Academy of PHYSICAL MEDICINE

Transcript

337 - Rethinking Repetitive MSK Presentations with Joanne Elphinston

Steven Bruce
Hey, good afternoon. Great to have you with us for another 45 minutes at lunchtime learning. terrifyingly, there are only three lunchtime shows left before Christmas is upon us. But they're all going to be great. Of course. Today, it's all about movement. Joanne Elphinstone. She's been on the show several times before, and she's the founder of gems, which is all about helping people to get the best out of their bodies through movement. She herself, she's recognised internationally for expertise, and incorporates all sorts of things into philosophy, biomechanics, neuroscience, all that sort of stuff. So very much in tune with what we try to do ourselves. today. She's hoping to help us overcome that repetitive cycle of treatment, relapse, further treatment, what she calls the merry go round of treatment by JOANNE

Joanne Elphinston
Hello, Steven, thank you so much for inviting me back,

Steven Bruce
though. It's great to have you on here. As always, though, not least you're one of our smiley as guests. But also you're somebody. You're very active show with you, isn't it? And just before we went live, I had no idea you had a connection with the Royal Marines. I was only doing so I was very pleased to know that you've been working with proper servicemen in the past as well. Which

Joanne Elphinston
is absolutely absolutely funnily enough, I've I've done the I've done the Royal Marines, I've done the army. I've done the Navy, but funnily enough, not the Air Force.

Steven Bruce
Yeah. But the trouble is, they didn't do any exercise in the Air Force. Probably more in need of movement, and the other services, less likely to get injured, obviously. Again, another thing that you touched on before we went on air we came alive is that and I didn't mention it in the intro is you work with elite athletes, and I know you're working with an athlete over specific things at the

moment. Perhaps at some point, you can tell us how you what you do is useful to people at that level of performance, which includes Olympic athletes and others, doesn't it?

Joanne Elphinston
Absolutely, it does. And you know what's so interesting, Steven is that I have spent a lot of my career doing both performance consultancy with elite athletes and dancers and high performing musicians. But what's so interesting when working with these people is the things that they really need to unlock persistent problems are the same things that we would use for people at any level of function. Right? That's what's so exciting, because we spend a lot of time now really separating people into certain populations, and we lose what unites us as humans. We're so focused on what is different?

Steven Bruce
Yeah, yeah, I understand that. And obviously, you might have to adapt your, your programme for someone who's 80 years old, as opposed to someone who is in their physical prime when he's performing elite sport. But I certainly get that.

Joanne Elphinston
Well, again, it's really interesting because the like, only ever see people, and this is why I've picked this subject today. Actually, I only ever see people when they've had problems for a long time. So I might have somebody who's who's in the very top echelon with sport, but they've been treated with sports medicine. And that's a problem because it assumes a certain level of function. But they're also human beings, with the same kind of autonomic nervous system that we have. Same nervous system, okay, it responds and reacts maybe slightly differently. But ultimately, it's very, very similar. So the kinds of things that I need to do to to just kind of gain entry into someone's nervous system to start, the process of change is indistinguishable between that athlete and the 18 year old. In fact, I think way back, like 20, something years ago, I had a clinic where the waiting room could see the exercise area. And waiting in the waiting room was an 80 year old lady, and working with me in the exercise area was a 23 year old professional rugby player. And he left and she came in, she said, You know, I can do that better than he can? Do you know what she was? Right?

Steven Bruce
So is that part of the therapy then to have them able to see where the other people are being going through the programme?

Joanne Elphinston
Well, I mean, these days, I don't have that set up. But at the time, I was working at the Welsh Institute of Sport and that's the way it was because the general public could come into the clinic as well as sports people. But I you know, it really, it really shows us the lesson of how empowering it is because I also have quite a passion for I have lots of passions, you know that. So it might be children, but our older population are often given such uninspiring you know, work. No, I remember walking in my first NHS job and I inherited the Total Knee Class, and I look around and there's a lady sitting in a chair or with with her feet on little pedal out facing the wall. There was another one lying on her back on a slide board just going in And now with her leg, it was it was all so dispiriting. And I had actually brought two of the big fitness balls in my suitcase from Hawaii, which is where I lived before, and brought them over. And I brought them in and started implementing these. And one day I came in. And they were to elderly gentleman, I think come in specially early, and they were having a little kick together, they were reliving their glory days. And I can't ask for anything better for weight

