

This is the “T” of the Jing HFMAST protocol - teaching your client self care exercises.

It is really important that your client goes away from the session with an idea of some activities they can do to help themselves. It is very easy for clients to feel out of control and helpless when in pain and this is not helpful for the healing process.

Clinical experience and research shows that encouraging the client to take a part in their recovery leads to a more positive outcome. There are many self care exercises that can be helpful but the key to all of these is empowering the client to feel they are in control and not just reliant on “experts” (including you!)

Giving clients self help techniques

- When giving clients self help techniques always make sure you demonstrate the exercise first.
- Then observe your client carrying out the exercise and help and modify if needed.
- Make sure your client is carrying out the exercise in a way that is safe for their body. This is particularly important with the stretches where you need to help the client work with the breath and body awareness.
- Emphasise to your client that they know their own body best and if anything hurts in a “bad” way (rather than the “good” feel of a stretch) – DON'T DO IT!
- When they return for the next session make sure you watch them do the exercise again. You would be amazed at how they may have re-interpreted things in the meantime!
- We recommend giving no more than 3 self-care exercises at any session. Any more than this will be difficult for the client to absorb. In many cases only one well taught suggestion will be enough.
- You will need to use your own clinical skill and judgement to decide which exercises are appropriate for your client – for some people a range of stretches will be needed while for others a simple breathing exercise will be enough.
- Make sure you try the exercises yourself first so you know how they feel on your body.
- Remember to always stay within your scope of practice and limits of indemnity insurance for your own profession- for example do NOT give out nutritional advice if you are not qualified or insured to do so.



Advice and reassurance [1]

Many clients who come to you will feel completely out of control about their pain condition. They may have internalized many wrong and unhelpful beliefs such as “I can’t carry on running” “It’s arthritis, I will end up in a wheelchair” or “Whiplash always lasts for years”.

For the most case these beliefs are without foundation and modern neuroscience proves unequivocally that such negative thoughts in themselves can increase the pain experience.

Most musculo-skeletal injuries will heal naturally by themselves within a period of days or weeks. Acute injuries often become chronic because negative beliefs about the injury lead to unhelpful behavior such as lack of movement and anxious thoughts.

This can cause the brain to literally “turn up” the pain signals. In many cases real pain persists even though there is no longer any actual damage to the tissues (although there are likely to be trigger points and fascial adhesions which are sending persistent nociceptive input to the brain)

Providing the client with up to date information about their condition can enormously help recovery. Let them know that the body is programmed to heal and educate them about how their beliefs about the pain condition may be contributing to their pain.

Explaining about the concept of trigger points can really help by giving clients a rationale for their ongoing chronic pain situation.

Time spent with your client reassuring and educating in this way will be extremely valuable in speeding recovery time.

CLIENT EDUCATION

Chronic pain

- Hurt does not always equal harm, especially in chronic pain situations. Although the pain your client is experiencing is very real it is not necessarily in proportion to any tissue damage.
- Our brains have much more control over the sensation of pain than previously realised. Messages do not just go from the 'bottom up' but can also travel 'top down'. In other words, our brains can turn up or down the 'volume' of the pain sensation. **(2)**



Our brains can literally 'turn up' or 'turn down' the volume of pain sensations.

- The nervous system has the ability to increase or decrease its sensitivity (neuroplasticity). Emotions, stress, and our beliefs and behaviour about pain can cause an increase in pain. **(3)**

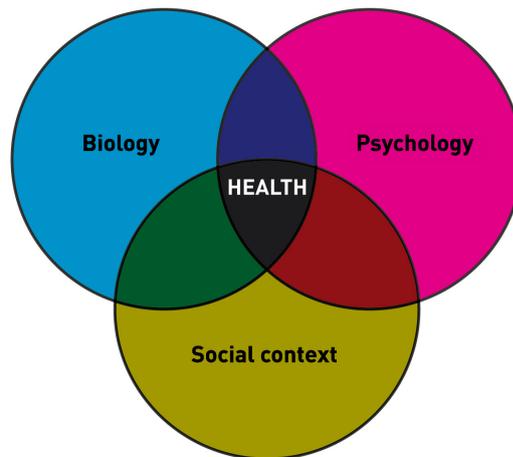


Emotions and stress can cause an increase in pain

- Any activities or behaviour that help decrease stress or change negative thought patterns will be helpful in decreasing pain. **(4)**



- Activity is desirable. If activity hurts this does not mean we are doing ourselves more damage. Building up activity gradually over time is the best approach.
- Pain indicates 'threat' rather than 'damage'. Is there anything your client feels that may be a threat to their physical or emotional wellbeing? Is there anything they can do about these factors?



