Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy (notes compiled by Katarina Halm July 2020)

Previous notes for our project:

---

* yet to add images ~ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy, Matilda, Celeste (notes compiled by Katarina Halm) 200714

https://thinkinginmovement.ca/wp-content/uploads/2020/07/Feldenkrais®-Osteopathy-Developing-Collaboration-with-Ian-McCarthy-Matilda-Celeste-notes-compiled-by-Katarina-Halm-200714.pdf

---

* with excellent images ~ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy (notes compiled by Katarina Halm) 200707

https://thinkinginmovement.ca/wp-content/uploads/2020/07/Feldenkrais%C2%AE-Osteopathy-Developing-Collaboration-with-Ian-McCarthy-notes-compiled-by-Katarina-Halm-200707.pdf

Current document below * perhaps to add images ~ Feldenkrais® & Osteopathy, Developing Collaboration with Ian McCarthy, Bonnie, Celeste (notes compiled by Katarina Halm) 200721

COLLAGEN / HYPERMOBILBITY / CELESTE'S KNEE

McCarthy refers to the two annotated * articles from a Master class
(links to an informal reading and to the articles by request)

QUESTION 1: Collagen & Rehab & Hyper-mobility

IAN REFERRING TO CELESTE'S KNEE
Collagen is quite important.

It is amazing how frequently misdiagnosed this condition of Hyper-mobility is. 8-9% of the population have benign mobility syndrome. Gastrointestinal issues, a family history of varicose veins, even mental things like depression can all tie into something that stems from muscular or skeletal conditions. Joint dislocation, skin conditions, etc. are at least a few that we are now aware of.

Yours is a typical case. The primary subjective criteria that you need for the diagnosis for you is you have a dislocation of your knee cap. It is a perfect example. But for many people It is harder to diagnose. An MRI might be needed.

IAN REFERRING TO TWO MASTER CLASS ARTICLES *
The authors of those * articles are the leaders in the current research. I have not looked for more papers recently so there might be more up to date research.

(CELESTE)
Many people coming into Feldenkrais® from dancing have joint problems. I wonder if most of these cases may be instances of Hyper-mobility.
IAN
I always ask patients if they have done gymnastics or dancing, these are highly correlated. There can also be over-stretching in yoga.

Hopefully your rehab will be 90% motor control stability activation work. Then you will need strength. That will come 6 months later. And I am referring to raw strength - gym, kettlebells, weights. [*One good side to aging is, hyper mobile people will experience less pain. One good side to hyper-mobility is that with aging hyper mobile people will experience less pain.]*

But the problem with the knee will stay there! [For example I lost the quadricep strength].

You need to do [the rehab] progressively and safely. [Your rehab] might start with wall sits, isometric strength. That might take a couple of weeks. But you will get there. Even the term “dead lift” may be scary but we all should be doing some form of resistance training. Tendon rigidity is immensely important for force production. Ultimately, muscles themselves contract, but it is through the tendon where most of the force is transferred. And the strength there is achieved through actions like dead lifts.

QUESTION 2: Feldenkrais & hyper elasticity

BONNIE
I have a Feldenkrais client. She has hyper elasticity. She is a swimmer, and experience various types of pain. She attributes her pain to having too much collagen. Is that an accurate thing?

IAN
Hyper-elasticity means hyper-mobility to me. Has she dislocated something repeatedly in her life? Is she able to put her palms on the floor flatly? What was she like as a child, super bendy?
How I end up finding out whether someone is hyper mobile, is by a quick screening as follows: Palms flat on the floor. Hyper extension of the elbows, hyper extension of the knees. Thumbs to the wrist. Pinky to the wrist. These together are indications of hyper-mobility.

BONNIE
My patient talks about it as a disease. I’ll ask her about joints.

I do not know where she got this information from.

Doctors.

IAN
It is usually the opposite. But I would do the screening with her. IF she scores at least 5, she is likely to have *benign joint hyper-mobility syndrome (BJHS)*. Even if she does not have *BJHS*, she could just be very flexible. And even if there is not a diagnosis, these people will still need similar help - stability and strength. It will be beneficial for her to know if she has *BJHS*.

