The Author's Philosophy: Overview Movement Dysfunction and Corrective Exercise

The human body is a complex, dynamic, integrated tensegrity system; the "whole is greater than the sum of its parts" (Cook, 2010, p. 20; Schleip, Jäger, & Klingler, 2012). Examining whole-person health-wellness-fitness or [movement] function-dysfunction includes identifying and assessing the domains of influence (e.g. work, school, family, leisure, etc.) while considering their neurological, developmental, biological, psychological, and social impact on an individual over time.

Movement dysfunction or MD (from a traumatic event or chronic/overuse) is a perturbation in the system which may present locally/globally (i.e. regional interdependence or RI) as (but not limited to): sub-optimal joint centration; muscle imbalances; mobility-stability issues; reduced adaptability; coordination/timing-activation problems; poor/inefficient/ineffective movement patterns; breathing disorders; problems in the integrated spine stabilizing system (ISSS) and intra-abdominal pressure regulation; and other maladaptations involving neurological, developmental, and biopsychosocial factors (Cook, 2010; Frank, Kobesova, & Kolar, 2013; Page, Frank, & Lardner, 2010).

Not all MDs are immediately disadvantageous; non-painful functional dysfunctions allow many athletes to perform at extremely high levels. "Correctives" may be contraindicated until after "retirement" or if pain emerges later (On Target Publications, 2011). A whole-person client-oriented approach is necessary in order to avoid myopia and unnecessary/ineffective intervention.

Baselines (e.g. screens/assessments) are necessary upon client intake to establish a basis for comparison in order to evaluate the effectiveness of an intervention. This is true for "corrective" or "performance" interventions. One should start with the "big picture" or global perspective (e.g. movement patterns) of the client before "zooming in" (e.g. muscles, joint-by-joint or JBJ, trigger points) (Cook, 2010; Page et al., 2010). One should always reassess after a particular intervention (and before discharge) in order to determine the next course of action. Address one issue at a time and reassess; by "correcting" one issue, other areas may be affected (RI). A practitioner should establish some kind of "standard operating procedure" (SOP) or framework (Cook, 2010).

How the Joint-by-Joint Approach Fits In

The JBJ approach originated from Gray Cook and was popularized by Michael Boyle in his *Advances in Functional Training* and "Strength Coach 3.0" series. JBJ is just one part in a larger SOP, but if taken just by itself, JBJ is myopic and runs into the same problems as the biomechanists' paradigm (Cook, 2010; Page et al., 2010). JBJ is also not the first step in client screening/assessment, but it could be 2-3 steps into the process. JBJ is congruent with the author's philosophy and the author's experience in previous classes--JBJ is part of a larger context. JBJ takes into account RI and the kinetic chain concept by considering (and clearing) structures above/below (Boyle, n.d.; Cook, n.d.). The concept (and observations by Boyle and Cook) of joints "tending towards" restrictions in mobility or lack of stability is similar to Janda's observations of muscle imbalance (e.g. upper-cross/UC and lower-cross/LC syndromes). Similarly, many organizations including the National Academy of Sports Medicine teach Janda's UC/LC syndromes out of context leaving students with incomplete knowledge and ineffective skills. Context is key.

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