Biopsychosocial model **(5)**

- The current dominant model of pain is known as the 'biopsychosocial model'. This emphasises an approach that treats the whole person, taking into account mental and social factors, rather than just the physical symptoms of disease.
- **Biological (the 'bio' bit):** the biological components of the pain condition include factors such as disease, tissue damage or abnormalities of structure. For example, in musculoskeletal conditions the 'biological' components would be nociceptive inputs such as damaged soft tissues (sprains and strains), degenerative joints (osteoarthritis), disease processes (rheumatoid arthritis) and herniated discs. Our prevailing biomedical model of health usually assigns these components primary importance, however, this is only one piece of the puzzle.

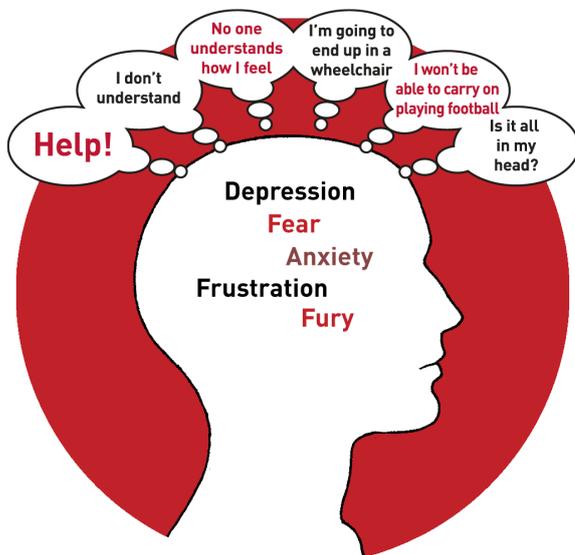
• **Psychological:** psychological and cognitive factors also contribute to the pain experience. These include:

- Emotions: there is a complex and often self-perpetuating relationship between pain and emotions e.g. depression can lead to episodes of chronic pain and chronic pain can lead to depression. Our brains are literally able to turn up or down the volume of our pain experience depending on how we are feeling.

- Pain related beliefs: our belief about the pain condition can also have a huge effect. A common belief is known as 'fear avoidance'. Often individuals in pain become terrified of movement, believing that this will cause more injury and therefore more pain. The reality is, however, that fear avoidance and lack of movement by itself leads to increased pain and disability.

- Catastrophising: This refers to unhelpful thought patterns that basically foresee the worst possible outcome. Research has demonstrated a consistent relationship between the tendency to catastrophise and the heightened pain experience. (6)

• **Social:** You are more likely to experience chronic pain if you have lower education, low income or are unemployed.



Red and yellow flags (7)

• Red flags are warning signs to the practitioner that factors other than musculoskeletal issues may be at work. For example, these would include signs such as the pain being unrelenting even at night, accompanying systemic ill health, unexplained weight loss or a recent accident.



• The presence of one or more red flags in musculoskeletal pain conditions may be indicative of a more serious pathology and in these cases the client should be referred back to a medical practitioner to have this checked out.

• Yellow flags are indicators of psychological factors that may be involved in perpetuation of the pain issue. In acute situations, unaddressed yellow flags may mean that the pain is more likely to become chronic. In existing chronic pain conditions these elements can be a barrier to recovery.