Q3: IF I have developed pain under MY knee cap, could you clarify whether that could be a symptom of an underlying issue?

IAN
What we talked about is the condition BJHS. It is HEREDITARY and it manifests as a musculoskeletal problem. It involves LAXITY in the CONNECTIVE TISSUE. We discovered that Celeste had her unstable knee [cap/s]. When I hear of [unstable knees or ankles occurring repetitively, along with pain in ribs and shoulders] I begin suspecting BJHS. So I ask the person whether she/he has any digestive issues, fainting, low blood pressure […]. For some people there are very random symptoms. So that is the link I was making. I am sure osteopathically we could connect [immobility or hyper-mobility] to other conditions, but the issue of mobility is not going to directly drive [the related complaints.] [emphasis added]

***BJHS* syndrome is a softer version of EDS is a softer version of "Ehlers-Danlos syndrome (EDS) which is a severe condition.**

Benign joint hyper-mobility syndrome (BJHS)

"is the occurrence of musculoskeletal symptoms in hypermobile individuals in the absence of systemic rheumatologic .."
... "Benign joint hyper-mobility syndrome is thought to be a mild variation of EDS and most closely resembles EDS type III (hypermoblity type), which consists of joint pain, marked hyper-mobility, mild extra-articular involvement, and mild skin changes without scarring." https://jaoa.org/article.aspx?articleid=2093276

EDS "Ehlers-Danlos syndrome

"(EDS) is a disease that weakens the connective tissues of your body. These are things like tendons and ligaments that hold parts of your body together. EDS can make your joints loose and your skin thin and easily bruised. It also can weaken blood vessels and organs" https://www.webmd.com/a-to-z-guides/ehlers-danlos-syndrome-facts#1

IAN
There is a very common pelvic pattern that I find very prevalent in the population. Left interior chain pattern. We are not perfectly symmetrical as humans. Anatomically we have a heavy liver on the rightsize, heavy heart on the left side, so lots of visceral asymetries. Larger right diaphragm. Neurologically we are predisposed to sit and walk on the right leg more than on the left. We are fighting to be symmetrical.

Does anyone have a patient who has more flared ribs on the left side than on the right?

SO we are more predisposed to stand no our right leg. When we stand more on the right leg, then the left pelvis anteriorly rotates. And the right one posteriorly rotates. Then you get shorter left hip flexors and long left hip extensors.

You are standing on your right leg.

Short muscles:
L hip flexors
R medial hamstrings
R ADDUCTORS

Long muscles:
L medial hamstrings
R hip flexors
R gluts and external rotation muscles
L groin (ADDUCTORS)

-
[Diagram here?]

So eventually my pelvis turns to face the right side of the room. Now my femurs want to match that, my right leg will externally rotate. But you cannot walk or run like that. The body fights it.

So your brain will shorten and contract your ADDUCTORS on the right to turn you back forward.

Postural Restoration Institute. They claim about 85% population are in this pattern. I believe a good chunk of population will have that. I would make the argument that a lot of people would benefit from having left hamstring strengthening and the right glut is strengthening to get the balance back in place.

If you are working with stability and strewth, you should be 20% more hamstring work on the left. You want to try and shorten it to pull the pelvis back into its neutral position.

One you are more square, the overworking muscles can start firing correctly. That's only step 1.

So if you're walking with this pattern, It is difficult to watch someone and pick this up by just looking. But you can assess it.

Lastly - strengthen your right ABDUCTORS and EXTERNAL ROTATORS. It is very important to understand when you are working with people. But that is not for everybody. I encourage you to test it.

A typical left EIC pattern is commonly paired together with another pattern, BC pattern. The upper body has to turn back to the left hand side, the right shoulder has raise itself up and the neck has to derogate to get square. So you'll get tighter right diaphragm, tighter muscles on that side. So if your patient is lying down and their left ribs are flaring up higher, so weaker left diaphragm. That we are genetically supposed to have.