transference, dynamic balance. And it wasn't an exercise. And if we get into the neuroscience of it, because that's quite interesting, they've been doing studies of when you take an older person and get them into a situation where they are able to conjure up the memories of when they were younger, it can literally help them access the movement patterns that they had before. Right, which is like the most powerful thing in the world. But But what happened is, we could actually transform this into where you get to do cool, groovy stuff, too. Just because you've got a birthdate at a certain point doesn't mean that we stop being creative. And it'd be a great stuff to do.

Steven Bruce
So what's some, what's the stimulus for today's topic, this merry go round of treatment that you talked about?

Joanne Elphinston
Well, part of it coming, part of it came a little bit a little while ago, I'm looking at my clinic listing going Do you know, if I look at them, this person's had a problem for three years, this one's had them for five years, this one for 10 years, this one for 20 years. These are all, that's my patient demographic. But they all have made beautiful changes. And when people come on the courses, and they give feedback, what they're finding is that the treating these people have been kind of not written off, per se, but being managed. And the therapy is kind of managing them. And they kind of go on, but we're not really aspiring beyond that. And and so what inspired this is to say, well, you know, what, if we looked scratched a little further and looked at some of the other resources, we have said, Well, does it have to be that way? If we actually look at the whole human being, is there more wiggle room for us to actually have a more permanent, you know, effect for this person? So hence, and so if for me, I have a slide? Yes. And can you just advance by one? Thank you. So it comes back to big questions, because most of us have been trained exceedingly well on working out where the problem is. And that itself is a skill. But the next level skill is saying that why? Why is this happening? Why is this structure under pressure? And the next question after that is, well, how is this person using themselves? So it's, it starts a different thought process, you know, beyond diagnosis. So for me, what we used to call diagnosis was that's the area that's the, that's creating the pain. For me a diagnosis actually, is one step further to say, well, but why is it happening? And therefore, what can we do about it?

Steven Bruce
So this is possibly some members of the audience who will be a bit offended by this because they'll think, well, we don't just treat the cause of the pain, we treat the things that produce that cause of the pain, but I suspect you're looking at it from a slightly different angle on you. Were saying, Well, okay, there's a pain in the lower back, is there something in the ribs of the neck or wherever else which is provoking that you're looking at what, what in lifestyle perhaps is giving rise to all of that?

Joanne Elphinston
Well, it's absolutely and I absolutely have no intention to make any offend anybody. But let me explain and maybe it'll make clear. So if I advance to the next slide, Paul.

Okay, so this is something in gyms that we call a holistic functional model. Okay. It's, it's quite a simple model. But it's one that can maybe help us to understand this. So let's give an example. Let's say the patient has come, they play the violin, and they have a wrist problem. So the wrist is the sole bar. So that's the local circle, the green circle, smallest one. So great. I know where the problem is. And I can see that those joints are very sore or the soft tissues are very sore. So the next question I

have is why. So I'm going to first of all look at the relationship between the rest of the body and the wrist. Now in the function ring, I see okay, they play the violin. Let's have a look at this. And with a musician, I would always get them to bring the instrument. Okay, so let's have a look at this. But even if you didn't, what does someone need? And I'll ask someone just to show me show me the position you go into. And you look at it and you think the first question is right? Is that risk doing more than is actually necessary? You might have tested at all out and gone. Yes, it's very sore, but it's quite mobile. So I'm probably not going to mobilise it. So now, what am I going to do? And then often people go, Well, I'll strengthen it. But again, you were kind of just searching around for stuff to do this orbit. But if I saw instead, when, do they have enough? Supination? At the elbow? For example, yes or no? And if they don't, does that mean that I then have to use more in my wrist to be able to get my fingers to the strings? Okay, if I found a restriction there, I would use my manual therapy, put it back in and this doesn't make a difference. I'm going to go up the chain, do they have enough external rotation in the shoulder? Yes or no? Do they have an issue because they're shunting the whole shoulder forward to try and stabilise stabilise the instrument. That's a whole different ballgame. So it could be as simple as something in the environment ring, which is having a higher chinrest. Or it could be that the person doesn't have enough global stability to be able to support that upper limb. Now I've seen this even in someone very, very elite. Yeah. And a huge belief that they had to fix that chin down to keep that violin stable. But when I saw her playing a big passage, fast passage, you can see the entire body moving around and was like, Okay, if the entire body is moving around, but we have to have peripheral precision, I'm going to have to look together somehow. So the unfortunate thing then becomes that I've locked in together, compromised my wrist position, increased the tension. And for a while I can play better, until the pain becomes a really big problem. So it could have been a real global control issue that I need to look at. So we've still gone, I've identified I mean, that was important that you needed to know, has it come from the neck, for example, you know, is it a neural thing? And that's, again, where we use our manual therapy to either restore those interfaces or do whatever we need to do. But then we want to know, well, how can we stop this coming back? Because that person usually gets told they have an overuse injury, and they're wrong, then everyone says, Oh, well, you have to play this amount. So we'll just do this treatment to keep you going limping through the rest of your career. And that happens a lot. So over the top of all of that, if we go back to the slide there pause for a minute. It's coming.

