the end and see if we can see the distinction between exercises and movement. Does that sound like a fair idea? Okay. So my patient had contacted me just before the whole coronavirus thing kicked off. He's a professional musician, a percussionist. Most of my people come and have to travel for some distance. So we hadn't actually got him in the schedule before this actually happened. And so I contacted him and said, right, well would you like to do a remote session?

Joanne:

And he was a bit like, well, you know, there's nothing you can do remotely. You know, I've seen all these people and I don't really see the point. So that's where we started with him. So, if we flip to the holistic functional model slide, this is the simple model we're going to use for him and one that I teach on my JEMS courses as a way for us to frame a patient assessment and treatment. Okay? Now what you're going

to see here is the green circle. That's the local physical. So that is the structure that is problematic. Now in the case of this patient, it's one of his lumbar discs. So he's had an MRI. It shows that he has a small herniation there. So we have a local physical area. Then above that we have the global physical. So this is the context within which this local area is operating. So how does the rest of the body influence that area? Then we push it out into functional tasks. So what does this person have to be able to do? And then what environment are they actually operating in? And then over top of all of this, we have something called arousal level. And we've lost the arousal.

Steven:

Oh no, on my preview slide, I can still see it, but it's not there. I'm sorry.

Joanne:

Okay, well if you just imagine that there's a circle that crosses all of these circles and it says arousal level and arousal level is made up of these four categories. So first we have beliefs. So if we think about this patient, his belief is that I can't help him remotely. So that's a great start. Then we have self efficacy. So that's his belief in his ability to be able to do something that might be able to change his situation. Now he has reasonable self-efficacy, but this has now been going on for some time and he's made small improvements but not anything tangible. So it's starting to waiver. But he's quite confident in himself. Then we have the understanding. So what does he think this is all about? At the moment he thinks that it's a purely pathological problem. I have this problem because I have something wrong with my disc and a little bit later we're going to show that that's actually not a deep enough understanding of the problem.

Joanne:

And then finally we get to emotions. So at the moment we are in the frustration edging into anxiety part of things. Okay. So, understandably, you know, he started out, thought everything was going to be okay. He's seen a lot of people, it's not okay, it's getting frustrating now, it's getting worrying, and then he's got a big tour schedule that's going to be coming up and is he going to be okay? So if you just keep that in mind, we're going to work through that little model.

Steven:

Can I just clarify for people. We didn't actually explain what JEMS is. JEMS is your philosophy wrapped up in your business called Joanne Elphinston Movement Science isn't it? It's JEMS on the slide and people might be wondering why it's called that.

Joanne:

Very good point. So yes, JEMS is this whole philosophy and way of working with movement. So we've set the scene with this chappie and I've done a bit of sneaky

surveillance on him. So I've gone to YouTube and I've put his name in to see if I can find any video of him performing. And, sure enough, I found some things and I see that, first of all, let's look at his sitting posture and he's in a deep posterior tilt of his pelvis. And I'm looking at that and going, well, that can't be comfortable over the hours for that disc.

Steven:

When you said he was a percussionist, what sort of percussionist? Are we talking orchestral or are we talking a drummer in a band?

Joanne:

He's going to have drums around him. So I'm looking at that and I'm also looking at the fact that ,to be able to sustain that position, his poor hip flexors have to hang on like crazy. And so I'm pretty interested in that too. So I write him an email and I explain that I've seen a few things that perhaps we could examine,if you would be up for it. He said okay, we'll give it a go. So we agree to meet. And before that I ask him to have somebody video him playing, from the side, from the front and from the back, and send that to me before we have the evaluation. Now, even if we weren't in this particular time, I would still have a patient do that for me. And that's a huge advantage for you as a clinician because it gives you a little bit of time to have a look and form some thoughts. It's not so easy when you're there and you haven't got much time in the treatment session and they pull out the video and then you're under pressure.

Steven:

So you're seeing a video of him with a problem aren't you? You're not seeing the video of him without the problem. So does that influence how you're looking at this?

Joanne:

Well at the moment , all I can see is, I have pain when I do this. This is where we are with it. So, that's kind of good enough for now. So what did we see? Well again, we have a sagittal plane problem. He's actually sitting in a way that's sustained flexion in that lower lumbar spine. So that's something we need to query. I noticed from the back, he's actually orientating his weight onto his left side. So the left side of his pelvis has taken all the weight and if you think about that and combine it with the sagittal, he's now going to be going in to flexion but it's going to be an asymmetrical force. So I'm really interested to find out from him which side his back pain is on because I'm willing to bet that this is going to be a left sided problem.