Celeste, going on to you about long hamstrings.
One simple test is to check their straight leg raise. (shows) Left leg might lift higher than the right one.
Second test is (cannot understand) The right hand might drop down lower in that test.
The third test is check their lumbar rotation. Their lumbar spine may already be rotating right, so they might have very little right rotation. But a lot of left rotation. Knees together on the table...

BONNIE
From a Feldenkrais point of view I am looking at it a little differently than 'strengthen this', you know, but it is very good information. I really appreciate the help with knowing what to do with my client, because when she said there was too much collagen that did not make sense to me either. So that was really useful.

CELESTE

I am surprised by what Bonnie says about her client, because for me lack of collagen... I know that and have difficulties when I try to take collagen supplements. It is not good for me. I start having problems and see that I am doing better when I stop.
The other test is the skin test. If you pull your skin and it is like paper, I do have that since some years ago, so I know I fit well for hyper-mobility syndrome. I do think it is lack of collagen.

So maybe it was a misunderstanding about a lot of or a lack of collagen.

[inaudible conversation about the groups.]

IAN
I will just continue where I left off.
The two tests we are looking at so far:

Hamstring length:

you typically find the vast majority of the population have a longer left hamstring than a right one and a shorter left hip flexor which was the test to grabbing that knee and falling back and see how far the leg drops down.

-

[Diagram here?]

Again, on the left side you will typically find it will be much higher, so the hip will not drop (?) in the extension as well.
I think I stopped just as I was showing you the lumbar rotation, so typically patients will have limited right lumbar rotation compared to left because they are already in right rotation.

The other test you want to look at are manual muscle testing and strength testing of the glut medius minimus on one side

which is typically done pretty simply by sitting on your side this way and testing the top layer and back in an extended position here, and resist the patient - they are pushing up as you are typically pushing down into their hands. How strong are they here?

[Diagram here?]

And then you will flip them over and try the same on the opposite side to test the strength of the glut medius minimus and the ab and ADDUCTORS. For groin testing there is something called a Copenhagen Lift, which is basically like a sideline hip abduction exercise.

I cannot show you here by myself, but to test the strength of the groin you can also just get the patient to lie on your back. It is a little easier test that I tend to do if I am in a hurry.
Lay on your back this way and just resist the pushing in on the right versus the pushing in on the left.
Again, the vast majority of the population will typically have a weaker left than right groin.

Another worthwhile test some people might even want to try now. It is not an official test, but is something I have been playing around with myself. The 90/90 hip position, where you put one hip in exterior rotation 90 and the back in internal rotation 90 and the key is to try to stand as straight as you can.
A good chunk of the population will struggle when the right leg is in front in external rotation and the left behind, because in this position the right diaphragm internally - the transverse abdominus etc - needs to open as the left side needs to compress.
But because of the Right BC Pattern that we are typically predispositioned to be in we will really resist that and will want to be more in this type of position, when I am compressed on the right.

[Diagram here?]

Even I find this easier, and you might find the same. It is easier for me to stay here because my right diaphragm is in a compressed position and my right obliques are in a compressed tightened position, which is what we prefer, than the left side. Because the left side just needs to open up and this is easier because it is already opened up in a Right BC Pattern. This is typically longer, weaker, overstretched. And in this position here that is exactly what it is - longer and weaker and is going to be overstretched, but I need to contract the right side. It is kind of frees this position to be in that pattern.
So that is the 90/90 hip position.

This is kind of a roundabout way of saying this, but talking about hip/ab and adduction and length/tension relationships, I think it is a really good idea to make sure patients are or are not in a Left AIC Pattern before deciding what to do with their hip ab and ADDUCTORS. But, again, most of the population will need stronger right gluts and stronger left groins.

Now, you might be wondering what type of pain would patients come in with that are in a Left AIC Pattern. Numerous, is the answer. Everything from knee pain to neck pain really, because you will typically find in this pattern, with the lower back turned to the right and side, you typically get right SI joint hyper-mobility and left SI joint compression. So they actually complain of SI joint pain.
If they come in and say they have a history of a bulging disc or slipped disc (awful term, because we all know that discs do not slip), it will typically be on that right side because the peak of the rotation occurs ... ? and... S1..? on the right side. It would very often be right-sided back pain.