Steven Bruce
There we go. There

Joanne Elphinston
we are. Good. So we've briefly talked about the local, the global, the functional, the environmental, and only, I mean, there are so many factors. So some of you work with musicians, you'll say, but what about this, and this and this, totally accepted, but within the confines of the time, you know, we know there are other things, but over the top of all of this is what I call arousal level. So we think have things like their autonomic state, their emotions, their understanding, their self efficacy and their beliefs. And boy, patients come in with all of these things that we need to play with. So if I contrast this person to somebody else, cellist same kinds of problems, terrible wrist problems, but when I saw play, she immediately went here, you know, so part of this is the belief I need to be very upright with my posture. So we have a belief, we have an embodiment, which is, when I'm stressed, and I'm under scrutiny, this is how I embody that. So I go up at the front of the ribcage down at the back. And now I've lost a secure Centre for my body to support my upper limbs. So for her, we took a different route, and said, Okay, let's just find out about your breathing from an improper hand on your chest and one on your tummy. And we'll do something that I call it a quick check breath, just to

find out when you breathe in, and maybe you can all do this too. When you breathe in, does all of you breathe in oil does it just is it just your chest, is it just your tummy. There is a belief out there that the tummy is the better thing. And I'm say to people, this is one big canister. The air comes in, we have more pressure here, but that creates more pressure down there. So all of its going to expand makes it much simpler. And once we actually establish that she is very up here and then when she let herself settle Then the ribcage reconnects with the pelvis, she's no longer sitting on her, you know, anterior to her sitting boundary. And now she's sitting on them. This is now also Cuba. And now the upper limbs can be in a different place. Because there's a very basic principle is that if we have, like a secure Centre, we can have relaxed periphery. But if you are hanging on in your centre, then you're going to increase the peripheral tension. So frequently, people with peripheral issues, actually, it starts with what's going on in the centre. So you see that these things start to wall, bounce around and play with each other. When

Steven Bruce
you're violinist because I was thinking, Well, surely the movement for a musician is all part of the performance, isn't it? I don't mean, deliberately engineered for the audience. But if you're, if you're in immersed in the music, you're going to want to move move while you're playing. And yet, the implication was, you said you removed or reduced that movement.

Joanne Elphinston
I love how you've picked that up. That's brilliant, Steven. So this is what is by choice, and what is not by choice. So one of the things in the Western tradition, often people are taught in a very stiff way. And I remember being in Rome by the standard Spanish steps, and it was like a gypsy fiddler. And what was so evident, you know, it was how he could let the forces flow through his body, without restriction and without tension. And if I give an example of like with the kinds of people who are the concert soloist, so they're the ones who stand, often, they're standing very rigid in the lower body, trying to be very expressive in the upper body. But what we've got is all of the motion and the stress going on up top, with none of the support from below. And actually, for those people, we started the feet, and just getting soft through the pelvis. And then we start to practice some relaxed bowing without the tension, but actually being very grounded. And that is the same in a seat. So what we're asking for is just that you you can move, but move from a place that continues to allow the forces to be shared, rather than locked up. So you see so many people up here, they've locked themselves, and then they're trying to move. But if we actually start from somewhere neutral, we have all those possibilities. But we're doing it again from a centred place.