Joanne:

So I've just set forward a little hypothesis here and we'll evaluate that hypothesis later And the last thing I noticed is that he only can really rotate one way. He needs to be able to rotate both ways when he's doing his thing, but he can only rotate one way. So I have three things based on just what I've seen that I'm now going to

evaluate, question him more about and see if we can change. So three clear things. We're going to start with number one. And that's that sagittal posture. So if you can imagine for a minute sitting there with his posterior tilt in his pelvis and the lumbar flexion. And I asked him a little bit about this because I'm fairly certain that the practitioners who have seen him before will have mentioned it and of course they have.

Joanne:

One of them has made a helpful suggestion that he sits on a higher seat, which he's done and it's helped a little bit, but it hasn't taken the problem away. So we obviously need something else. Now what often happens is we look at someone in this kind of posture, and we think, Oh, we need to give them a cue to come up. Now the problem for this young man is that he stays with his pelvis in posterior tilt and then extends his thoracic spine. And of course if you try doing that, you'll realize that very quickly you're going to get tired and you're going to start getting aching elsewhere. So he has no motivation to use those kinds of growing up cues. So we need to give him an idea of where to put his pelvis, so that his pelvis can actually carry his spine. So this is where we're going to break into a little bit of a practical exploration. And to do that, I'm going to zing out of the frame and put myself on this chair here. Alright, can you see the chair?

Joanne:

Alright, so, and we can do this together. So I've invited him to first of all, put his hands underneath and find a sitting bones, which I'm sure we've all done before and he's sitting in posterior tilt. And so I ask him whether he thinks he's actually sitting on his sitting bones or in front of them or behind them. And he tells me he thinks he's sitting right on top of them, which I can see he clearly isn't. And again, I'm sure you've all had that experience of the patient telling you something that clearly isn't the case, but it just tells us something about how they sense their body. Now, if I asked him to see if he could bring himself over in his sitting bones, all he's going to do is this. And leave his pelvis behind. And again, you can really see this issue of a blur about where's my lumbar spine, where's my pelvis? I need something else.

Joanne:

So I'm going to ask him to imagine that his sitting bones are like arrows. And I'd like to know, and he thinks his arrows are pointing to the floor and I think they're pointing forward. So what I'll do is I'm going to ask him to see if he could point his arrows back. And in doing that and being very focused on just the sitting bones, he gave me a change in his pelvic position. So his little arrows are pointing backwards, I said, fine, well can you point your arrows forwards? This is a very familiar place to be. And so after a while of pointing backwards, we both realize that he has some apprehension with pointing his arrows forward and that this causes a little bit of back pain. And I say, well that's a really great thing to find out. Now where would you put your arrows if you were to take yourself somewhere more comfortable, which meant that he actually found his way to somewhere new.

Joanne:

And this is so important because this is his discovery. And if we make it his discovery, then we keep reinforcing the self efficacy bubble in that holistic functional model. So it's, it's very, very important for us to have him own that because also it means that he will be able to find it for himself again. Now we want to get a little bit more information about this. So I've got my hand back underneath, but this time I'm going to find the front of the pelvis and I'll say it's a bony bit on the front here and some fingers on the thigh. And I just like to know, when you point arrows back, what happens to the space between these two, the fingers and the thumb? And he's able to tell me they come closer together and then they moved further apart. So we've made a connection now between, this is a pelvis to hip relationship as well as a lumbar spine to pelvis relationship.

Joanne:

So right now what's happening in his brain is there's an explosion going on as the brain starts to understand the distinction between these body parts, because before he just had one big blurry unit as far as the brain's concerned. However, he's going to say, well, this is all very well, but why am I going to want to play here? This is not natural for me. And so this means I need to nail it down to get him motivated. Now we had a ball, he had a ball which we can use, but you can do this on your own thighs if you don't have a ball. If there's a ball, I put it between his legs like this. But if you're just using your own thighs, I'm going to invite you just to find the place where your arrows are pointing to the floor.

Joanne:

Put your fingertips on your thighs, press down with your fingertips into your thighs, and then work out, well what do I sense happening in my body? Where do I feel it? So when I asked him, he said, I don't really feel anything. And most of us would think, Oh no, he doesn't feel something, but wait for it, because we're going to give him contrast. And this is part of the art of movement teaching. Contrast makes things obvious that weren't obvious before. So I'm going to let him point his little arrows forward, which is where he normally is, and I'm going to ask him to press again. And he immediately said, Oh, I feel like it's pushing the pressure right into this part of my spine. So we came back up onto arrows to the floor. We press down and then he tells me, kind of feels like I'm using all of myself.

