# The Compliance Component in Health - Ref 275

*with Claire Minshull & Serena Simmons*

7th December 2022

# 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 Bruce**
Well, here we are just a couple of weeks to Christmas and our penultimate show of the year. Welcome, ho ho ho and all that. Actually, for most of today, I have been starring as Father Christmas in a video that we're making, and I tell you what, I'm struck by the fact not that Santa gets around all those houses in one night, but by how he puts up with that bloody suit and beard because it's really hot and really itchy. Anyway, I think we've saved two of our best shows for the end of the year. But I guess that's for you to judge, of course. The first of those shows is tonight. And sitting next to me here in the studio I have Claire Minshull and Serena Simmons. Claire, you might remember, she's a former British powerlifting champion. Actually, I promoted her on the last show to world champion, but she corrected me. It actually makes no difference at all because she can still beat me at arm wrestling. But she did suffer a horrible back injury years ago and she assures me this was nothing to do with lifting ridiculously heavy weights. But since then, she's become a real expert, I mean, a seriously important expert in rehabilitation, in particular strength and conditioning. If you care to look up her PhD, it's in something again, ridiculously complicated neuromuscular performance and exercise stress associated with stabilisation of the synovial joints. Trips off the tongue, doesn't it? But the bottom line is she really knows her stuff and she's great fun to talk to. So Claire, welcome back to the studio. Also joining us this evening is Serena Simmons. Now Serena's experience is in psychology. She has been in this line of business for over 25 years, both as a lecturer and as a practitioner. In her academic life she specialises in serial murder, but she's here this evening to talk about behaviour change and compliance. What's more, she's got a small white fluffy dog called Barney, so she must be a nice person. Serena, it's great that you can come and join us as well.

**Serena Simmons**
Thank you, Steven.

**Steven Bruce**
Now the interesting thing is you guys have set up a project between, you haven't, you called Joint...

**Claire Minshull**
Joint Aproach, yeah.

**Steven Bruce**
So the reason you're in together is because we're all interested in getting people to do their exercises and stuff like that. And one of the challenges is in the psychological aspects of it. So tell me how it works for you two?

**Claire Minshull**
Yeah, I mean, that's ultimately it, isn't it? Whilst I'd like to think that it's all down to me and people getting better through their amazing exercise prescriptions.

**Steven Bruce**
Sometimes I get the impression in the NHS that you measure the success by the fact that they took their exercise sheet from you and went away.

**Claire Minshull**
Oh don't get me started on exercise sheets. But yeah, even if that exercise sheet is the best exercise sheet produced ever, if people literally go away and put it in the drawer, put it in the bin, it's absolutely no use whatsoever. So the whole Joint Approach ethos, so it's myself and Serena and co-director, Mike Brownlow, it's a multidisciplinary team, we treat people as a whole, a whole person.

**Steven Bruce**
What's Mike's specialisation?

**Claire Minshull**
He's a physiotherapist by background, so he's the clinical arm, if you like, or leg, to the business and the programme.

**Steven Bruce**
Does Barney have a role?

**Serena Simmons**
Mascot.

**Claire Minshull**
Therapy dog.

**Steven Bruce**
This is the first time we've had a dog starring on the show. We haven't miked him up, unfortunately.

**Claire Minshull**
But yeah, that's the whole point. The psychological component of a person, there are a whole and complete being and they come with their own barriers and motivations and preconceived ideas. And these individuals who we're dealing with are often, have often been, on the waiting list for a very long time. So there's a lot of things we need to unpick as well as support them. So psychology has to come first and foremost, else a lot of what we would do thereafter is probably redundant.

**Steven Bruce**
I remember, people will be bored because I say this on so many of our broadcasts and elsewhere, but I remember going to meetings at the NHS, where they had an approach to deal with acute problems and an approach for chronic problems. And then they admitted that they never deal with any acute problems, because the waiting list, it's either a watchful wait for 12 weeks, or the now it's just a waiting list. So they never see acute problems. So where does the psychology start? What do you do that's so clever that makes people do what we want them to do?

**Serena Simmons**
Well it's not being a clairvoyant, which is what some people think, I don't know what people are thinking. But it's kind of, following on what Claire has said, illustrating really nicely that everything begins with how we think about something. So if I were to ask you to undertake something in your own life, you would

think about it for yourself and think about how it fits in for you in your life. So when you're asking someone to do something, possibly incredibly novel, like exercise, so say for example, on the Joint Approach programme, we've had people in their 60s, 70s, 80s, who maybe have never exercised before, and we're asking them to comply to a programme of exercise, that's a really big change in someone's life. So just first of all, tackling the thought processes that they might have around that in itself is the starting point. And we can support people with that, kind of carry them on the journey, giving them tools to help them adhere, which is ultimately what they need to do.

**Steven Bruce**
So what are the tools? The people watching this evening are going to say, well, that's all very well, but what do I actually physically do in my clinic that's going to help get these patients to do what they need to do to get better? I don't expect you to give us a psychotherapy degree all in a 90 minute broadcast here. But what are the key things we need to bear in mind?

**Serena Simmons**
So there are some really simple things that I think everyone can do. And when I work with people, and I work with a lot of practitioners, so physios, osteos, surgeons and doctors as well, where I'm looking at helping them implement the psychology. And actually, just as a side note, what I noticed is that lots of people that I've spoken to that do do this work, they haven't had any psychology input in their training, which astounds me. So I don't know if anyone watching tonight can relate to that.

**Steven Bruce**
Of course they will. Everyone will, yeah. But no, we don't get any of that. Yes, we get you give people rehabilitation programmes, we called it that when I went through my training, but frankly, some people give you a handful of exercises and say, well, these are the sorts of things you might want to tell them to do. Ten repetitions three times, three times a week. The stuff that we've talked about before, Claire. Yeah, we get nothing, I think, which is focused on the psychology of compliance.

**Serena Simmons**
Which blows my tiny brain because it's a whole and complete human that we're dealing with. And ultimately, you have to impact how they think about something before they will engage with it. And often that's difficult, because there's an assumption sometimes, not always on the part of the practitioner, obviously, but the person that maybe is dealing with them, that this is going to benefit them so of course they're going to engage with it. Why wouldn't you do something that's going to help you? But actually when you unpick the psychology just in terms of how someone might think about that, something that is different, so if someone has an exercise, it can bring up a lot of fear. And ultimately, you're dealing with behavioural change, which is quite complex at times. But there are some really simple things we can do. And one is just to get them engaging in conversation with you about some of the issues that they see around their engagement. And one of the key things I always say that you can do as an initial, just as a starting point, is just to ask somebody why they want to engage with what you're asking them to engage with, which isn't a trick question.

**Claire Minshull**
It goes further than I've been told to come here, right? That's the really important bit.

**Steven Bruce**
But surely for most people, the answer is going to be, well, I've got a pain, I don't want a pain.

**Serena Simmons**
Right, so that's when we want to go beyond that surface level answer, we don't want answers like because of pain, well, we want to hear their pain story, it's very important that someone feels heard. I think we've all been to a doctor or even called a call centre when you don't feel heard and it's an awful feeling.

**Steven Bruce**
You don't feel looked at either, because of course, they're tapping away at their computer while you're talking and of course, they are listening, taking it all in, but you don't feel engaged with, do you?

**Serena Simmons**
And actually, that's another interesting point. So when I teach people, we look at the whole psychology around how people process information. So we know from the research that someone tapping away and not looking at you has an impact on the patient, because we know from the research that that gives the impression that you're not listening. And often we find that then people disengage, they don't feel like you're someone that they can trust. And that means that if someone doesn't trust you, ultimately, in that interaction, they won't tell you the truth.

**Steven Bruce**
Interesting, I just thought they wouldn't tell you the whole truth. Do you mean they will tell you something, which is actually not true?

**Serena Simmons**
Quite possibly because they fall into those maladaptive patterns that they have. So we won't go and look start looking at parents. But you might slip into that parental old pattern. So I'll just tell them what they want to hear, get them off my back, kind of just to stop this from happening, as well as what you've alluded to there, which is they just may not tell you everything. And actually, we need to know everything when we're working with a patient.

**Steven Bruce**
Just out of curiosity then, tapping away on the keyboard, as my doctor certainly does whenever I go to see them, and as a practitioner, I understand why they're doing it, that has an effect on the patient's acceptance of you as a therapist, what about if you're writing on a piece of paper? Because that's the alternative, you've got to write down what they say. If you're having to do this while they're talking is that the same, does that have the same effect or does that look more authentic?