Steven Bruce
Doesn't that contrast with or conflict with what you've told us before, though? Because when you said neutral, you did that. And yet, in previous shows, you've always said that I'm supposed to have a helium balloon tied to the top of my head that pulls me up, right?

Joanne Elphinston
Ah, but that's the individual embodiment thing. So just looking at your movement there. Because we don't use the same cue for everybody. So for you, I just saw you respond to the upward by doing this. Yes, yeah. Yeah, that doesn't happen for everybody. I mean, you're a former military man, you're already here. So you've got nowhere to go up. So the brain goes, Okay, I've got nowhere to go that well, you want me to go somewhere. So I'll go backwards. Whereas if I was starting here, and I was given this possibility, totally different. Yesterday in clinic, I had an athlete to work with. And she's very much like this. Now, if you give her up for her posture, she just goes even further into

where isn't very helpful. But when I cued her from the feet, just like the Earth is like a giant spring, you know, and we have this lovely upward push. And that's what actually helps propel us. So let's just find the upward push. And sometimes I tell people that the Earth itself, billions of organisms, billions, and trillions and gazillions of little organisms, each of them has a charge, that creates a field. So just open yourself and let that come into your body. And it's so interesting, because you see them elevate from the ground up without all of this tension. So it's a great thing to pick up seven, because this is where when people say, Oh, what's the cue for this? Like, I can only give you options for what you could consider, but from person to person, we all embody differently. And that's where we run into trouble with, you know, people who just like, oh, where is it and the evidence base and that Well, the thing is that humans are multi direct dump multi dimensional organisms with infinite combinations of possibilities. So that means that we get to be creative and responsive, rather than just trying to get it right. And then when it doesn't work with that patient, we think, oh, oh, I should have I should have done something else. I should have been better at it or, or they should be better as we get into this dynamic. There's so much not necessary, was like, Okay, I did the app. I saw it happen. I don't go oh my gosh, I did it wrong. No, I'm just like, that's just information. What does it tell me? She needs to be cued from the ground up. That works like a dream. She's texted me today going, Oh, it's also much easier today. Great. Yeah. But it's about being willing to be responsive to the individual.

Steven Bruce
Can I read you a couple of things from our audience? Yes. First of all, Phil has said, he's described what we were talking about as being what caused the cause of the pain because we were looking just a little bit beyond the immediate factors, as you said, Cookie sent in a couple of things. Cookie says I had a patient this week, I'm gonna go see him cookies a man. He says I had a patient this week, tell me telling me she couldn't turn over in bed without shuffling. Or getting in it with one with one leg at a time. Being a mobile therapist, I asked her to demonstrate the techniques on her bed. Then I said, Show me how you used to do it. And after three attempts, she then went into a full turn. And on the bed without the precautionary efforts, she first displayed. Sorry, the text there has not been translated quite as it should be, I think. So. That's one example. And then cook. He also says I tend to work in a similar way to trying to understand the person's working style, the beliefs of posture, lifting, rotation, etc, addressing the vertical as well as the spiral chains. As humans, we use vertical chains too much and forget the spiral.

Joanne Elphinston
Exactly, he's spot on. And I love how that that first example absolutely maps on to this research about harvesting existing associations and using them in the present.

Steven Bruce
So how do we? How do we take some of your expertise and steal it from you to use in our own practices?

Joanne Elphinston
Oh, well, do you mean in terms of like, concept I have more to share? Or do you mean in terms of trainings?

Steven Bruce

No, I'm well, I mean, people want to go away from the show thinking, well, I've got something now, which might help my patients get over their problems a little bit more quickly or more. for a longer period, what would you suggest? What should we be doing?