A great mnemonic for remembering the major yellow flags is the '**ABCDEF** and **W**' sound bite. Gentle and open questions around the areas below will help you to tease out the role that psychological factors may be playing in perpetuating your client's pain condition:

- **Attitudes:** what is the client's attitude towards the current problem?
- **Beliefs:** unhelpful beliefs about the pain can be absorbed from friends, the media or misinformed professionals.
- **Compensation:** is the patient awaiting payment for an accident or work related injury?
- **Diagnosis:** ask the client what they have been told and what it means to them.
- **Emotions:** clients with high levels of stress or other emotional difficulties, such as on-going depression and/or anxiety states, are more likely to have chronic pain issues.
- **Family:** both under-supportive and over-protective attitudes can play a role in perpetuating the pain.
- **Work:** lack of a meaningful occupation or feeling unsupported, bored or being bullied can exacerbate pain states.

The issues are not always in the tissues. Sometimes pain is in the brain!



USING PACING AND GRADUAL EXPOSURE

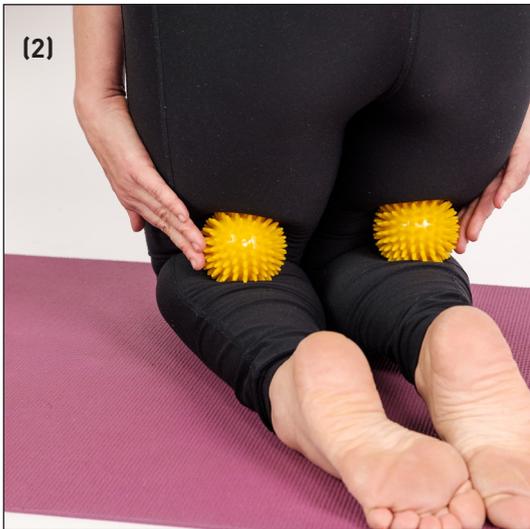
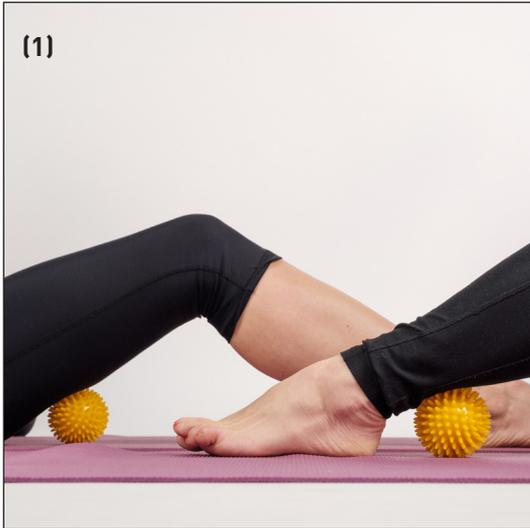
One of the challenges around recovery for clients in pain is determining how to advise them on exercise, movement and the challenge of returning to both necessary and enjoyable activities. All too often clients in pain fall into some level of inactivity due to their pain levels.

Clients' attitudes often fall into the categories of "boom and bust" (push through the pain then drop with exhaustion) or "avoidant" (avoiding potentially painful activities altogether)

A more sensible approach involves gradually increasing the level of the activity in question. Movement is important in recovery from chronic pain and it is important your client is encouraged to gradually return to the activities they enjoy.

- Decide with your client which activities they want or need to work on (cycling, walking, tennis, playing with kids, dancing).
- Determine their baseline - this is the amount of activity the client can do without pain flaring up. (Might only be 3 minutes cycling on a flat surface but that's a good start).
- Encourage a planned progression of the chosen activity - the client does a little more than they did yesterday but not much more (i.e. 4 minutes cycling the next day).
- If the pain flares up return to the previous baseline for a while.

For more intel on chronic pain check out 'Massage Fusion: The Jing Method for the treatment of chronic pain'.



SELF TRIGGER POINT AND ACUPRESSURE TREATMENT

SELF-MASSAGE USING A SPIKY BALL (1)

- Show your client how to stimulate the whole length of the areas of pain including gastrocnemius, hamstrings, tibialis anterior.
- Use the floor to apply extra pressure.
- Put the pressure into the ball before you start to move it.
- Play with it!