**Serena Simmons**
So I think it's just about communication. I think certainly, again, we've all been in that situation where you walk into a doctor's surgery, and they're already doing something, and they're not engaging with you, that just sets someone off on the wrong foot. Because again, we know from the research, there's some fascinating research out there around things like the subtleties of your behaviour. So we know again,

from the research that having an open body language, being open in posture, being welcoming, giving eye contact, really, really simple things but really important. Also, interestingly, we know that patients are watching how you interact with your team. So if they see that you're actually not communicating very nicely, or think that you're aggressive, they take that on board, and it actually changes their interaction with you as well. So I'm not saying, obviously, that once you're in consultation that you can't write, because obviously, I would need to do that even in my own consultations. But again, it's just about communicating what you're doing, while ensuring someone feels heard, that they feel really listened to. And there's that active listening, which we can't always do when we're writing or typing. So again, if I was in consultation, and certainly what I teach practitioners to do, is to at all times where you can present an open body language, with active listening, and that looks like often repeating back phrases that someone has said, clarifying that they're hearing the right thing, and then it's almost a permission to write, do you mind, I'm just going to have to write something because I don't want to forget what you're saying. That makes them feel heard. It makes them feel important. Versus just keep chatting, I'm not gonna tell you what I'm doing, I'm just gonna sit here typing, it can feel like you're disengaging, and they may lose that kind of trust.

**Steven Bruce**
There was a suggestion some time ago, and it was from a GP, that a lot of GPs are told not to make eye contact because it extends the length of the appointment, and they've only got eight minutes. And of course, I'm not one of those people who believes that GPs don't care about their patients, but they do care about the subsequent ones and not making them wait two hours for their appointments and so on. And it's not easy for them is it? It's a lot easier for certainly osteopaths and chiropractors, most of us have a lot more time with our patients. But I did notice that actually when we sat down here, how Serena has turned herself. You haven't, communication's crap here. You've turned yourself and I'm getting loads of eye contact. What about, treat this question as you will, where your eyes go? I don't where they're supposed to go when you're telling fibs, is it up to the left or down to the right or something?

**Serena Simmons**
There's very mixed research on that actually.

**Steven Bruce**
I thought it sounded like a social media nonsense.

**Serena Simmons**
it is a little bit. I mean, there's mixed research. Obviously, you can find research to suggest that we do look in particular places when we're thinking particular things. I think there is definitely some research to back up the fact that often we look away when we're searching for information. Which I think we can all relate to, because if you think about if I ask you a question, I wanted to ask you something that was non-invasive, and I couldn't think of something.

**Steven Bruce**
And if you keep staring at me, I'm gonna be quite intimidated as well, aren't I?

**Serena Simmons**
It's hard, it's especially hard to retrieve information when you're looking at a human face, ecause the tendency is to emotionally interact with that. So we do tend to look away to retrieve information. But I think the myth is around particular directions for particular types of information.

**Steven Bruce**
I'm gonna write this down, Serena, because I'm going to tell my Claire about this. She keeps telling me not to keep looking up at an angle when I'm on camera thinking about something, because this doesn't look good on telly, but I can't just stare at the cameras.

**Serena Simmons**
Yes, it's hard to isn't it.

**Claire Minshull**
I definitely do that. I catch myself kind of searching while I'm thinking, looking away.

**Steven Bruce**
So you do a lot of rehab? How does the joint approach work? I mean, you say to people, you've got to go and lift ridiculously heavy weights to get yourself better.

**Claire Minshull**
So it's, as I said before, it's a multidisciplinary approach, a joint approach, to looking after people with principally osteoarthritic knee pain. And the clinician refers into the programme, so that they're safe to exercise, that type of thing. And then we have kind of three main components. And it's all online and it's very, very simply designed. A lot of work, you know the work that goes into producing things, a lot of work has been put in to make it as simple as possible. So nothing's more than two clicks away, for example, or in the app two kind of presses away. We're dealing with people that are possibly very literate, some are very literate, but some less than others. And they have a programme of exercise, which is obviously strength focused. So that's high intensity efforts and we coach people how to do that, how to symptom modify. So I know we've spoken before about okay, that's well and good, lifting heavy or going to a five rep max, but I've got a sore knee or clinical restrictions, I'm not allowed to bend my knee beyond whatever. So we teach patients how to symptom modify, so modify the exercise before they would reduce the colour band.

**Steven Bruce**
So you said this is online. So some of this has got to be live, if not all of it.

**Claire Minshull**
So yeah, we've designed it such to be appealing to...

**Steven Bruce**
You're looking up.

**Claire Minshull**
Yeah, I'm looking up, what's the word? We designed it to be appealing to what we think is a general population base. So for me, for example, I like to train and exercise on my own, I don't like to go to classes. However, I'm quite aware there's a cohort of people that really like that supportive environment and that cohort. So there's two options and you can mix and match as well. So you've got pre-recorded videos which take people through the suite of exercises, or you can join a live exercise class. And we've just completed a pilot service evaluation in NHS Wales, and the research that Serena led so we did a qualitative piece of research, quite robust piece of research through interviews, questionnaires and focus groups, and also a quantitative as well as we've got the objective outcomes. And what came through from from your stream of research, or one of the things, is that the individuals that have joined the group absolutely love the group interaction. And as the exercise programme and process continued, so it's a 12 week programme, people got a lot out of interacting with each other as well as interacting with the practitioner. They were exchanging internet advice and talking about the different surgeons and the like. So yeah, there's two options for exercise. And that progresses over the 12 weeks, as you would expect. And then there's kind of the psychological component, which we've called mindset because there's some times different connotations. If you're seeing a psychologist it may or may not be a good thing to some people. So we've called it mindset. And Serena's designed a suite of progressive exercises and reflections and interventions for individuals to progress through from starting something that might be brand new to leaving a programme, to instil that consistent behaviour change. And then there's a nutritional guidance in there as well. So the nutritional component of just assisting people with food choices And importantly, we've got a whole block on what osteoarthritis is and what pain is and what there they aren't as well. So what came through strongly through the service evaluation was that that was really important. So we went away and re-recorded a lot more on that. So we've worked really hard to deliver patients the information that they want, the scientific information that they want, not patronising them through stick figures and cartoon animations, properly designed, but kind of put into more lay language. Yeah. So those are the key components to it.

**Steven Bruce**
One of the things that struck me right at the start of what you were saying here is, and going back to those exercise sheets that people hand out, is that there's a sort of an assumption in that approach that all patients are the same. And of course, they're not. And I guess this is really one for you, I mean, do you divide them into specific categories or is there a spectrum and you just say...? And I don't mean that in terms of autism.

**Serena Simmons**
Yeah, I think the plan there is to touch all of those learning styles and know that something will stick and also taking kind of a multi-pronged approach as wel, in terms of we do provide visual aids, if you like, there's videos for people to watch. Obviously, there's a kinesthetic element, because they're having to move their body.

**Claire Minshull**
They get booklets as well.

**Serena Simmons**
And they get booklets. So funny about the handouts, people like a handout, I wouldn't stop giving them something in physical form. Because they certainly got a lovely booklet, designed by someone on the programme. And everyone loves to have that. And also, one of the things that we did get people to do was to track their progress, obviously, as well. In terms of the psychology there, obviously, people who are visual then will see their progress, as well and that's also really, really important for that kind of process in that brain to get the feedback that you're moving in the right direction. So, we tried to kind of tackle all of those ways of learning so that people got the most out of it.

**Steven Bruce**
You intrigued me with the handouts business, because of course, we do run quite a few courses in the studio here and online and things like that. And even when I know that the slides are largely decorative, people still like to get six slides to a page showing them exactly what was displayed on screen.

**Claire Minshull**
It's a security blanket, isn't it?

**Steven Bruce**
That's my question, how important is it that they get the six slides to a page with all the illustrative graphics, rather than two sheets of bullet pointed stuff, which brings up the text that was on those slides, which is the important stuff? Or does it not really matter at all, as long as they get something in their hands, they feel that it was a good course or a good programme, a good bit of therapy.

**Serena Simmons**
So I would ask someone, because it will be different. So there'll be someone who might prefer it as bullet points, to be honest. I think when you go and do a course, there's just the basic psychology around thinking that there's more value in something if you get something in your hand, as well. But certainly for someone like me, who is very visual, sorry I keep tapping my mic, who's very visual, I wouldn't want bullet points, the spacing of something is very important to me. To be able to write notes and kind of be a bit more creative and go off piste on a piece of paper. I'm also someone who would want to print something off, and I know that there are other people who have a similar learning style. So yeah, I think, again, if you can take a multi-pronged approach when you're kind of putting anything together in that capacity.

**Steven Bruce**
It's difficult as a therapist, though, isn't it? Because in my clinic, in your environment, you can't say, or can you, I've got 16 different types of thing that I give to a patient depending on what sort of person I've assessed them to be.

**Claire Minshull**
Yeah, we've worked hard to try and identify, I suppose, the different types of requirements of that particular age group with that particular set of symptoms and diagnosis. And also I think, as well, when they go to the clinician to be referred on, to come away with something, I think adds a level of endorsement and importance. And as Serena said, within that physical booklet, they are able to engage more with the programme and if they work better on a kind of printed out paper versus online, then we're

able to accommodate that and they're able to do that. Versus if you've got it and you don't particularly use it all that much at, that's alright. I mean, yeah, it's paper that possibly we didn't want to use and resource that we didn't want to use, but the bigger win is, okay, they feel like it's important, they go away with that, plus some heavy-duty resistance bands. This is a physical programme, but it's in an online environment. But if they don't use the booklet so much, everything that they need is online, which might be their preferred way of engaging.