Joanne Elphinston
Right? Well, if Paul would give me the next slide, I can start giving you some little examples of this. Okay. There we go. Okay, so you can see I've got five circles there. And I'm going to start off this physical circles, then there's emotion, we've got the brain, we've got the interpersonal dynamics, and then we have us. And so all of those things are playing together with our patients. So if I give you start with just physical, and we look at how do we use the mechanical neuro muscular and fascial connections, so I'll start with a very low level example. And we'll go to a higher level example. So the patient comes with bilateral anterior hip pain. She's in her 60s, this has been very problematic, her whole life, she's very hyper mobile. And she tells me that she's done all the glute exercises, and she can't have them. I hear that a lot. And so I have a little look at her. And I noticed this stand up here. And in fact, I'm going to invite anyone who might be watching perhaps to do this with me, I notice that the ribcage is very downwardly rotated at the front. Now, if you do that, find your greater trochanter. And then just allow yourself to collapse down in the front of the ribcage to to rotation, and just notice what happens in the hip. So the hip goes forward. Yep, perfectly normal. And you might have one of two responses then. So one very normal responses that your glutes just basically go Placid. You know, I've got nothing wrong with my glutes, but they don't do anything in this position. Some of you will have actually had a reflexive clinch with the glutes. That's problematic as well, because we actually need to have some mobility in the hips to absorb respiration. It's a whole other subject. But anyway, you look at it. We've got pressure through the front of the hip. She's like, yep, that hurts. This is where I am. So we play. You're just like, What can we put here? She's like, I don't know. Maybe. I think she put a sunflower in here. So what happens then? So we open this up and what happens? Well, we're now bringing the hip back onto the bush again. But she won't. If I say what do you feel she won't know. Just like just notice where you are on your feet at the moment. And now just get back to where you were. Oh, I mean, my heels. Yeah, to end it. I get it. Indeed. Now bringing me your sunflower again. What happens I'm more on my feet. And I feel something different. Sometimes people don't know what they feel, but they know it's different, or they've suddenly become aware of something. So we have a physical, are you gonna do all the glute exercises you like for those hips. But if this is where she is, then there's nothing we can do that the next level is to take the physical circle and join it together with the emotion circle. Like when do you find your interest? The most going to meetings at work? And how are you feeling? Well, I'm usually very anxious. Okay, so how would you like to feel? Well, I'd like to feel strong and confident. But I also want to feel kind. I'm like, Okay, could you show me strong, confident and kind? What would that look like? And she brought herself back up here, again, the sunflower position. Now, ah, and what have you noticed? Oh, that's the sunflower position. Exactly. So now what we've got is we've linked the physical with the emotional, or autonomic. And now we brought it into the brain, which is understanding, I have a choice here, with where I'm going to put myself in such a way that I take the pressure off my hips, that reverse engineers back to emotion, because now it's not so anxiety provoking, because we have a sense of control. And it makes sense. So we start to play with these, and there's nothing about that, that was complicated. What I will point out is the dynamics, the interaction that we had, is not a conventional interaction, the conventional is very patriarchal, you know, we, we, our job is to fix them. Our job is to know things and then to dispense that information. But what we do for gyms, we tell a whole lot less, and we ask a whole lot more. So all the way through this, I've just been asking questions. What do you notice about this? What do you notice about that? Aha. And what do you understand about that? It's, she's actually having this

unfolding process of understanding, which is a far more powerful than me saying, Oh, you have to get your pelvis back on your feet. And you have to line this up here. Maybe even draw your tummy and squeeze your glutes a bit. That's very conventional. But if we actually do this, we're actually coming into a collaborative partnership with the patient. She's learning and the next time she comes back, she's more than likely to tell me something else she's discovered. So that's created a very different forward momentum for our treatments than just was it better?

Steven Bruce
Yes. So I guess I was I was going to ask me, what is patient compliance, like, I imagined, from what you've said there that the benefits are being reinforced all the time. So chances are, they'll want to carry on trying to be a sunflower?

Joanne Elphinston
Absolutely. In fact, compliance actually then just goes away as a problem. You know, and sometimes people say, Oh, how many reps? And how many sets? This is the clinicians who come on the court? I'm like, well, that's a discussion you need to have with your patient. But where is the time in their day? Are they a busy mother of three who only has between 6am and 615? To herself, then what we do is we do what can be done there. And because so much of this is about awareness, these things can be happening through the day. So when this lady starts to feel some pain in her hips sometime in the day, she knows she could actually just check or by going back here again, do I have a choice? Well, I do have a choice. And so it's less about repetitions, and more about the awareness and the empowerment to know you can make a different choice.