Joanne:

And that's it. And then what does it feel like when you go back to your place? Oh, it feels weak and I feel it going into my back again. Right. So I said to him, I noticed when you were playing, sometimes you have to be really forceful with the pushing down. So how motivating would it be then to be in a place where that's not hurting your back? You could see the engagement. Suddenly it's like a light bulb went on. He got very interested because now it's relevant to him. I'm not just lying him down, making him do some trunk exercises or whatever, hoping that's something that's

going to make a difference. What's happened is through this process, he is working his core muscles. He's working them appropriately in an automatic way that is relevant to his function. So we've stitched together the local physical, the disc ,with the global physical, with the functional. Okay. So everyone's good so far.?

Steven:

Yeah. We had a question from Lee who asked, which way can this patient rotate,? You said he's put his weight on his left side, he's forward and he's posteriorly tilted his pelvis. Which way could he rotate?

Joanne:

It's coming next. So if we've sorted out the the sagittal part to start off with, and as I said, I've noticed that he's accustomed to having his body very much more on his left side and he's completely unaware of this. Now, if I just ask him to see if he can find the weight and make it equal with both sitting bones, he still can't detect that. So again, I don't keep beating a dead horse. I need to find a different way to do this. And most people will go straight to a lateral pelvic tilt, which if you've done that with this kind of patient, you'll find that you'll ask this, this is the side that they can usually go on,and then they'll do this. Okay, this is clearly not what we want. What we want is this ability here, but instead you're getting this and this.

Joanne:

So we have the leaning tower of PISA going on one way or the other. So instead we're going to do something called a sky reach. They start with the side which is going to be easy. So one of the things we say at JEMS all the time is set them up to succeed, make it easy. So what we're going to do is I'm going to invite him to come with the left hand up on to the left sitting bone, right? So I'm actually on the left sitting bone stretching up here. Now I'm going to go up onto the right. And what we saw with him was he got to get here and it was like his arm was on its own, didn't know what else to do with that. And then we repeated up.

Joanne:

Then he found -collapsed outside door. That's not it either, but you're never correcting, you're just saying, what do you notice about this? What do you notice about that? And then, I'm going to give him a different answer, which was going to be hold your hands on your ribcage, right here. When you get over there and you feel like you're going to fall over, you're going to take your ribs up away from your hips. Because his ribs are stuck down to his pelvis. Can't lenghthen here. So now we're up here and we can start to realize there was one side that was a lot easier than the other, but now I can feel both sitting bones, because to answer the question about the rotation, if I'm on my left side, and you can do this for yourselves, if you bring your weight just onto your left, you'll find it's very easy to rotate to the right, but very difficult to rotate to the left.

Joanne:

Yeah. And what we saw with him, he could rotate great over here. Really could. What he was doing was he's shunting his shoulder back to try and get around onto this side. Now we've started to work out this equalization from one side to the other and now we need to go back and see is it enough to treat the thoracic spine? So let's see what the motion is like. I tend to do a rotation with my hands here. It just stops people from doing this with the elbows. So I'm going to ask him, to see, what do we have in this direction? What do we have in this direction? Stuck. Okay, what am I going to do about that then? If you're in your clinic, you'd have all sorts of different possibilities. If they're at home, we need something else. So I taught him something called sternal search lights.

Joanne:

I'll be posting this on my Instagram and my Facebook, so you'll probably know it already, but for those of you who don't, you're going to put your hand on your sternum. It's like a Searchlight straight out in front of you. You're going to, this will just draw it in, let your shoulder blades come right around and push it out. And then we're going to go into an abbreviated version here. We're going back to the right and forward to the left. Yeah, and we can go back to the left and forward to the right. And what we can do is start to just find out where were the little stiffnesses ? You realize that you've got all these different angles. Because if you think about the number of joints involved between the ribcage and the sternum and the ribcage and thoracic spine. And once we've done that, we're going to just draw back in again.