Then periformis syndrome on the left side. Pop question, can you guess why it would be on that side? If you can get close you are rock stars.

Okay, if the left femur is internally rotated to match the orientation of the sockets. But what muscles are working triple time to try to keep your left leg rotated. My left femur is turned in this way because the pelvis is turned right. My gluts and external rotators are going to be working super hard to try and keep the left leg rotated outward.

Now, you will very often get periformis syndrome on the left side in these patients because their external rotators are working insanely hard to try and keep themselves balanced. They can also complain of anterior knee pain, on the kneecap, on either side because if you think about it a weaker left groin on the left with an over-dominant... I should not say 'groin' - let me be more specific.
I will take it one layer deeper, just to confuse everybody.

When I say the left leg and internal rotation and the external rotators are working really hard, I talked about the gluts, periformis, gemella, those deep external rotators on the left, but actually another muscle that externally rotates the femur is the vastus lateralis. Your outer quad muscle externally rotates your leg. Your outer hamstring, your b??m??s also externally rotates the leg.
So these muscles are also in a shortened position. If your vastus lateralis is working much harder than your groin and your VMO? on the inside, that is one of the major drivers behind knee pain. So that is another ab and adductor tie in there.

It is the exact opposite on the right hand side. If you have got an over-active shortened groin, ?BMO, but you have weaker external rotators, like the gluts, periformis, gamella etc, that can also cause anterior knee pain. So .??.?… impingement... , patella ... .??.?…. pain syndrome, quad ..?, all those things can often come from that as well.
So that is SI joint pain and lower back pain and anterior knee pains.

Then of course there is the upper body, with the right ?bc? pattern they will tend to get a lot more tightness on the right shoulder because in the Left AIC Pattern the right shoulder is lower. So trying to make the body level the brain will fire the upper trap muscle to square the shoulders up, it will turn the neck through here to there, so you get a lot of tightness in the upper left neck and the right shoulder region to try and keep square.

Very often, just looking at how somebody sits in a chair in front of you and they start .??.?… splaying ... .??.?… I will start smiling to myself that I know what is wrong with them already. Sometimes I even say that to them. They will say neck pain, headaches etc etc and I say okay is there anything else you have had in the

past or are currently experiencing and they will say oh yes left knee pain, and oh yeah I have been getting chiropractic treatment for my right SI joint for the last six months.

I had a patient this morning I saw for the second time and that was exactly it. I was smiling to myself saying I know what is wrong with her already, because the ...?... [he talks so fast!!!] the pattern and the way she was sitting, way back in her chair on her right side. You could see her belly button and torso was turned to the right hand side, and then she is listing all these complaints in all of the muscular areas that are technically short in the Left AIC Pattern, Right BC Pattern, so you can kind of put things together before you even assess them.

Then you go through two or three quick assessments, look at their hamstrings, groin and glut strength, their rotation and one other main test that I cannot show you without someone else being here. So you do all these tests and realize they are in a Left AIC Pattern and they go home with left hamstring strengthening, left groin strengthening and right glut strengthening.

Are there any questions about ab and ADDUCTORS? It is a very broad topic and I could probably talk for hours on it, but I just wanted to make people aware of that pattern in the population because I find as a general rule you cannot go too wrong by sending people home with more right than left glut strengthening and more left hamstring and groin strengthening, than the opposites.
So, any case scenarios you have found with your own patients?

BONNIE
Not exactly, but I have an idea. In some of the lessons we do in Feldenkrais we are asked to work from one side more than the other. I think that could match with what you are saying because we do not know why he did it that way. We think one side learns from the other, but I think some of the times the lessons are structured because we do have to work more with the right side. Mostly it is the right side.

IAN

Most certainly. Particularly in the thorax, because of the larger right diaphragm, the liver being on the right. We are innately, primitively if you will, predisposed to working very hard in this region. I find as an osteopath that does a lot of visceral manipulation and release that you typically get a lot more tightness on the right side than you do the left. That is why I say the rib flare on the left side is more prominent in the population.
So I agree, I think we work far too much from the right side, particularly in the thorax.