Steven Bruce
Does that make sense? Yeah, that makes that makes perfect sense. Was there a fifth circle that you haven't talked about? Because you've

Joanne Elphinston
Yes, that is the circle where we actually look at ourselves through through perhaps more of a lens than we normally do. So we often we find out more and more things to do for the patient, without necessarily attending to what are we bringing into this? Alright, so the great gift of COVID is that I've been able to run much longer programmes to help with implementation, but also the feelings that come up when you're working with patients and we start to find out things like if we're going to work with patient regulation, how regulated are we? Are we coming screaming into the clinic at the last minute because we've had to, you know, feed the cat and get the kids to school, and then we've got the news on, and we've got all of this happening. And then we open the door and take our first patient. So are we actually regulated in ourselves? Order our expectations, you know, when we're all in different places, but things that come up with a lot of people think, you know, they're, if something doesn't pan out as expected, that they've failed, or they've made a poor choice. And sometimes it's just a case of well, actually, it was a really good idea. But that person's nervous system needed a little bit of extra information to make that work. So we talk about this and say, well, have they come in highly activated? Do we need to bring them to a more, a calmer, more receptive place? Is it that they have the muscle capacity, but the brain hasn't quite made a connection, let's put some sensory input in there. And then see what happens next. So we keep moving forward, rather than getting caught up on, I had an expectation of an outcome from that exercise, and it didn't work. I keep saying to therapists and clinicians, don't be so jolly attached to the outcome of the exercise, because whatever you see, is just giving you more information. For the next step, know how we change that. There's so much I can talk about, you know, in terms of the

feelings that we harbour, and it really contributes to things like burnout. You know, I see so many clinicians who are, they're worn out, they're exhausted with having to know enough to keep up with everything. They're feeling overly responsible for their patients process, instead of actually letting the patient have their process. How do I make the patient do this? Make a patient do anything, you know, if I've actually given them the opportunity to sense what's been going on in their body, and I link it to what is functionally meaningful to them to give them an understanding of this, they have to make a choice. If they don't, it's not my job to make that choice for them. I've done my job reasonably well. Most of them come on board. Indeed,

Steven Bruce
the second of your circles, or one of the five circles was that emotional aspect of what was going on? A lot of people might wonder whether you need specialist skills to delve into the emotions. And I wonder what training you've had? And to what extent you think somebody's coming on one of your courses, let's say and I don't know how long those courses are? To what extent they can understand that adequately.

Joanne Elphinston
Yeah, no. So the programmes, you know, they're more lengthy now. So what people do is they come they do some self study for the first month, then they have two half days with me. And then they have another month, now they have another two half days with me, and then we do it again. And so we're really taking them through this journey to explore some of this. Now, you don't need specialist training to be working with the autonomic nervous system. Most of you are doing it naturally, without necessarily realising it. Yeah. And just a little extra knowledge. Because I mean, heavens, there's people that like the trauma informed thing is like, it's out there everywhere, you know, from and some of it being done very well, some of it. But I mean, yes, I've got I've got quite a lot of background, in in this kind of field. But what I've taken from that is what you actually can, within your scope of practice do very well. So for example, recognising right from the beginning, this patient is either on hypo, responsive or hyper responsive, before they even come in. So you might have had a treatment plan, but it's not going to be relevant today. And if you stick to the plan, then both of you are going to get to the end of the session, not very satisfied. So that's number one. Number two, how can we start to help someone to self regulate enough to be able to engage with what you want to do, because unless the nervous system is actually, you know, in a calmer, more receptive state, you cannot expect change. So I see this over and over again, with people that an athlete I'm working with at the moment, has had years of problems. And I've got to the point where I mean, he's an Olympic finalist level athlete, but he's now not able to function. He's had all the normal stuff. But the overwhelming impression when he's sitting in front of me is he is so stressed. He's virtually levitating. And it was so interesting. I did all of his objective tests just like you always word. He had a particularly painful hip. I tested the hip. It was very restricted. But in that time, I needed to give him the most important thing for him. And that was actually to sort out the breathing, because he couldn't have any kind of centre, a court without having intra abdominal pressure. So it's going to work on a mechanical sense, I'm particularly going to help him breathe down into his pelvic floor, which for men can have the most profound effect on chronic hip problems. I've seen such a lot of that, but it's also working on him autonomically. And so interestingly, he came back a couple of days later, and his hip range was great, hadn't treated the hip, just gone through the autonomic nervous system. That's where he holds his tension. Yeah, I don't have to go into all the whys and wherefores of his family history. And his childhood is not my business and not my scope of practice. But what I can do is understand how the breathing mechanics can address certain holding intention patterns that are having a mechanical effect. Right.