**Steven Bruce**
Yeah, interesting. In my clinic we use a programme called Rehab My Patient, which I'm sure you're familiar with, and there are lots of have others around. We had Tim Allerdyce, who runs it, on the show and are members have a discount with Rehab My Patient. And I don't know if any of the others are as good, but it's good enough for our patients. But what you're suggesting is that actually for some of them, we should print this stuff out, as well as say, go to Rehab My Patient, log in and do the exercises as demonstrated there?

**Claire Minshull**
Potentially. I'm not saying it's absolutely necessary for everybody, but certainly in our cohort. Because I think that these particular individuals, this particular one we've done the service evaluation on, they are the end state, they are next in line for surgery, right. So they have some possibly some different expectations, some different ideas, they've been through a multitude of clinical consultations, inverted commas have "failed" physio, this is the only treatment option that's left for them, if they don't get the knee replacement and many of them still haven't got their knee replacement, because of the huge waiting lists and delays. I think it just adds a level of an endorsement that this is physically something that you can do to help yourself. Here's the infrastructure, that is all online, however it's physically here. And I admit we've not done the research into evaluating the components, or formal research, I know you've done interviews with a lot of them who said that they really liked the booklet, but as a proportion, I couldn't tell you.

**Steven Bruce**
Well, Claire, there's a limit to the amount of research you can carry out. You've got other things to do.

**Claire Minshull**
We've got four or five academic papers, I think, out of this.

**Serena Simmons**
I've got four, at least, on my own.

**Steven Bruce**
You've got a whole load of research papers to your name when I looked through them. What's the bigger challenge then? Because I suspect that although we practitioners like to think about the biopsychosocial model, actually, we probably a lot of us pay lip service to the psycho bit. So convincing therapists, whether they're strength and conditioning coaches, whether they're osteopaths or Pilates instructors, or whatever, or the patients that the psychological aspect's important? Because if I said to a patient, look, there's a

two-pronged approach, you've got to listen to Serena and follow this course and do this psychological stuff. They might think I was saying they were either barking mad or it's all in their head.

**Claire Minshull**
They've got that in their consultations, right?

**Serena Simmons**
I do. And I don't think it has to be separated in that manner, because it is, again, holistic. So I think the way to deliver this is in a holistic way. It's integrating the psychology into practice. Which is again, why go back to what I said before, in that the fact that this isn't a part of structured training for people who are doing this work blows my mind, because everything begins with how we think. You're dealing with a human who is a whole and complete individual with a whole life and a certain way of thinking and therefore behaving. So first of all, we need to be able to work with their thought processes, in order to be able to help them, which might be then affecting their behaviour, which might be adherence to exercise, coming for more treatment, engaging in rehabilitation, whatever it might be, we need to first understand someone's thinking and be able to have a set of tools or interventions that we can use to help someone. So I wouldn't ever separate it. Unless you're deliberately signposting someone for extra help for something that you identify as an issue. So something I do certainly when I train practitioners is to talk about signposting. I.e. there might be a time at which this person needs to seek psychological input that is separate from what you're trying to do. And that might be because someone is stuck, someone's not engaging, someone's stuck on their story.

**Steven Bruce**
Stuck on their story?

**Serena Simmons**
Stuck on their story. So for example, you might have someone...

**Claire Minshull**
The "Yes, buts."

**Serena Simmons**
I call them the "yes, but patients", yes, Claire's heard me talk about this lots before. You have a solution to their issue. You need them to engage in this programme of rehabilitation. And every time you suggest something they say, "Yes, but." "Yes, but you don't understand this is really painful." "Yes, but you don't understand that I can't fit it into my schedule, because..." So there are lots of tools that we can look at that I help practitioners implement to get someone past the "yes, but" and you will have success with a lot of those. But there are some that want to stay there. So there's also power in knowing, as a practitioner, when you are unable to help someone at which point you should cease, if you possibly can, interaction with them until they've sought extra help for that issue. They're often also the people that seek multiple opinions from multiple practitioners. So you will realise that you're one of many people that they've seen. And in actual fact, if you're not buying into their story, they may well just find someone that does or keep seeking out further audiences. Does that make sense?

**Steven Bruce**
It does actually, I'm thinking of one particular patient at the moment. Not one of mine, but somebody who I've spoken to, a consultant who this patient sees, and the consultant has admitted, I'm deliberately disguising what I'm saying here, just in case the video ever gets out, I don't want to give away any patient confidentiality details. And the consultant has said that I've had to resign myself to the fact that I'm going to have to spend an hour with this patient every six months and listen to him, because he won't let me get a word in edgewise. And that's a difficult patient to deal with. The consultant seems to have coped with it.

**Serena Simmons**
That's one way of coping. I'm sure that that person, I would almost put my mortgage on it, but they are also holding court in many other arenas in their life, there'll be many people that are listening to them in that capacity. I wouldn't say that surgeon is necessarily helping at that point, although it might be the path of least resistance for them to say, well, I'll deal with this for an hour every six months. But there might be some strategies that they could use as well.

**Steven Bruce**
Okay, let's go down there. What sort of strategies would you suggest?

**Serena Simmons**
Well, there's lots of strategies that I would take for motivational interviewing. So there's a very clever way that you can craft a conversation whereby someone, the patient themselves, you're encouraging them to come up with the answers. That's a skill in itself, to kind of learn the skills around motivational interviewing.

**Claire Minshull**
So like, if somebody says, I can't do this, because I just have no time.

**Serena Simmons**
So what I would do is get them to elaborate on where they feel they don't have the time, be able to summarise some of those key points that they've made around their lack of time, and then repeat it back to them, getting them to either clarify that or find a different path to explain it. So it's getting them to problem solve the problems that they're presenting. Often you reach a stalemate, but then the job of the practitioner is to call that and to be open and say that they see the issue.

**Claire Minshull**
So if I keep saying," I can't do this, because I've just got such a busy life", you'd be going, okay, so how is it so busy? And then I'd elicit a series of responses and you could clearly see potentially a window where I could fit this in, but there'd be an excuse in those individuals that are resistant to it, the yes buts, whereby it would never work, because every other Saturday, I've got to reshoe my unicorn or whatever.

**Serena Simmons**
Well, yes. And what you would do in that situation that, see what you're doing when you're doing this is you're not only getting them to problem solve something, but you change how someone processes

information when you repeat something back to them. So it's a very clever little trick in psychology, really. So you're maybe so stuck in your story that often times some of it is just second nature to you.

**Steven Bruce**
So Serena, I have got a really painful arthritic knee.

**Serena Simmons**
Very sorry to hear that, Steven.

**Steven Bruce**
Thank you, that's very kind of you to be sorry. Has that changed my processing of the problem?

**Serena Simmons**
There'd be more of a story around that. I'd want to know the story around your painful knee. But going back to the point that you've made there, someone often ends up having to say, or you are able to repeat back to them. So what you're saying is, they've literally just said it, that you that you refuse to be able to fit this into your schedule, because they actually ended up saying that to you. So then they have to hear back their own words. So we actually had this as an example on the joint approach programme. Someone in the monitoring group, so someone who chose to not engage with the programme, I was interviewing them for the research and towards the end of the conversation, and I've been given permission by Claire, at that point, to be able to offer the programme to those because we're at the end of the programme. So although they'd, for the duration, been in the monitoring group, essentially the control if you like, now, the trial has ended and I could for ethical reasons offer them the programme.

**Claire Minshull**
The key thing there was, I think if it's the same individual that I'm thinking of, "I would have loved to have done this, it just wasn't the right time for me. I really love exercising. But this just wasn't the right time for me." And then you said...

**Serena Simmons**
In the conversation, I challenged them on this and help them problem solve how they could fit it in and then I said, well, luckily for you, we can offer you the programme, you can actually do it. Well, we got into that little dialogue around, oh no, they were they were coming up with excuse after excuse. I said, what I'm hearing is, correct me if I'm wrong, what you've just said is, I don't want to fit this in. And she burst out laughing and she went, you've caught me out, I don't, I don't want to do it. Even though for the duration, the last hour in the interview, she was telling me that she couldn't do it because she was time poor. So when it came to actually challenging her, we found pockets of time, but she told me, no, you've found me out. I don't want to do it. And so it's again, sometimes we don't know what we don't know about ourselves because we are stuck in a story.

**Steven Bruce**
How did it go with that particular patient? What's the answer then, so, okay, fine, you don't want to do the programme?

**Serena Simmons**
Well, you can't force someone to do it. We've all been in a situation where, we want someone to change, but really, they have to make the decision to want to change. It has to come from them.

**Claire Minshull**
This solution, or any solution, is not going to be right for all people at all times. And it's silly to think, like we were saying before about individualised care or treating people as an individual, we're all very, very different. And some people, if you think about continuum of behaviour change, will have absolutely no propensity to change behaviour whatsoever. The solution sits with a surgeon who's going to put my new knee in, and that's it, it's your responsibility to get me right, and the kind of dissolving responsibility. The majority of patients, certainly in our trial, are challenged, but they're looking for the support and help they're really looking for that. I feel challenged, I've got a sore knee, is there anything I can do? And when you give them the solutions, then they're like, okay, and they'll engage with that, but some people will never change.