Joanne:

We're going to point it to the floor. We are going to go along the floor. We're going to go up the wall, we're going go across the ceiling, we're going to go down, we're going to go across the floor. And then we're going to swish it around in all kinds of directions and find anything that feels like it needs a bit of a scratch from the inside. Yeah, it's like scratchy. So what we've given him now is a new understanding of where to be between his spine and his pelvis. We've given him some ways of understanding how to find both sides of the pelvis and also a way to address this rotation. And, and that's more than enough for somebody for a session. In fact, that's been massive. But what's happened as a result of it, at the end of that session, we've challenged those beliefs.

Joanne:

Okay. So the belief was you can't do anything for me. Someone's got to put their hands on me if they're going to be able to treat me or understand me. So clearly that's not the case. Self-Efficacy, we have preserved because we've taken him through a journey over the time of the treatment session and he's been making discoveries and everything he does is right. Yeah. On the way. It's another step. And that just keeps me just one step ahead saying, how could I make more awareness for the next step? He's definitely got a better understanding now because that

moment when he pushed down in a supported position, and it didn't hurt his back, was suddenly like, Oh, okay, so it does make a difference how I use myself. So we can come out of the whole patho-anatomic model and into the functional model.

Joanne:

And then that starts to work on an emotional level, just like, Oh, okay, so there is some hope here. There's something else other than just being medicalized. So we've looked at the local physical, the lumbar spine, we've looked at how the whole body impacts on that in terms of how he uses himself. We've matched it specifically to his functional tasks and his environment. So now when we look back at our initial discussion, we're talking about a subtle distinction between exercises and movement. Can you see that this is quite different to saying, Oh, he needs to stretch his hip flexors? You know, this is the normal stuff, stretch your hip flexors, do some core stability, do your posture, whatever that means. Patients often come to, Oh I've got to do my posture. What does that mean? You know, it's different depending on what your context is.

Joanne:

And so you've got a very clear way through. I left it with him because , well, you know, , we'll see how it goes and I'll leave it with you. Interestingly, he emailed me back a couple of weeks later asking for another appointment and then that appointment informs me that, actually, much better for the back and now he's interested in knowing can I help his hiking? Great. Okay. So I wanted to use him. I thought he was a good example. Using very basic principles, which are getting an axis to sit on. You can't rotate if you don't have an axis. And that we need to have some kind of equalization between our lateral sides in order to be able to make that possible. So simple, simple principles.

Steven:

Well, Claire has sent me an email saying she hopes everybody else was doing those exercises with us. Otherwise we might feel a bit foolish just being the only ones doing them. Actually it's really useful to go through them oneself and just feel, you know, what that patient might've experienced. But to drag you back to the initial part of what you said, you said you've done a video, you've asked the patient to take videos .Vispi's asked how you got those videos? Have you got some sort of portal that you put them through?

Joanne:

Yeah, it's an interesting one because obviously with GDPR coming on board, we've got all of that kind of thing. I'm currently trying to set up a secure holding zone. What he did actually is he just got clips on his phone and sent them to me with WhatsApp. And you know, I basically said, well as soon as I get them and I see them I'll delete them. So,they're his property, they stay his property. They're not actually living anywhere on my system so that I can at least comply with the GDPR.

Steven:

Well I just want to stop you there because GDPR is one of those things about which I feel very strongly because we're all convinced that we can't do anything thanks to the data protection act. Actually if your patient has sent you those videos, there's no problem with you having those videos because he's given you consent by sending them to you and as long as you don't start sharing them with other people and you've told him you not going to do that, it's okay to have these things. I was going to say you made a really valid point about reeducating the patient and overcoming their beliefs about what's going wrong. How important has it been to you to actually reeducate practitioners into realizing that we can do something other than face to face? We can actually achieve something beneficial through online consultations. Because at the beginning of this problem, lots of people were saying to us, I don't think there's any point in us doing that. We can't do anything valuable if we can't get our hands on patients.

Joanne:

Oh, do you know the feedback I'm getting from my community is actually quite the opposite. People are finding that initially they're a bit wobbly about it and people weren't too sure about it. But what we're finding is we have a couple of key roles here. The first of these is actually a lot of people become very, very anxious about what's happening to them. And so number one is what we're doing actually with people's autonomic nervous systems. And that's unbelievably important, especially with this remote business in terms of it's so easy to say something that can increase the worry. But it's also, if you're aware of yourself, you know. And I was saying to this patient the other day, and he was worrying about particular kind of injury that he has and we're going through various self self treatment techniques as well as some movement therapy and so forth,

Joanne:

And I was saying, isn't this amazing because you're learning how to treat yourself and you'll always know how to do this. So he brightened right up and relaxed and smiled and it kind of took the whole frown and the anxiety somewhere else. The feedback I'm getting is that it is actually making people really watch their cueing. And we teach a lot about cueing on the courses. And many of them have said, it's just so easy to just go back and say what we always say, it's a patter that we have, and now it's actually forcing us to slow down. And often they're finding that they're doing fewer things in the session, but going more deeply and actually the clients are enjoying it. The pressure's off. They're not rushing to the next appointment. They can actually take their time with them.

