Structural Integration

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Cover image: Certified Advanced Rolfer™ John deMahy demonstrating correction of an anterior sacral torsion, based on assessment findings from his Lumbar-Pelvic Algorithm.

Ask the Faculty

On the Subject of Pain

Q: *Could you discuss your current thinking on the subject of pain as it relates to Rolfing® Structural Integration (SI)?*

A: Pain is a theme worthy of discussion in that it invariably surfaces in the context of our work. And rightly so, as the insidious aspect of pain is how it separates us from, rather than engages us in, the larger world, affecting our emotions, relationships, and sense of connection in community. Small wonder that vast research and a considerable amount of thought has gone into how to treat, prevent, medicate, relieve, and avoid pain. Not to mention the fact that there are so many, virtually infinite, varieties and types of pain. What is a mere practitioner to do in the face of such an enormous undertaking? Small wonder those of us in the medical and somatic arenas involved in working with pain reduce it to a quantifiable 1-10 scale of intensity.

While this quantification may be useful as a starting place for the client/practitioner conversation, there is difficulty if we remain in this "measure," which is the domain of the brain's left hemisphere. As we can appreciate, pain does not limit or contain itself to our cognition but is felt through the whole of our being. Ultimately the various how-to approaches and techniques that promise to eliminate pain in "five easy steps" tend toward a cognitive approach that may or may not include the body in the process!

I'm sure I'm not alone when I relate how frequently clients will respond to an inquiry as to what they *feel* by replying with what they *think*. This typical response illustrates the strong tendency in our culture to detach from our direct experience in order to speak about and conceptualize the experience. But pain, like poetry, is "before the mind." In his poem "Love," Rumi states: "The cure for pain is in the pain. Good and bad are mixed. If you don't have both you don't belong with us."

Currently in my practice I'm very interested in ways to engage with the client in an exploration of his/her experience of pain in a qualitative way. Part of our role as somatic educators involves guiding our clients to stay connected to the felt sense of their physical bodies within the larger context of gravity and ground. This approach entails a paradigm shift for the client who often comes with the expectation that the practitioner will somehow either remove the pain or enable him/her to overcome it. Instead of this adversarial approach, my intention is to negotiate a more gentle relationship with the pain. Engaging the client's interest in the qualities of sensation has been an avenue into deepening and enriching the integrative process. Assigning the sensations qualities of texture and flavor invites the client to go beyond the stories associated with the pain. Although not always comfortable, our willingness to feel and embody our direct experience helps to ensure our greater participation in life as it naturally unfolds.

Sally Klemm
Advanced Rolfing Instructor

A: Pain can mean a number of things. What aspects of pain are relevant? In the Rolfing SI domain we should consider: pain caused by our touch; pain a client comes in with / tells us about; pain that is brief or chronic; pain that we can live with and pain that makes life not worth living, and pain that is physical, emotional, or existential. We hope our work will help people adapt better to all of these forms of pain. Adaptability is a Rolfing principle and changing one's relationship to pain – changing the way we respond to and shift our experience of pain – is a way of describing what we do. Acute pain from fresh trauma, while we endeavor to meet it when it presents, is not our primary scope of practice. Typically, it's the persistent pain dilemmas for which our work has the best fit.

Neurologically, we can think of pain as afferent information that the brain interprets in such a way that we experience pain. Pain in a healthy body is a signal to take action. Pain that plagues a person and that actions don't alleviate can represent an organizational failure in the brain. Organizational failures can result in all the versions of pain. They include chronic pain and the noise a person experiences as burning pain following immobilization. All pain is, ultimately, a brain phenomenon. We don't usually say this to a client in pain. It certainly doesn't feel like pain is in the brain when we are consumed by it. But, it's what science tells us.