**Serena Simmons**
Yeah, I think we have to be mindful that that's a very small portion, really, that don't want to change. Some people do want to change, but they just struggle. We've all been in situations, we all have things in our own lives that we want to change, we know the struggle, the battle, to change that behaviour. So some people are actively looking for help, and they want you to support them in that journey, they're looking for strategies. And certainly on the programme, we found that people, those that really engaged well and have done incredibly well on the programme, were searching for answers, were searching for help. Lots of them were being very proactive, looking for physio, looking for things they could do to help themselves. So they're really kind of prime examples of people that want that help.

**Steven Bruce**
Is there any milage at all with those people who come in looking for the magic pill or the magic operation to fix them? Is there any scope to change their mind ever?

**Serena Simmons**
I think, yes, there is. Again, with the strategies that we use, which are often things like just really, really deep active listening and communication, really knowing someone's why, helping them develop really, really good habits, strategies around kind of nudging them, nudge theory, nudging them and helping them make decisions, motivational interviewing. There's lots of things we can do to help somebody. We haven't got time to go into all of those strategies, obviously. But one of the other things is, you as a practitioner can be incredibly inspiring. And that can encourage people to change. So often, one of the things I cover when I teach this a lot is motivation. Often we think motivation is the key. But the example I often give is, I don't know if you can think back to a teacher that you found inspiring. Often those teachers that were inspiring, you may not have liked the subject, but gosh, you wanted to do well in it. You wanted to do it, didn't you? You wanted to engage, because they made it so fun and so interesting. So often when I train, one of the things I end up doing in kind of the latter part of any training is looking at you as the practitioner, looking at what you bring to the table because your energy, your enthusiasm, your desire to help rubs off. And people feel energised by that support, energised by your passion. You exude it when you love something, and people can be really inspired by that. So yes, you can shift people's thinking, absolutely.

**Steven Bruce**
Again, coming back to the psychological aspect of therapy, as opposed to being patient, of delivering therapy. Many practitioners worry that they don't have the answer, that what they're doing might not work, call it impostor syndrome, or whatever you want to call it. Is there a way that you would recommend they overcome their own self doubt?

**Serena Simmons**
Impostor syndrome is a really juicy topic. In fact I want to put a training on that in the new year because everyone asks me about this one, I find that fascinating. Imposter syndrome is fear. Fear that we're not good enough, it doesn't necessarily mean that we don't have the skills but we feel a sense of lack. It's fascinating to dig down deep on this with particular people because it always goes back to your interactions with your parents growing up and the messages you took from that and why you feel the need to maybe play small, be a small puppy. I think there's nothing wrong, there's no shame in not knowing something or not knowing the answers. And actually, you can empower people by co-creating a pathway of care, to say, this is my area of expertise, this is what I know, but you are an expert in your own health, only you know your body. You know what, I don't know the answer to that, that's fascinating. I'm really looking forward to actually doing a bit of research when I go home. And kind of co-creating that pathway of care together. I talk about integrated practitioners, actually. So I, when I work with practitioners, what I am actually very focused on is, you do the work for you first, and then you translate it to your patients. And by that, I mean, when I train, get used to all the exercises for yourself on yourself, so that you know, obviously, how it feels, what you're looking at, how you would have those conversations, thought processes and reflection, because it's really important that we integrate that before we try and do it with other people. Like you would when you're working with someone physically, it's the same psychologically.

**Claire Minshull**
I know, having been a patient quite a few times more than I actually would have desired for empathetic reasons, I know when I've been to see some exceptionally good people, and I'm very, very privileged to have been recipient of tremendous care, I know that not everybody has the answers. And I feel from a patient perspective, that honesty that they don't know, but they're gonna go away and find out or they're going to call a colleague, just looking purely at a patient perspective, it makes you feel important, it makes you feel that you trust them even more, you're not being fobbed off. Not that I'd ever think this or anybody that's that's kind of treated me but admitting that you don't know absolutely everything, we're human, we don't know absolutely everything. But actually, I'm comfortable in my skill set, I'm comfortable with the colleagues that I've got, and I can go away and find that out. I think it's actually reassuring and instils another level of trust in the patient.

**Serena Simmons**
It's a little bit different to, going back to what was said at the start, I wouldn't want someone to start Googling something in front of me. I have had a doctor do that, I thought, good lord, I could do this at home. And in fact, I did do this at home before I got here. So no, I'm not suggesting that you look really inept. But I think anyone just being really confident in themselves and not feeling the imposter, is comfortable to say, this is what I know and actually, that's really interesting. I'm gonna want to be a little

bit more sure about that. Find out some information, like you said, ask a colleague. And that does, I think, create another level of trust. And you shouldn't know everything.

**Steven Bruce**
I was beginning to worry that one of several things was happening in this conversation. The nice one is that we're all so fascinating that no one's asking questions, or second, that my technology has failed. But Kim has asked a question. Please ask lots and lots of questions. And don't forget the button under the screen on the website, if you're watching through the website, you can come in live into the room. We've not had anybody take us up on the video option yet. And we'd really love that to happen. But anyway, back to Kim's question. Kim says, fear for the patient is a big obstacle. If you can help your patient by showing confidence and empathy, it can change their approach. And I think my first assumption was correct, because Kim says your speakers are really, really good. I should include you in that as well, Barney.

**Serena Simmons**
Definitely, Barney's the best. No, I agree with Kim wholeheartedly. And again, I think we can all feel, well, we've all been a patient ourselves, haven't we at some stage, we've all sat in that chair being really unsure. I think it's a really important reminder to think about what that feels like. And those people that have that empathy and can do that, as I think Kim's alluding to, are going to be better.

**Steven Bruce**
If I put this in it affects me in treating patients. Yes, I suffer from that sort of imposter syndrome where I think, oh my god, I won't have the right answer for whatever this next problem is or I'll misdiagnose it. Will I get it right? Will I get it wrong? But also I'm very conscious that unlike going to see my doctor, this patient's giving me money for my opinion, and they're going to expect something for that and not having the answer if they've given me money seems like failure.

**Serena Simmons**
Are you asking a question?

**Steven Bruce**
I am, you're gonna reflect it back on me and tell me, you think you're a failure, Steven?

**Claire Minshull**
Where does that come from, Steven?

**Serena Simmons**
What does feeling a failure look like and feel like to you, Steven? Do you want to talk about it?

**Serena Simmons**
Where's that spotlight? It comes back to the same conversation, you can only do what you can do, and you will still give value in that consultation. And you give value in other ways, it's not just coming up with the answer, again.

**Steven Bruce**
Oh my god!

**Claire Minshull**
I think as well, speaking from both the recipient of care and also being a practitioner and seeing others who have that fear as well, I think the commonality between all of those individuals, is generally that you can back yourself to be good, or at least back yourself. Because if you've got that fear about not being good enough, or you're not offering the value, or whatever that fear is, you will, at some stage, go and try find out or find out somebody that could. And I think that personality trait means that you've probably done a hell of a lot, before you've seen that patient in your training, in your practice, that means just back yourself a bit more,

**Serena Simmons**
Also, I think just to be mindful of the fact that there is the possibility that you might not be able to help them. And that's also okay. It might not be something that you can deal with. So I might see somebody, for example, where I don't do any therapeutic work anymore, they might come to me and there's actually more of a therapeutic need for that patient. And I will say, in an initial consultation, we might have that as a coaching session, which is typically what I do now, that you know what, from here I think actually, it's more important that you have some more targeted therapy on these issues. And that's fine. There's no failure on my part, it really is a case of what's best for that person at that particular time. So there's also kind of merit in knowing where your professional boundaries are as well.

**Steven Bruce**
And that's the next question, for me. My professional boundaries are limited to my physical expertise. And sometimes if I think there might be something psychological, or there will be something psychological going on, but let's say I think, taking something around some child abuse, maybe, in the background, because of something that patient said. That's a difficult topic for me to raise with a patient because I know it's outside my area of expertise, and yet it might be something that needs addressing. What do we do?

**Serena Simmons**
Well, you've raised, I mean, you've gone right for the jugular there, with what you've said, haven't you, if it's child abuse.

**Steven Bruce**
You're the one who brought up family issues.

**Serena Simmons**
Well, everything goes back to patterns from there. I think in that situation, I would leave it a little bit longer to develop more of a relationship with that person and help them for the need that they've come for. I wouldn't, in that situation direct someone immediately on to further help, I think it would feel inappropriate in those early stages. And they might feel a sense of rejection, because they've come for something that for them feels unrelated at that time. So I think to give them the time and space to deal with what they feel they need help with and once you've developed a further relationship with them, I think you'll feel like

you know when the time is right to have a conversation around other therapies. What you're actually raising for me there is, that actually comes from how you promote your business from the get go. So again, when I work with other practitioners, I often work with whole practices. So say I go into a physio practice. I look at them, for example, creating a very clear identity for what they do as a business. It's very clear from the off, in that initial consultation, if we feel, if any of us feel, or as I'm working with you, that you may need signposting to other services, we will do it as a practice. Because we have awareness, we've been trained, we feel it impacts your health in these ways. And so do we have permission to signpost you? So you do it from the off, you set it up so that people are aware that that may come up. And then that reputation preceeds you. Because again, that's also taking care of the whole and complete human. You're not saying that you're experts in that, but you're saying we may signpost you to the right people. And that's the other thing I would do is have contacts that you know, like and trust, that you can refer people to. We should all have those. I know people who do different therapies, and I will always refer on to those particular people.