So there's many elements of this. But like I said, people are dealing with it in their clinics, but maybe not so aware. And just with a bit more understanding of the various autonomic states and how they show up, you know, then you can actually adapt what you do. The rhythm of the session, for example, to understand, you know, some people who are coming in a very heightened state is no good try to go into some breathing work, because they can't, they can't settle, they need to move. So Fine, let's do something a bit more vigorous, and we'll gradually bring them into a more settled state, maybe that's the best state for them. Or maybe we need to just bring them back up again, just not as far as they came in, we can change that with the rhythm of our session. So for example, if you decide that your normal is to spend 90% of your treatment in a hands on lying on the bed, and then a rushed five minutes of exercises, then you've got a rhythm that's a little bit out of sync for helping that person to go back out into the world. If you're actually aware of that, you can have a profound effect on how effective your treatment then is.

Steven Bruce
Sounds a little bit as though rather like a dog trainer, you spend as much time training the practitioner as you do the patient. Yes. And I don't mean that in a disparaging way, because sometimes we get stuck in our rhythm or stuck in our patterns, don't we? And and then we tend to blame the patient if they're not getting better. But we do get very stressed, I find myself getting stressed if patients don't get better, exactly what am I doing wrong? Yeah,

Joanne Elphinston
exactly. We turn it on ourselves. We've been trained in a fairy tale. And the fairy tale is we do an assessment, we do a treatment, they improve, you make a plan, they come back, you do the plan. And it's like, it's a fairy tale. You know, the plan might have been perfect for where they were last week, but since last week, they've lost their job, you know, their child has failed their exams there or whatever, they're in a completely different place. And what we're saying here is, let's just be humans, working with humans, rather than trying, you as a clinician trying to fit into some kind of model of what a perfect clinician is, and trying to get them to somehow get into the mould of what a patient should be doing. And let's just throw all that away and go, right, where are we both today? Because I think one of the things that really comes through in the programmes, people come for all the movement work, but they find as they go through it, that they're starting to experience those and these feelings and beliefs become obvious. And to be able to work with that.

Steven Bruce
I've got a couple a couple of questions that just come in. One, I think you'll probably dispense with quite quickly, Danny Says, did Joe just reference stress to be causing hip dysfunction in an Olympic level athlete? And I sense an element of astonishment in that?

Joanne Elphinston
The answer is yes. Yeah. Yes. And the thing is, when we say stress, we think it's something up here. Yeah, stress isn't up here. Stress is fully embodied. Yeah. And we all have different patterns for that. So how is it being embodied? And you know, I've seen it in elite squash players. Same thing. I've seen it in many, many people. But with men, it's so so interesting that posterior pelvic floor is where a lot of tension gets held. And if we think about the pelvic floor and the accurate ligaments coming into the hips, anatomically, there's no mystery here at all. It's just understanding that what is happening in the body is not separate from, you know, what's happening emotionally, and that what's happening emotionally is an entirely embodied experience, not just something that's in the head.

Steven Bruce
Well, here's a good question from Caroline, which we've probably got time to deal with. Could you enlarge on what you said about breathing into the pill? Vick floor, please. So there's lots of people thinking, right, I've got a new technique that I can use on men that they will find very effective. So how do we do it? Yeah,