If you find a trigger point, wait and hold for 8-10 seconds.

MEGS 3-IN-1 SPIKY BALL SPECIAL (2) (3)

- For a 3 in one 'Meg spiky ball special', kneel and place the spiky ball between the hamstrings and the gastrocnemius.
- Now lean back and meditate!



MOBILISING AND STRENGTHENING

MOBILISING KNEE AND ANKLE

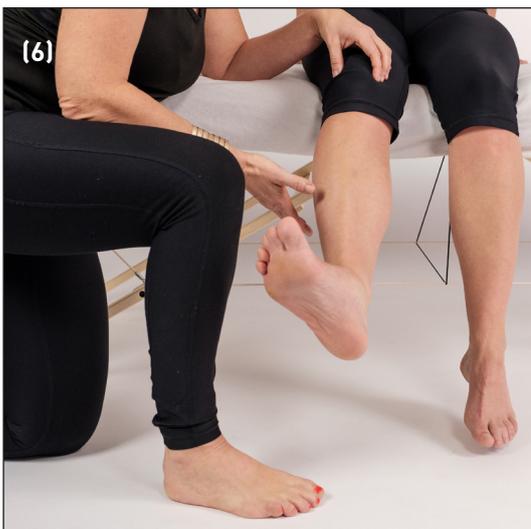
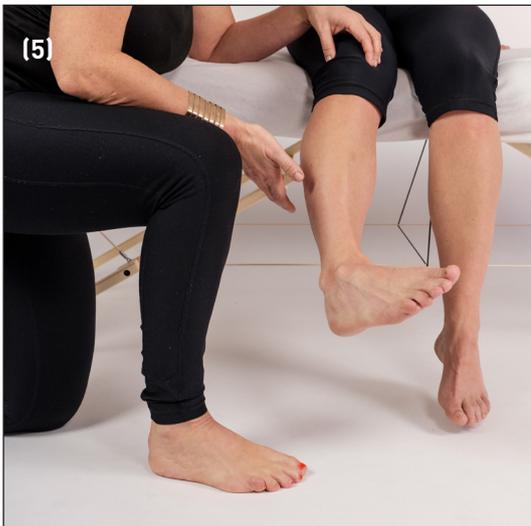
Instruct the client to do the following several times a day for at least one minute each time:

Knee (4)

- Sit on a high table and alternately swing the legs and knees back and forwards.
- Client just takes the mobilisation to the end of their range of motion.

Ankle (5) (6)

- In sitting with the leg lifted and supported, circle the ankles first one way then the other.
- You can also instruct your client to draw letters of the alphabet with their foot which will encompass several ranges of motion.
- Point foot away from you and towards you, 10 x each.
- Turn sole of foot inwards then outwards, 10 x each.





Knee strengthening

- In sitting on a chair with the knees bent, lift and lower the lower leg so it becomes extended (you can use a weight around the ankle if needed). Repeat 10 x 2 sets



Proprioception and strengthening training for ankle

- A great exercise for general hip stability, strengthening and proprioception (the ability to sense stimuli arising within the body regarding position, motion, and equilibrium).
- In standing rise and lower on the toes of both feet 10 x **(7)**
- Progress to one foot **(8)**
- Progress to standing on a cushion or wobble board.
- Progress to standing on wobble board/cushion.



STATIC STRETCHES

Our top tips for teaching self-stretching are:

- Fully demonstrate the stretch.
- Talk the client through the stretch.
- Make sure that the client is holding the stretch for the full period of time you are requesting (30 seconds at least).
- Encourage them to breathe in then out on the stretch and tune into their own body to where the stretch 'feels good'.