**Steven Bruce**
What sort of people should we be looking for? There's a whole breadth of different talking therapies that are available. We've got all sorts in my own clinic but is it easy for us to recognise who we should be signposting people towards?

**Serena Simmons**
If all else fails and you just don't know what to do or where to signpost them to, Mind is a really good place to start. And I would as standard practice have that on your website, if people have any kind of mental health issues or things that they'd like to discuss and talk about, Mind is a great place to start. You can pick up the phone, it's free, you can talk to someone the end of a phone, they will guide and direct you to the right person. Obviously, you can also go straight to your GP, and they should also be able to at least signpost you somewhere. I know that there's obviously issues with that in and around the NHS and wait times. But Mind would be a good place to start. They're often really fantastic. They are fantastic at signposting you to the right person. And then it's a case of the right therapy for you. And just as a little side note there, I would say that any therapist, whether they're a counsellor, psychotherapist, psychologist, because there's lots of, like you said, different people you can see, whoever you choose to speak to, it's like a pair of shoes, you might have to try a few pairs on before you find the right pair. So it's very much about the relationship that you have with that person. So if someone is struggling, it may be that they have to go to a couple of different people to find that right connection.

**Steven Bruce**
We actually had, I did an interview with somebody from the local Mind on the show a couple of years ago, I think. And you're right, they came across as being incredibly helpful. Very, very helpful, very, very useful, and very approachable as you'd expect. Maybe I should point out to people, they could have a look at that broadcast, because they came up with, I think, a number of things that they would do and areas where they would signpost people.

**Serena Simmons**
And that's what I mean, it's a great first point of call. If you don't know what to do just to have that on your website or be able to advise that people go to Mind and go from there. It doesn't dissolve you of responsibility but certainly you've done something to point people to where they should go.

**Steven Bruce**
What about mindfulness? I'm assuming it's a credible approach to dealing with people's mental wellbeing, is there good evidence behind it?

**Serena Simmons**
Excellent evidence for mindfulness practice, which is also linked to obviously meditative practices as well, but incredibly powerful. I think that's a whole show unto itself.

**Claire Minshull**
Quite mixed in some environments, you know, they've taken the mindfulness, I suppose it's like any new thing, you kind of blanket put it in everywhere. So there's obviously the research in schools had no impact on schoolchildren that's come out. But the applications otherwise...

**Steven Bruce**
Well, a surgeon did point out to me some time ago that what I do with people's bones always works, provided you give me the right patient. Well it's true, isn't it? And if you put somebody into a mindfulness programme who doesn't need it, doesn't want it, doesn't respond to it.

**Claire Minshull**
And what is mindfulness, as well? What is mindfulness?

**Serena Simmons**
It's bringing consciousness to whatever you're doing and actually being focused on that. So if I was to drink this water, to not think about what's around me, but to really concentrate on the experience of drinking the water.

**Steven Bruce**
I just have to think about not dribbling.

**Serena Simmons**
That might be a start. And then we would get you to be more mindful about the taste of the water, what do you sense.

**Steven Bruce**
Why am I getting benefit from that?

**Serena Simmons**
Because it's about slowing down your brain, it's about slowing everything down. And to do things with more presence and more consciousness in your actions. The slowing down is really, really important,

because we do often do things at 100 miles an hour, we're trying to process lots of things, we're not often very mindful or concentrated on the one task that were supposed to be focused on. I mean, just think about how difficult it is to stay still. If I said to have a day without your phone, or a day of not working and without your phone and no kind of audio stimulation, how would you feel?

**Steven Bruce**
You wouldn't get a single teenager on the programme.

**Serena Simmons**
Well, there you go, so it's very hard for them to be mindful. So yeah, it's a very, very powerful practice, because we need to be able to quiet our minds and research, current research, is showing that actually rest is as important as sleep for humans now. So again, it could be that by doing something mindfully, we're in more of a restful state.

**Steven Bruce**
What is actually happening? Because, forgive me if I say, it sounds quite glib to say we want to slow our mind down. Clearly, the neurons in my brain are doing whatever they do, probably at the same speed no matter how I think about things. So what chemically or physically is happening to change outcomes when we go through a mindfulness programme?

**Serena Simmons**
So I'm not a neuro psychologist or a neuroscientist, so I can't answer from a specific chemical basis.

**Steven Bruce**
You're forgiven for that.

**Serena Simmons**
Thank you. Going back to what I said earlier, I can't answer that. But research would show it's incredibly important for really entering that restful state and to bring consciousness and awareness to whatever we're doing. Which like I said, most people do struggle with on a daily basis. We don't do it.

**Claire Minshull**
Thinking about cognitive load and fatigue and the umbrella term stress, as well.

**Steven Bruce**
Cognitive load.

**Claire Minshull**
I'm straying into waters that I'm not expert in.

**Steven Bruce**
We'll get you some weights to lift while Serena answers the question.

**Claire Minshull**
Cognitive load, take the Stroop test, for example, it's a very well-known test where you're loading, cognitively loading a patient or person to measure, I suppose, accuracy of outcomes. So the Stroop test is, you might see, so you see a colour and the spelling of that colour. And you have to select the colour, not what the letters say. So, if you've got blue, written, but it's in black, the correct answer is black. So that's one way of implementing cognitive load and measuring, you might measure that pre and post some sort of fatiguing class.

**Serena Simmons**
Well done.

**Claire Minshull**
Thank you very much. Tell me if I'm correct or incorrect, as w ebecome more loaded, more cognitively challenged then things, our accuracy, our fatigue, our speed, this is where I do know some things here obout neuromuscular responses and choice reaction times and things like that become elongated.

**Steven Bruce**
Because of cognitive load?

**Claire Minshull**
because there's too much to think about. I don't know what the neurochemical processes are enough to give you a very accurate description. But the cognitive load means that there's so much to process, that information, that things are slightly impaired in terms of speed and accuracy.

**Steven Bruce**
Yeah. And I guess also, from the practitioner's point of view, that cognitive load contributes to what we would call central sensitization, and therefore pain isn't modulated in the way that it would be if you weren't under that load. We've got a question from Emily. Or at least, I don't know if it's a question, it might be an observation. Emily says, I'm so grateful if something really baffles me that I can write, with permission, to their GP, asking their advice on future treatment, scans, blood tests, etc. I like working alongside other medical professionals. And I agree that the patient may really appreciate this too. And I get two kisses, that's nice. Well, I don't know if it's for me or you.

**Claire Minshull**
Spread the love.

**Steven Bruce**
Well, it should have been three then shouldn't it? Emily, I'm rather disappointed. Well, yeah, I suppose, I don't know, I think as osteopaths and chiropractors, many of us find it really hard to build a relationship with GPs. You probably less so, I would have thought, because, first of all, you've got a well-established research programme going on. And they wouldn't see you, as many of them do us, as some sort of charlatan healthcare practitioner.

**Claire Minshull**
There are other challenges, though. And the challenge is referring patients for a principally exercise based therapy/treatment, however you want to describe it, and it's really down to the GP and/or practice. So you might get exercise on prescription. In Scotland, you've got the kind of prescribing nature effectively and outdoors activities. But I don't think it's as easy as perhaps you might think. Intuitively with all the research it does make absolute sense, but unfortunately, it comes down to one, the beliefs of those individuals who are doing the relationship building, which is why you've got to find individuals with like-mindedness. And I also teach this in my courses as well, with therapists and exercise specialists, create those symbiotic relationships, so you've got that overlap, so they don't suddenly drop off the clinical kind of framework and they're suddenly in an exercise setting. You've got that linkage, bridging that gap. But it also comes down to spreadsheets and their bottom line. And often people are very short sighted in terms ofmonetary and fiscal things.

**Steven Bruce**
They're also constrained, aren't they?

**Serena Simmons**
I was about to say that.  I think that's one of the bigger issues, actually. Yeah, I do feel for GPs. They're very, very time poor and they're often up against patients who want a pill. Fix me is the mentality when they come into the surgery.

**Claire Minshull**
Which is why the language and communication is so important at that level, isn't it?

**Serena Simmons**
Yeah. So one of the things, I do a lot of training with GPs and surgeons as well, where I talk to them and train them in language to use in consultation. The nub of it being when someone comes to you as a patient, when you are a GP or a surgeon, particularly, you are the expert that they're looking for. They do, going back to what we kind of alluded to before, they do expect you to have an answer for them in some capacity. So merely delivering that with confidence and enthusiasm has a huge impact. Now, if more, in our opinion or certainly mine, if more surgeons were utterly enthusiastic about the benefits of them exercising and being able to do something for themselves. And actually, it reminds me of an old colleague of yours, Dai Rees, who often I believe used to say, Well, the good news is, is that you don't need surgery. The good news is, is the exercise is going to fix you. Now instantly, you've gone to that person as the expert, you altered their mindset. Versus the head scratches, I don't know what this is about. We did have someone, for example, on the programme who was the opposite to that, who said that their surgeon had said, well, you'll never be walking without a stick. So obviously, that's already set them up. Obviously, the only word I need to use here is placebo. We've already told someone what their outcomes are going to be. So yeah, so someone will step into that. And great gravitas is given to the words experts speak and how you communicate that. So again, one of the jobs that we have at Joint Approach is educating as many people as we can around the benefits, so that they can genuinely and with enthusiasm, talk about what that will do for the patient, because the patient believes them.