Joanne Elphinston
yeah, absolutely. Do you know I just yesterday I had a patient who had had really immobile hips, it had to give up paddling, it was his passion. He couldn't move through his hips, he was getting increasing dysfunction. And this was the big game changer for him. And he was telling me about how he uses it. Now, mountain biking, he said, You know, I couldn't bike without getting really awful shooting pains in my adductors. And that's why I do the pelvic floor breathing, and I don't have any pain. So there we go, how? Well, I usually start either depending on the person, it could be sitting or it could be lying down. I start with quick check breath, like I did before to find out, not just for me, but for them to find out what is my habit. I encourage them first to breathe, where it's easy to become aware of it. So if they're an upper chest breather, I get them to imagine there's a balloon inside them. And that that balloon doesn't just expand forward, but it expands backwards. I mean, they expand in all directions, and they balloons. And often people are only going up, and they're not getting the full expansion. And once they get that we move down maybe to the diaphragm area, and then we move down to the abdomen area. And then we don't doubt it and we put the balloon in the pelvis. And as we breathe, we imagine that we're breathing are sitting bones apart, and then they settle back in again, as that posterior pelvic floor in women often alter, I'll start with the feeling the pelvic plates, the Ilia. And as you're breathing in that balloon is expanding them. So they just allow for the expansion and they settle again. Of course, it's it's not like your bones are actually doing this. But what it's doing is it's changing the tensions. The other day I had someone the most effective thing they needed was to actually breathe the little coccyx away from their pubic bone and create space in that dimension. But overall, I would have to say the breathing your sitting bones apart for men for that posterior pelvic floor can have such a profound effect. So yes, I would I would crack into that. Like I said, there's I could talk to you all day just about breathing techniques for different scenarios. But that's, that's an easy one to see. Foreign.

Steven Bruce
We'd love that. I've been pressuring you into getting back into the into the clinic here where we can get a model on a treatment table. And we can go through some routines, which you know, people can put into practice themselves. Cookie has come back and has confessed to being a man as I suspected. But I'm reading this because he says Joanne is a complete gem, which is a lovely play on your business name. He's had the opportunity to sit. He's had the opportunity to sit on a sitting on your therapy Expo seminars in the past years. And he learns a lot. So he's thanking you

Joanne Elphinston
so much. Okay, it's brilliant to hear from you. I'm so glad. Yeah.

Steven Bruce
Well, it is nice to hear, isn't it? We did, we did talk about courses. And in fact, before we went on air, I said, Well, you know, come and run one in the studio here. We've got a massive area with a dance floor as on this dance quality floor on the on the studio. So maybe we can set something up. What are you running courses at the moment?

Joanne Elphinston
Yes, well, what I've done, I'm not doing traditional courses anymore, because I'm so I'm really, really interested in not just giving people bits of information, bitty bits, but actually helping them to really embed them and find new new richness in their practice. And so then they're actually programmes that are like mentored. So the next one launches on February the second, we've just launched the bookings. And there's a 10% early bird discount till December the 15th on it, and then what happens is, like I said, I've done all of these lectures that are exactly like what are happening here, plus all these really high quality professional videos that shown real detail the handling the cueing the wonderful thing is that like with a face to face course, you can only give so much but with online that's taken away, and people can keep going back and perfecting and then when they come back and I still do some live teaching with you but But what I'm interested in like, well, how's it gone, what has surprised you what's really challenged you? And you also get to find out that the things that you're struggling with the same things that everybody else is struggling with, from either understanding or just how you're feeling. And and that's just incredibly empowering in itself to find out that you're not alone. Never. And it means that over time, we actually get that chance to help people to really go in with their patients. And then we're going to work with this. Find out where the rubbing points are come back and say Is it me or is it so

Steven Bruce
Joe we literally we're on right on the edge of time and where do people go if they want to know about this?

Joanne Elphinston
Okey dokey. So you want to flip that last slide up for me the second last slide. If you come in There's a QR code if you can take a picture of it, but if not just come to info.

Steven Bruce
I'll send it out anyway, I'll send it out an email either later today or tomorrow morning. Yeah. Yep.

Joanne Elphinston
So I've launched the course it's on links on the Facebook, Jim's Facebook, don't go to Joe and Elphinstone. That's just family photos. But Jim's on the Facebook at Jim's Joanne on Instagram, and LinkedIn. So come join me. And if you if you join the the, the newsletter page, you'll get a little free mini masterclass download. And I've also got another downloadable of some of the really common persistent problems that come in and some movement solutions for it as well. So

Steven Bruce
that's really kind of I'm very conscious that people probably have patients at two o'clock and we do to finish right now. So yeah, thank you for putting a new slant on the term a regulated healthcare professional, because I think that that amuses me, I'm looking for a way to use that at some point in the future. But we're out of time. Thank you again for being such a great guest.

Joanne Elphinston
So welcome, and thanks for having me.