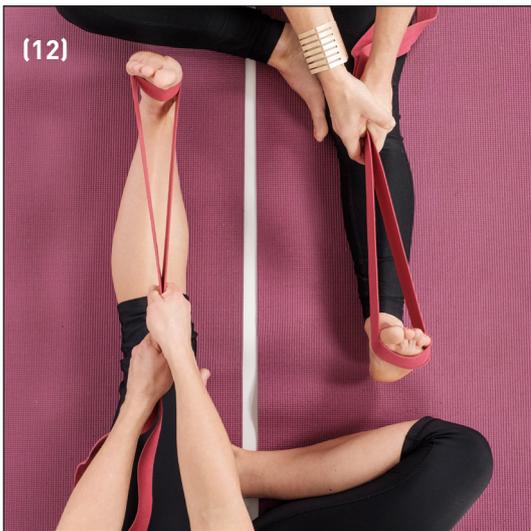
Quadriceps

- Client stands by a wall or table for support
- In standing, ask the client to lift one leg, bend the knee, hold the foot and guide towards the buttock and slowly take leg back behind body. **(9)**
- Hold 30 seconds repeat 3 x repeat on other side.
- An advanced variation for flexible and confident clients is to take them into the yoga pose 'dancer' which also stretches the rectus femoris and psoas (as they both cross the hip joint) **(10)**



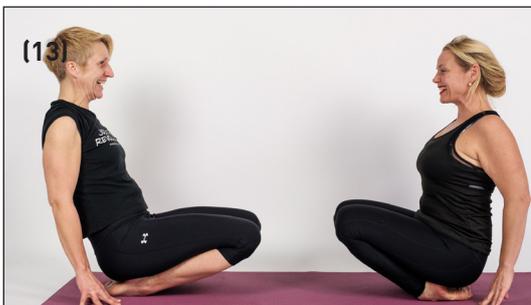
Hamstrings (11)

- Client lies on their back. Instruct client to wrap a belt around their foot and hold the other end.
- Instruct the client to raise the straight leg until they feel the stretch.



Gastrocnemius (12)

- Seated on the floor, client wraps belt around the foot.
- Keeping the knee straight, client takes toes to head (ie: dorsiflexes foot) to stretch the gastrocnemius.



Tibialis anterior (13)

- Client is kneeling with feet in plantar flexion.
- Instruct the client to slowly take the weight backwards, supporting with the hands, until they feel a stretch.



ACTIVE ISOLATED STRETCHES (14A) (14B)

Tips for teaching active isolated stretching as self-care to clients:

- Demonstrate the stretch on yourself first.
- Make sure the client is going to their end of range using ACTIVE movements.
- Ensure they fully assist the stretch for 1.5-2 seconds.

Quadriceps

- Client sidelying with knees curled up against chest in foetal position. Ensure neck and head are relaxed and on table.
- Client brings leg back as far as possible while keeping knee bent by contracting hamstrings and gluteal muscles.
- Client applies own assistance at end of stretch for 1.5-2 seconds using hand or rope depending on flexibility.
- Release and repeat. Do 2-3 cycles of 10 repetitions.

Hamstrings

Bent leg

- Client lies on back with both legs bent.
- Now instruct them to straighten one leg as far as they can.
- Client assists at the end with a rope or belt around the foot and holds the increased stretch for 1.5-2 seconds.
- Release and repeat. Do 2-3 cycles of 10 repetitions.

Straight leg (15)

- Client lies on back with both legs straight.
- Now instruct them to bring one leg up as far as they can to the ceiling while keeping the knee straight.
- Client assists at the end with a rope or belt around the foot and holds the increased stretch for 1.5-2 seconds.
- Release and repeat. Do 2-3 cycles of 10 repetitions.



Gastrocnemius (16A) (16B)

- Seated on the floor, with both legs straight, client wraps belt around the foot.
- Keeping the knee straight, client actively takes toes to head (ie: dorsiflexes foot) to stretch the gastrocnemius. Make sure the client is not just pulling on the belt to achieve the required movement.
- Client provides assistance at the end of the stretch for 1.5-2 seconds.
- Release and repeat. Do 2-3 cycles of 10 repetitions.

Soleus (17A) (17B)

- Client seated on the floor with the exercising leg bent (ie: flexed at the knee).
- Client takes toes to head (ie: takes foot into dorsiflexion) and assists stretch at end with hands for 1.5-2 seconds.
- Release and repeat. Do 2-3 cycles of 10 repetitions.