I have not taken any Feldenkrais training, so that is interesting. I learn from you as much as you do from me. It would be interesting to see specific details of what you learn in your courses and training and if that ties in with the whole Left AIC / Right BC Pattern, because of course in medicine there is more than one way to skin a cat and they could be identifying many of the same things.
But, personally in my career so far I have found that is actually the most detailed accurate description of what actually happens in a lot of pelvises in the body. I think it is probably one of the best courses I have taken. I have taken a lot but I think that is well out there with being one of the best because it is so damn accurate.

When you do identify somebody in that pattern the changes are amazing. The patient I saw this morning, a senior who spent two or three years battling a right SI joint problem, getting cracked up the wazoo with a chiropractor adjusting that joint. But that joint is actually hyper-mobile because she is in that pattern, and I saw her two weeks ago and when she came for the second appointment she was already better.

Now, she is only just learning how to stand and walk to get away from that right side, so it will be really interesting to see her in three weeks when she adds more strength to the glut and hamstring and stops sitting, walking and standing on the right side. I have a feeling she will probably be pain-free in about six weeks. So it is pretty cool.

[Replying to a comment]

That would be awesome. It would be interesting to see if they merge together. Maybe you could merge the left hamstring and right groin/glut strength work with some Feldenkrais and kind of put your own spin on it, because as I say there is more than one way to fix it. There is no one way. I bring in aspects from my athletic therapy, from osteopathy, some from sports medicine and mix it all together and find out the best way of doing things. **So there are multiple right ways and it will be really interesting to hear next week if you can tie some all this together.**

Okay, bye for now. Thank you

YOLANDA COMMENTS

This is fantastic. Personally I would be really interested in some practical exercises, even just for myself, with the left hamstring and right glut, as I am not a person who could give corrective exercises for a client. So, I just wonder what would that be.
Again, I would only maybe watch, think and hear again to match everything together, because there is lots of information. I get the idea as a general sense but to be precise I am a bit lost, because of the English.

Concerning my exercise, I found in the lesson of .??.?… Hebrew .??.?… the ATM lessons, from developmental process, the fifth and sixth, especially the sixth, lesson has this movement. He said to me to do it, the bridge. Doing the bridge but also for walking because Lessons 5 & 6 from .. .??.?…. book, I did one of the lessons for the child .... movement to start walking.
Maybe look for some of this position that you said before, having the leg backwards and the other one in front. I was thinking maybe from Esalen - choose to listen from Esalen because I think that is like a mini-training and we can find all the variations and themes from Moshé in those lessons. I will take a look and tell you.

KEY WORDS

left anterior interior chain pattern

heavy liver on right
bigger colon on the left
heavy heart on the left
[the **heart's** bottom-**left** chamber (the '**left** ventricle') is responsible for pumping oxygenated blood around the whole body, so it needs to be stronger and larger than the **right** ventricle, which only pumps blood to the lungs. It's this **left** ventricle that you can feel beating in your **chest]** https://www.sciencefocus.com/the-human-body/why-is-the-heart-slightly-to-the-left-in-the-chest/

asymmetries
anatomically
... neurologically predisposition to stand on one leg
and constantly striving to be more symmetrical:
left ribs commonly more flared in our population

MASTER CLASS ANNOTATED PDF & INFORMAL READINGS Two annotated articles on Joint hyper-mobility syndrome (JHS) with appreciation to Ian McCarthy July 2020

~ let Katarina know if you do not have these and would like to study them!

Manual Therapy 12 (2007) 298–309 Masterclass hyper-mobility and the hyper-mobility syndrome Jane V. Simmondsa,!,1, Rosemary J. Keerb,2 aUniversity of Hertfordshire, School of Health and Emergency Professions, College Lane Campus, Hatfield, Hertfordshire, AL10 9AB, UK bCentral London Physiotherapy Clinic, Harley Street, London, UK Received 5 March 2007; received in revised form 6 March 2007; accepted 12 May 2007