**Steven Bruce**
Yes. You talked about going into physiotherapy practices, I think you said, earlier on? I didn't know you did that. Is that something you do a lot, that people say, right, we want Serena to come and look at us and tell us how we make this better?

**Serena Simmons**
Yes, there's a couple of things I might do with a physiotherapy practice. One would be to go in and do some training, often it's around behavioural change. So how we can integrate psychology interventions into practice in a way that's quite seamless. So it is integrated, it's not you either need psychology or I'm going to help you in this way. The other thing I do is look at them, as well, on more of a business level, how they are functioning as a team, so that the team can do what they need to do effectively. Because it means behavioural change might be enhanced within the team itself. So like I said, working in that integrated way, doing the work with the team. If there's an issue with the team, and they're not communicating, they can't deliver quality care with a consistent message.

**Steven Bruce**
I'll tell you what, Serena, we should have you in the studio next week as well, because we're talking about chronic pain. Seriously, we're talking about chronic pain, and I think that chronic pain patients probably have more issues with their mental approach, their psychological approach to recovery, than somebody comes in with an acute tendon strain or something. And while you were talking there, I was just thinking well, I've got a lot of chronic pain patients coming through here and they are very difficult to deal with. Person, I mentioned earlier on is one of those and I don't have any tools in my armoury to deal with that psychological aspect, other than the vague knowledge of being cheerful and encouraging and sometimes telling them to bugger off because I can't help. In not quite so many words. I got a whole lot of questions. And still we've got nobody with a live question.

**Serena Simmons**
Come on, give us a Christmas present. You can be in your pyjamas, because I would be in mind now if I were at home.

**Steven Bruce**
I think you need to change seats because you're quite intimidating because you're a powerlifting champion. Whereas you can stare the camera in the eye and not scare them. Well, first one is Emily says, she's sending an extra kiss so that I don't feel left out. Damon says, are you linked to the NHS in what you do?

**Claire Minshull**
So the Joint Approach programme, yes. So we've delivered that as a pilot service evaluation in NHS Wales. And we've got lots of, I can't really speak beyond that, but yeah, potential links that are coming. So we're looking actually for private practitioners, too. So now we're extending the provision. So in the new year, private practitioners will be able to refer on to the Joint Approach programme as a part of their their business as well. So if if anybody listening wants to know more about that, go to the Joint Approach website, which is jointapproach.co.uk. But yes, we have several other avenues that we're pursuing.

**Steven Bruce**
We will, of course, share all those details with people after the show. I'll get an email out, I'm a bit late on the emails this week, but they will go out.

**Claire Minshull**
And then in terms of other trainings, yes, I work, to get back to sport, obviously, we do a lot of training in with NHS. And I know you do similar things.

**Serena Simmons**
I do as well, with the NHS. So I often go into hospitals and work with teams of surgeons, or physios or other healthcare practitioners and kind of work with the team in the various ways I described.

**Steven Bruce**
How much does the environment in which people find themselves when they go for treatment affect their outcome. So starting with the front door, the signage, the waiting room, the colours of the walls, the carpet, or lack of them?

**Serena Simmons**
All of it has a huge impact. Huge. Yeah. So lots of research around environment. I always say when I work with teams, what small changes can you make just to make this environment feel less clinical than it actually is?

**Steven Bruce**
Well, that was my next question. Do patients expect it to look clinical? Or do they prefer it not to look clinical, if they're gonna get a good outcome?

**Serena Simmons**
So when you say a novel environment...?

**Serena Simmons**
Well, again, this is a tricky one, because it goes back to the handouts, there might be some people that will prefer a very clinical environment. Depends again on who they are, their mindset, what are they coming with, in terms of their own expectations. They might feel that the more clinical it is, the more knowledgeable people are, we don't know what their kind of private connotations are around that. But there are some other things that you can do to make it a little bit more engaging. That can be, for example, when it comes to rehabilitation, creating environments that are a little bit more novel, or look a bit different in some way, just to challenge the brain a little bit more, to maybe challenge people's connotations, to get them thinking slightly differently, create new neural pathways, which means that change is more likely.

**Serena Simmons**
I think a great example of that: physiotherapy. Right? You go and see a physiotherapist who has a gym or is based in a gym environment. And either you walk past resistance-based equipment, or exercise type equipment, that isn't your stationary bike and one resistance band and a dusty med ball on the floor.

It's a novel environment. Now you might not feel confident and comfortable in that environment initially as a patient, but it just opened your mind to actually this is something, it challenges.

**Steven Bruce**
Would it be intimidating for an 80-year-old, little old lady?

**Claire Minshull**
Potentially, and potentially not. And way back, when you were talking about language and communication and kind of setting up patients, I honestly don't care what a person does in the first session, I don't care whatsoever. As long as they come back for the second. The whole part of that first session, and maybe even the second session, and even creeping into the third session, is that that patient feels, or client feels confident and comfortable in that environment. And if it's so novel, they're not going to and if they've got joint pain, and if they've got stress as well, and it's just doesn't matter, I just want you to trust in me, in the environment, and it's not threatening, and we go through things. We piloted the Joint Approach programme in person in gym settings, before we even kind of went online and went to the NHS. And there were individuals travelling a long way actually to come to a gym setting which had quite an intimidating environment in so much as there was a lifting platform, there was astroturf down with a prowler on there, as well as some other kit and equipment, it took people on average about three sessions to get up to a five-rep max symptom modified.

**Steven Bruce**
I'm gonna take you back several shows here, because you've said five rep max twice on this show and people might not know why you're talking about five rep max. So you're allowed 30 seconds to recap on the 90 minutes that we did all those years back.

**Claire Minshull**
So, this is all about determining exercise intensity and by exercise, I mean resistance exercise. So five repetitions maximum is a resistance or a load or a weight that you can move, push, pull, five times, but you can't do six. And that's one way of really relativizing and individualising exercise intensity, resistance exercise intensity, and for strength based, maximal strength based exercise, we need to be working very hard, but for very few repetitions so that three sets of 10 when you can do another 20, it's not going to do very much at all for strength.

**Steven Bruce**
I think on that show all those several years ago you said five reps max and 45 reps a week?

**Claire Minshull**
Wow, gosh, you're amazing. Yeah. So somewhere between 25 to 45 repetitions per muscle group per week is that sweet spot for optimising strength adaptation. Now, if you get somewhere close to that, because oftentimes, I mean, you're not going to do that in your first session, and you're not going to do that possibly in your first week, but getting somewhere close to that is going to be so much more beneficial than doing three sets of 10 something and not knowing how intensively somebody's working.

**Steven Bruce**
But, and this won't come as a revelation to anybody, I'm sure, going to the gym and simply doing some exercise is probably beneficial in its own right. Everyone knows, because they've all been told over donkey's years, that exercise is good for your health. So just going to the gym, psychologically that's going to help isn't it?

**Serena Simmons**
Yes, except when you're reading a magazine while on a bike or something and not really putting the effort in. So I think again, it goes back to mindfulness.

**Steven Bruce**
Really? I was thinking even the person who's sitting on the bike with their headphones on watching neighbours, or whatever it is on the TV that's part of the bike setup...

**Serena Simmons**
It might be good for their general mental health, different environment, they might meet some nice people.

**Steven Bruce**
And they feel that they're doing the right thing.

**Serena Simmons**
And they feel they're doing the right thing. So I'm not gonna take that away from anyone. Obviously, if we want to get the physical benefits from exercise, we need to put some effort in. That is, again, a mindful practice with effort associated. But I wouldn't take that away from anyone what you've just said. If you get something from that, crack on.

**Steven Bruce**
But you could get so much more.

**Claire Minshull**
Well it depends. What is the purpose of going to the gym? It's just about coming to determine your rehabilitation, or exercise, goals and outcomes. And then assigning the appropriate overload to achieve that. And if you want to get stronger, you need to lift heavy stuff a few times, if you want to get cardiovascularly fitter, there's possibly a few more options, but you still need to work pretty hard at some point, or reasonably hard for a longer period of time. You know, just doing something arbitrarily, might have some benefits and auxiliary benefits. And it's good to be in those environments. But if you've got a specific remit, then we do need to pay attention to can we get more out of that input output equation?

**Steven Bruce**
Do you think the 10,000 steps a day is more of a psychological benefit than a physical one?

**Serena Simmons**
That was made by someone who invented pedometers wasn't it? That was a marketing thing, it was an arbitrary figure that they made up, it doesn't mean anything. So again, if it psychologically makes you feel good, like you've done something.

**Steven Bruce**
You've ticked a box. It's like your five fruit and veg a day, there's no research behind that at all either.

**Serena Simmons**
Again, it was probably a supermarket. Although there's good research around, is it 30 different fruits and veg a week?