Joanne:

And it's making them start, the clinicians start, to become more creative with their language and also to come away from this idea that this is the cue, they do it right or they correct them. And that's it. Now we're like, well, have I really been clear? Am I

clear sufficiently about what I want to have happen? And so it's a very interesting time for self reflection for us as clinicians, but I found that the patients that I have seen on zoom have been very happy with what we've done. But it is a time for growth for us all as professionals. So just start to learn these skills a little bit more.

Steven:

In terms of the online consultation, Pauline's actually asked whether, as part of your consultation, you went through any neurological testing or assessed for neurological problems or any other red flags. I presume you did, but how effectively do you feel you can do that via telehealth?

Joanne:

Right. So I think with this particular patient, one thing I was fortunate about is that they had already had already had scans. They've already had various consultations. I've gone through some basics with them from a subjective point of view. I've gone through some basics with the movement. Obviously, I can't objectively test his sensation. I can't do a deep tendon reflexes, I can't do that kind of thing. But I certainly had more than enough to be able to move forward. And there was nothing in that subjective or the basic objective that I did that would have caused me concern. So the vast majority of patients will fall into that category. Of course you will have the ones, but I think the experienced clinician is pretty quick on being able to pick some of these red flags.

Joanne:

So I wouldn't use that as a reason not to be offering your services.

Steven:

Liz has asked us how you'd apply this principle to peripheral joints?

Joanne:

Oh gosh. It's all the same. So if you start with the question of why is this structure under pressure? And then we start to find out. Well, you always ask, when does it hurt? So now you're going to ask yourself, what is it about that movement? So is it, when I go upstairs, what is it about going upstairs? Is it going up or down? So let's say for argument's sake, going upstairs is a problem. What am I going to look at? Well, I'm going to say, listen, go grab a big book, put it on the floor, show me what that looks like. Now what do I see that's actually not happening? In this case, what we would call support in JEMS, which is the uni lateral acceptance of weight.

Joanne:

And if I see that my patient puts their foot on their book and I see this happen or the knee starts to move inwards, I know that they can't accept weight. And in fact if I just get them to just rock onto that leg a little bit. Yeah. So this is like a very small version of a static lunge. You can already start to see whether they're putting excessive

pressure. Basically what you're looking at is you're wanting to see, can this person actually manage the forces between the foot and the hip? Is it the pelvis that's actually going? Is it the knee that's going? What's actually happening there is amplifying forces in that area.

Joanne:

And so that would be then our next jump off point for how are we going to build that? This is kind of a long convoluted thing. It's almost a whole other subject with how we get into managing the foot to pelvis complex. But the very first place we're going to start is the foot and we use a technique called the listening foot, which is where we start to look at the tibio- femoral rotation and then how that affects how the foot is placed on the floor. Because we need that to be able to stimulate the reflexes that go up the leg to the pelvis. It's not just about glute strengthening. So this is another area where we get into giving exercises. So people get given lots of glute strengthening exercises and they move in exactly the same way.

Joanne:

Because it creates some potential, but the brain doesn't necessarily know what to do with that. And there's a massive difference between lying on your back doing a bilateral concentric contraction with your hip extensors and accepting weight unilaterally. If I imagine that I've got the whole vertical tibia here, my knee is still, and I can sense where my foot is on the floor and I'm going to just invite you to make your way across the foot towards the outer border, rocking onto the outer border of the heel as well. And then we're going to make our way back across the foot so you feel yourself rocking towards the middle part of the heel.

Joanne:

So it's a bit like a boat rocking and we're going to make our way across. So you're looking for the ease with which people can transfer their weight back and forth across the foot and the toes are staying relaxed on the floor. What we're doing here is creating a rotation at the tibio femoral joint. It's also what allows my foot to learn how to actually be on floor. And it may be that I take that learning and learn how to stack my body on that foot. So for example, one lady had a very poor outcome from ankle surgery and so I asked her to imagine she had a bowl inside of her ankle and she kept falling to the inside of the ball and we didn't want her on the outside of the ball.