**Claire Minshull**
Yeah, which includes nuts and seeds and things.

**Steven Bruce**
We won't go down the nutrition route this evening. I've got a lot of questions here and I've got to ask them or I'll get told off. The first one is going back to cognitive overload. I don't know if you need to answer this, but Jason says is that why Oleksandr Usyk juggles while he's doing calculus to increase his... Sounds pretty challenging to me.

**Serena Simmons**
There's actually good research around movement and cognition actually. So again, if you want to, in terms of neuroplasticity, creating new neural networks, you want to remember something. So for example, if you've got an exam or something coming up, to move your body and bring a physical motion to a thought process is a really good way of working.

**Steven Bruce**
Does driving my motorbike count as moving my body?

**Serena Simmons**
No.

**Claire Minshull**
Depends how much you rev, doesn't it?

**Steven Bruce**
Kim has said practitioner's knowledge is the key to dealing with exercise, and qualifying how and why the exercise is beneficial will help. Sometimes we give patients too much to do, how much is too much?

**Claire Minshull**
Added to that, we know from the research that knowledge of the task is something that will stop people from adhering as well. So if people don't really know what's expected of them, so if you give them a set of exercises, but not really why, but they will say to you in consultation, yes, yes, I understand that

absolutely, no, I got that. But again, it might be that their personality is to appease you. And it might because they're fearful, they don't want to seem silly, but they go away not really knowing what was expected of them. Maybe because there was too much to remember or understand, that they won't stick to the programme. They won't do that.

**Claire Minshull**
Yeah, again, that comes to overload. If you give patients reams of exercises, and you might have a strong rationale for each and every one of those, but if you kind of roll them out in front of them, we know patients will do two or three, though if they're not accustomed to exercising, they will not do any. So you're risking overload of the patient. And then from the neuromuscular system, again, if we are getting them to do too much, there's that potential interference effect and overload effect. So if we're doing too much of one exercise and too much of another exercise in very close proximity, you're likely to negate the benefits of both versus if you separate them out. And then if the individuals, again, are accustomed to exercise, giving them a very large dose at the very start of an exercise programme is likely to bring about certain things that might be less desirable, that would threaten their subsequent adherence like DOMS, delayed onset muscle soreness, which we've talked about before.

**Steven Bruce**
I've certainly been guilty in the past of giving people exercises and not sort of getting them to demonstrate the exercise because I thought perhaps, that's insulting to them to say, right, I want you to show me what I've just told you to do. And I've learned that it's actually quite a good idea. Kate says, for practitioners and patients interested in mindfulness and/or meditation, there's an app called Headspace that does a free trial. They have a short series on Netflix too, very good for people who may benefit from mindfulness practice where they don't need or don't feel ready for talking therapy. Sounds as though you've come across that before?

**Serena Simmons**
Yeah, really, really great app. And thank you for mentioning that. Really great. Headspace. It's a great app. I know lots of friends who use it. And lots of friends who are practitioners point people towards it. Also, if you don't want to pay for that, although you get a free trial as was said there, lots of things on YouTube. So just putting in mindfulness, 10 minutes of mindfulness. There's lots of things that you can work through. So lots of free things that you can point people towards. If you're a practitioner, again, I would maybe try and find a little bank of free things like that, that you can point people towards if you think it'd be useful.

**Steven Bruce**
Are there people for whom mindfulness is totally unsuitable, do you think?

**Serena Simmons**
That's a really good question.

**Claire Minshull**
I struggle. I really struggle with being still and quiet.

**Steven Bruce**
There's a reason why I ask that question.

**Serena Simmons**
I think that's where people then like yourselves need it more.

**Claire Minshull**
You're probably right. I find it very challenging to sit still and quiet my mind.

**Steven Bruce**
So your challenge is different to mine. Sorry to interrupt, but maybe you can address this, because my challenge is I can remember being taught mindfulness and thinking "This is bollocks, this is bollocks, this is bollocks." the whole time through it. And I know it's not, for everybody, certainly. But all the time, I was just thinking I just don't believe in it.

**Serena Simmons**
Ok, so your version of mindfulness. I think there's something that might be different, that's more suitable. So you mentioned riding your bike. Maybe you feel that you're in a mindful state while you're doing that. And when you come off your bike, you feel rested, you've enjoyed it, you feel like you got a lot out of that experience. Possibly for you, knowing you fairly well, it might be something to do with exercising, I don't know, maybe possibly. Anywhere where, I don't want to kind of go too much into the woowoo, about kind of flow state and being in your element, but I would argue that those practices that you might have in your life, where you feel like you've entered a restful state as much as being mindful and bringing attention to specific things. It might be that it's drawing for you or playing a guitar or playing a musical instrument. Where do you feel you are mindful in what you're doing? So it doesn't have to be sitting under a tree, omming. So find something that works for you, that has you feel like you've entered what I would describe a little bit more as a flow state. And Sir Ken Robinson, I highly recommend looking at any of his videos, if you want to put some links in there for people. Amazing work and research into flow and being in your element. I think that that really is a more palatable, user friendly version of some of the things we're talking about, versus kind of looking specifically at mindfulness.

**Steven Bruce**
Sorry, I'm moving on, ages ago Marie sent in a question to say she wants to know more about the Joint Approach programme than you've already told her. So tell us more about Joint Approach.

**Claire Minshull**
So jointapproach.co.uk on the site you can sign up to find out more about it or indeed we'll give some details that you can put on the link, so you can email us directly. So it's a multidisciplinary online programme for patients to go through to help manage their own joint pain. So it comprises of psychology, strength based exercise, and education with some nutritional guidance. It's a three month programme. And individuals can also choose to engage in live classes as well. And it's fully measured and monitored as well in terms of outcomes for individuals. But also if you're a part of a wider or larger entity, like an NHS Trust or health board or private hospital, we can provide group based data as well. So we measure pain, we measure function on a pragmatic test, which is a 30 second sit to stand, and we've seen profound

changes in just 12 weeks in some patients on this, quality of life and PROMs. We also monitor use of analgesia, and some barriers to exercise as well, at the start the programme. So full suite of research as well if you like or, or audit, if you prefer that terminology. So please do get in touch with us if you've got any questions or want to know more.

**Steven Bruce**
Yeah, I'm sure you are gonna get lots of people interested in this. Certainly I am. Jason says, I find that a lot of people don't understand what's meant by failure. They go on to compensate with other muscles thinking that they've not failed yet. Can you describe the failure level?

**Claire Minshull**
Yeah, absolutely. So people often describe it as fatigue. So train until muscle fatigue. Now, if I asked you and I asked you, and Barney, what their definition of fatigue is, we can all come up with something completely different. We've got all interpretation. But failure is quite difficult, if you give the parameters of an exercise, to misinterpret failure. So failure is, I am failing to lift that next repetition, with proper form and safely. So the good starting point is to use machine based exercise, because you're constrained, it's very difficult to use synergists and other muscle groups.

**Steven Bruce**
You can't flick the curl bar up, can you?

**Claire Minshull**
Exactly. The perfect technique and get kind of a hip thrust going and all sorts of bizarre things. So to understand what that's like, if you start with an isolation exercise on a machine, or indeed isolate a joint in a particular way, and load it up, then you can feel what it's like, and then go to more compound, multi joint, multi muscle exercises.

**Steven Bruce**
So the key thing in answering Jason's question is: not being able to perform another repetition but while preserving good form.

**Claire Minshull**
Yeah, yeah. And that's going to be different on a leg press versus a barbell back squat. So in a leg press, it's, I guess, a nice kind of hybrid to a compound exercise. So we're using multiple joints and muscle groups, but you're still sat in a machine. So your form won't particularly deviate all that much. Unless you're kind of limiting the range as you progressively go through the set, so you're not able to lift as much. Versus you need to be quite proficient to do a barbell back squat in terms of technique. So you probably need to learn that first before then you set out to do a five rep max on it, because it's technically quite challenging. Once they've got the technique then actually does become a lot easier to be able to overload that.

**Steven Bruce**
Is that the sort of exercise for which you really do need some sort of spotter or supervisor to keep you safe?

**Claire Minshull**
Again, it comes down to individuals' exercise and training history and proficiency. So if individuals have never done that before, then I would definitely counsel a progressive approach to that. And if they don't, I'd actually recommend more that they maybe start it in a smith machine. So you can you can easily rack the bar. Or another progression to developing full squat would be a box squat. So you're actually starting sitting on a box or a bench. So if you do fail, you sit down.

**Steven Bruce**
I was going to say, you've talked a lot there about squats, actually, it must be very hard to do a squat to failure because by definition, you're at ground level and it's hard... I suppose you can drop the weights, can you? Most gyms object to you doing that on their floor.

**Claire Minshull**
Yeah. That's where you become quite, again, it's down to exercise proficiency and training history. So you get to understand your own body that that actually is your last repetition. If you went down to parallel, again, you probably wouldn't come back up. In which case you then would get a spotter. But what I'm saying is somewhere close to that, somewhere close to pushing the musculature. Maybe it is, you feel like you've got, we could talk about repetitions in reserve here, you're doing five, but you know you've maybe got one or two left. That's probably a safe place to be if you've got nobody spotting you and you're relatively new, but you've got the technique to something like squatting.

**Steven Bruce**
I suppose just, I don't know if we mentioned it while you were talking about the five rep max thing, but you've done a lot of research into this and found that five rep max, while being very good for developing strength better than other reps and so on, is actually good for overcoming the pain of say, knee arthritis, which you've concentrated on a lot. Is that right? Basically, strength is good for it.

**Claire Minshull**
It is, yeah, it is. So if we flip that coin, look at muscle weakness. Muscle weakness is related to, this research and evidence base, increased experience of joint pain in osteoarthritic patients. If we were to improve muscular strength by 30%, then it's got a clinically meaningful difference on experience of pain and function in those OA patients. And we've integrated that into that Joint Approach programme. It's a progressive approach and you will not have experienced what it's like to work to failure before, unless you've actually actively tried to do it. Because in your everyday life, how often do you pick something up or push something where you can only do it three or four times? Your shopping's definitely not that heavy. Usually. Especially now with the cost of living. Although you might be pushing your car.

**Steven Bruce**
Resistance band work isn't ever that intense though, is it?

**Claire Minshull**
Yeah, often that's not even that challenging. So it does require kind of a progressive approach to understanding what it's like. It feels very different.

**Steven Bruce**
Can I move back on to mindfulness? Because I know we're running out of time. Fiona says, you've talked a lot about mindfulness and very negative views from patients regarding any help. But what about rehab and patients wanting positive help and positive exercise? Maybe it was just me being negative about mindfulness.

**Serena Simmons**
No not at all. I think, again, to get the most out of a patient, there's often a way when you integrate any psychology, I would recommend that there are things that you can do just to get as much information as you can out of someone to help them on their journey. Because once we know as much as we possibly can about the person, we can help them set more realistic goals, we can tap into their motivation, we can tap into the things that inspire them to want to move forward. So any kind of psychological knowledge that I would impart, hopefully would help with any interaction that you have, because it's about understanding that person's psychology and how they process information. If someone isn't struggling, then arguably, a lot of the strategies I have, you don't need to use them because they are just doing what they need to do. And that's fantastic. Lots of people bring me in, because they are having problems getting people to adhere to something. So behavioural change strategies are only needed if someone is struggling. You don't need to go and seek help for something, I wouldn't to take my car into the garage tomorrow, if there was nothing wrong with it, and just say, can you have a look over it for me, see if we're okay. Well, it might be for a service actually and I do recommend to people ongoing coaching and therapy is really good for you. So the strategies that you can use in terms of just psychology are useful, but you might not need to do much. If someone's inspired, you just need to keep doing whatever you need to do to keep them motivated, which you should know by that stage, if you're working with someone to help them stay on track. And that's a real joy. That's a pleasure. And we've all had patients or clients like that too, haven't we? Where, we know that they're flourishing, and they're really enjoying the process. So that's a really nice place to be. That's when we can look at things that are a little bit more novel, a bit more playful, a little bit more outside of the routine. And that's kind of a really nice evolved place to be, in terms of interaction. Very different kind of person to deal with.

**Steven Bruce**
We've got time for one more question here. It's not really a question, well, there is a question at the end of it. DM has complimented the pair of you on your enthusiasm for what you're talking about, but says that there's a lot of reinventing the wheel going on, because NHS physios were doing all this until successive cutbacks. Have you heard of the latest iteration of this process called the pain clinic? I'm sure you have heard of the pain clinic.

**Claire Minshull**
I think there's two parts to that, really. So if physios were doing all of this, I would say that perhaps good physios might have had the capacity to do all of it, or maybe some of it. And not that I'm saying they're bad physios. What I'm saying is, it's very difficult to deliver all of this in clinical practice, or all at once, and to have the level...

**Steven Bruce**
Sorry, we're being interrupted. Barney doesn't like the camera operator moving around.

**Claire Minshull**
I mean, he's right, absolutely and there's been just such profound cuts. It's awful, the stress that physios are under, and the workload is just abhorrent really. But what we bring in with Joint Approach is that reassurance of, so you've got Serena who clearly knows her stuff. She is a qualified chartered psychologist with experience in behaviour change, profoundly. You've got people like myself PhD in neuromuscular exercise, physiology, rehab. We've got the clinicians on board. So we've created that multidisciplinary team, which physiotherapy is a part of.

**Steven Bruce**
It certainly sounds as though, people might have been trying to do it years ago, but this is a big quantum leap forward.

**Claire Minshull**
And also, our knowledge has improved from years ago. And again, I'm not suggesting anybody was deficient before or even now, but there has been a development of that knowledge base in, just thinking about understanding of pain. So pain isn't just nociception. You know, it can be influenced by fatigue, a lack of sleep, it can be influenced by how you relate to that pain. So people on the Joint Approach programme felt less pain in two weeks of doing it. Now, clearly, that's not the strength benefit, is it? We're not generating muscular strength gains all that much in two weeks. It's going to be something psychologically that's going on.

**Serena Simmons**
I just want to say something in response to that too, because you've answered the question. But I just want to acknowledge that I also appreciate that there's a lot of struggle for people, particularly in the NHS. Obviously, I'm going in all the time and I really, really feel for the teams that I'm working with, because it's often the case that for the most part people have incredible ideas about what to do, but they're up against management not being able to help them implement it. They would love to change their environments, but there's no support in changing the environment. The people in their teams that they really want to come and do the training, didn't want to come and do the training. I think there are amazing practitioners out there. It's usually the ones that are incredibly enthusiastic, really passionate about their work, that are probably also doing things like this and listening to this tonight and not watching, I don't know what's on, Coronation Street? So I think that yeah, I feel for you and having worked with them so often, a lot of the work I do is also, as I said, listening to the practices and just working with them and building their resilience, dealing with their stress levels, their wellbeing, because to integrate it, it starts with you as the practitioner, how are you? And then we look at kind of what you do outside of that. So I really feel for them.

**Steven Bruce**
Serena, I don't know what's on television tonight, but whatever started at nine o'clock, we've slightly overrun. People love this, in fact a comment here from Rachel says, academic content's always interesting and this has been hugely well presented. But she wants more cute dogs on the shows. You did ask me before we came on air how many people I thought we would have watching. I said 400, we had 395 watching this evening. I hope there's a lot of people who've really enjoyed what you two have had to say, because it's been great fun, as always. And I did tell you that both of these speakers were

real livewires, I hope you accept that as being the truth here. I also said this was gonna be a great show and I hope you enjoyed it as much as I did. And of course, most importantly, I hope you've got things that you can take away and use in clinic yourself or at least work on to improve how you deliver your therapy. As I've said, we'll share details of what Claire and Serena do, their courses, etc, in case you want to delve into it in greater depth. And as an APM member, I hope you'll get a small discount or an added bonus of some sort. We get them from you don't we, Claire, so we'll make that public to our members as well. See, we can always twist their arms a little bit. They daren't say no. Last show of the year next week. That's Tuesday evening. Once again, I've got two guests, I've got Nick Birch who is a spinal consultant. He has been in the studio several times before and he is an absolute mine of information. He's going to be talking about the latest approaches to treating chronic pain, as I suggested earlier on. And he's in with John Graham, a fantastic rehab physiotherapist, who's also been in a couple of times before, in fact the first time he demonstrated this amazing robot body for paraplegics and I had to go in it, it was great fun, I have to say. On Tuesday, he's going to be talking all about neurofeedback training using some kit which is currently going through patient trials in New Zealand. He will be demonstrating how it works. And so between them they're going to provide us with a heap of really useful evidence based stuff that hopefully will help us in our practice. No broadcast then till Wednesday the fourth of January. Kelston Chorley will be joining me that evening to discuss how hysterectomy affects how we treat patients and how they respond. Now that's a subject that's been requested by a member so don't forget, if you've got a particular interest, let us know and we'll do our best to find an expert to cover it for you. Last thing, three courses to consider early next year, running another online first aid course on Sunday the 12th of February. That's live and supervised by me and Malcolm, my paramedic assistant. It definitely meets the requirements set by both the GCC and the GOsC. In fact, it goes way beyond their expectations. And what's more, it's good fun. You can find that one at apmcpd.co.uk/help! that should be on the screen at the moment. And then we've got the hypopressive breathing course on the weekend of 25-26th of March. Do help me spread the word about this one, because it just seems such an important course and it's suitable for anyone who deals with postnatal ladies: midwives, nurses, Pilates instructors. The technique is absolutely brilliant for fixing what we called leaky ladies on the broadcast we did, and so much better than anything else which is on offer. It's much better than simple pelvic floor exercises, the conventional approach to this. You can find that course as apmpd.co.uk/hypo. And finally, there's another Laurie Hartman masterclass now confirmed, minimal leverage technique. This will be the weekend of 1st and 2nd of April. Brilliant for osteopaths and chiropractors, it takes manipulation to a completely new and much safer level. There's an early booking discount still available for that for a few more days, plus a member’s discount. And that one's aommcpd.co.uk/mlt for minimum leverage technique. Enough for now. Hope you had a good evening and I look forward to seeing you next Wednesday. Goodnight.