Joanne:

We just wanted to see could she actually stack herself right on top of that ball. And then could she reach up? And initially she realized that whenever she came to that leg, she would slide off the inside of the ball instead of coming back on top of the ball and we learn to reach up again. This is called a stack and reach. You're going to stack yourself on your ankle. And you are going to transfer your weight so that the brain has to make some lightning fast calculations to work out, how do I start to

accept weight through that side of the pelvis. But I'm doing it at a level of load, which is not too high cause sometimes people want to jump into single leg squats and lots of like really dominantly single leg stuff. But for someone who is as fearful as that person was it's way too much load. So if we take the stack and reach and just to be there for her, that was a massive, massive challenge. But it's what started to get her hip abductors as well as her hip extensors fired up. Because if you take away the fear, then new motor solutions can come. If they've still got the fear, the new motor solutions don't come.

Steven:

I'm astonished how quickly the time has gone. Joanne, can I ask you one final question? Jill has asked how you would apply this to a degenerative cervical spine?

Joanne:

In two seconds? Okay. Well I had tossed up whether to use a neck patient today instead. If you're looking at this and thinking, I've got a degenerative cervical spine, when do I have the problem? The patient I've got in mind, I have problems with rotation. She doesn't realize that her whole body can rotate and that she needs an axis to rotate around. So again, it may be that you're cueing this posture from the top. So that's when we use our helium balloon imagery. But she might also need something from the pelvis to actually decrease the compression. For these people, often, if you get them a better central support, then the neck does very well. We see quite a few interesting to degenerative necks with all sorts of pathology, who do extremely well. Once you help them to find a central axis that is self supporting and effortless.

Joanne:

If they've got something like a ball at home, we'll often have them doing simple arm movements or simple bouncing movements because the degenerative neck starts off bouncing like this and then you point out, well why would you choose to do that? And they're like, Oh, right, okay. So what if you pop your balloon on your head and bounce and realize it's your hips doing it, not your neck. And it's like the light bulbs go on again. So it still comes back to the same process of what is putting that area under pressure and what kind of learnings can we can we have to help that nervous system make different choices instead of being stuck in the patho- anatomical model and just treating the sore bit and trying to strengthen it, well stretch it rather than helping someone to find a new way to use themselves.

Steven:

Joanne, thank you. We covered a lot in that 45 minutes there. Several people have asked about the title of the book, which is The Power and The Graceavailable through Handspring Publishing. And as you were going through that, I was thinking, yes, I've seen that in the book. I've seen the listening foot. You talk about the neck. In the book there's quite an extensive bit about forward neck posture and so on. And,

and to some extent the myth of the idea that there is a correct posture, which I hope that most practitioners are familiar with. And quite honestly, you can't see it on here, but it's just such a beautifully put together book. I mean, it's really laid out very, very well.

Steven:

I've told you that before and I'm not trying to blow smoke or anything, but it's a lovely book. So it's The Power and The Grace. And you've very generously said there can be a 15% discount for members of the Academy, which is very nice. And that discount code is on the members benefits page. And also we have been asked about your contact details. So it's not Joanne Elphinston, it's JEMS on Facebook, Instagram jemsjoanne, and www.jemsmovemen.com. So of course all of those will go up on the recordings page and hopefully there'll be a lot of interest in the book because it really is a great read actually and I'm not somebody who likes reading text books.

Joanne:

That's a really lovely feedback. It's doing exactly what I was hoping.

Steven:

Fantastic. And I should encourage people as well to watch the previous broadcast that we did with you, which is a 90 minute one, which we did in the studio. If they go onto the broadcast recordings page and they put your name in the search bar, it comes up. Because again, that was a really enjoyable one, and there was a lot more detail about stacking and force planes.

Joanne:

Yeah. I mean this is the thing that we just tried to teach, that we can understand movement using simple principles. It doesn't have to be too complicated. Yeah.

Steven:

I think what you've done today is you've blown away a few, not myths perhaps, but I mean the business that just strengthening glutes alone is something we should be trying to achieve because that in itself is not an objective is it? The business of core stability is great, but it needs to be functional, not just an aim in it's own right. And that whole business of making an exercise functional in turning it into movementsort of reaching, is actually quite a useful exercise because people do need to reach rather than the move. So some great stuff there. There's lots more in the book and I hope you get back to doing your practical courses, your hands on courses, soon as well, because I'm sure there'd be loads of people interested in those. That's all we've got time for, thank you.