What help is SI? What can our field offer a brain that is interpreting information as some form of pain? What can we do to offer help, and what does this teach us about pain? The signature attribute of SI is that it integrates. What does it mean to integrate? To borrow loosely from Daniel Siegel, it is the sum of two activities that improve function within a system: first there is the action of differentiation of parts within a system; then there is a proliferation of connections between the differentiated parts within that system. If the system we are talking about is a person, we help a person know himself/herself as an integrated and integrate-able system. An integrated system (or person) has more options and typically acts more intelligently than a less integrated system. We posit that pain signals a lack of options. In the Rolfing SI domain, more options equals increased adaptability – adaptability for, among other things:

- Coordinative adaptation to new demand.
- Economy of function in movement.
- Autonomic adaptability – improvement in heart rate variability (vagal tone).
- Reduced aversion/reactivity to unfamiliar sensation – capacity to allow body processes/sensations to occur, undefended.
- Restored proprioceptive function (so the brain turns off painful interpretation).
- Lowered reactivity in stretch reflex (higher threshold in stretch reflex) and consequent relaxation of muscular reactivity.
- Increased security at the sensorimotor level.

We evoke adaptability in all the activities of SI. These include touch that allows the brain to increase proprioceptive and interoceptive discernment. The client builds a field of sensory awareness that transforms from a pre-session, generalized (or dissociated) quality to a post-session sensory awareness that is more detailed and finely discerned. There is more conscious awareness of locations in the body as distinctly different

and separate but also experienced as connected. It is conscious awareness that becomes spontaneous. Fascial touch is especially helpful for differentiation and connection, at a conscious and non-conscious level.

We further assist clients to anchor differentiation and connection when they name aloud the sensory experience. Sense-based words strengthen sense perception and differentiation. We also ask clients to pause before initiation of movement, to select details of sensory awareness and imagined directionality that promotes ease of action. In this way we witness the organizational effect of new coordination. We assist the client to gain an improved sense of competence, the sense that one has some amount of control over how the body feels and operates, even if the familiar pains are not, at that moment, entirely dispelled. Pain is usually coupled with a felt sense of powerlessness and helplessness, so any shift in the ability to control what is sensed is significant.

Additionally, we support a process in which the client learns to alternate attention between places of distress and places of comfort. Levine calls this pendulation. It's part of the Somatic Experiencing® approach for self regulation and recovery from trauma, but it's a fundamental process. A person's capacity to regulate and feel a sense of control (in the positive sense) can grow. It's a form of skill building. We can recommend to clients that they cultivate these skills. To consciously notice sensation in specific places in the body: the hands; the feet; the sacrum; the skin, generally; and the sense of weight, generally. At first there's not necessarily much to notice. But perception is an action that, with practice, improves to the point we learn to notice abundant and rich sensations at these locations. It's easiest to attend to places where there are many sense receptors such as in the hands and feet. It's potent when we cultivate sensory awareness where the body places proprioceptive importance, such as the sacrum. It's refreshing to the body to notice a proprioceptive resource that usually goes unnoticed: the skin. These perceptions then become places of sensory refuge at times of discomfort. Sense perception assists the brain to reinterpret fixations of painful interpretation across all four dimensions of structure.

Differentiation of conscious sense perception affects the brain's ability to organize afferent information in the body. Some of the "noise" can evolve into information. When noise becomes information, what we call "pain" has the potential to change. It's a piece of the pain puzzle that structural integrators can legitimately claim to help with.

Kevin Frank
Rolf Movement® Instructor

A: Learning to work with painful areas can help your clients and enhance your skills. When it seems appropriate to explore an area that is painful for the client, relationship and support is imperative. As I'm sure you know, how you work with your client is as important as what you do. We're creating relationship and a supportive environment from day one. Things like eliciting client participation; checking in often; making sure we don't go too deep, too fast (usually the cause of pain, and not therapeutic); working at the client's pace; finding the place of discomfort and backing off a little; adjusting or changing our approach as needed – these are just a few of the hundred little things we do that create rapport. When you've established all of this, then you can invite your client to work with pain.

Although I've been talking about physical pain, we might also be helping a client experiencing emotional pain. The approach really isn't that different. It's about asking clients for feedback and adjusting our input so we're providing just enough challenge that their systems need to respond, while providing enough support and encouragement that they can respond in a new, meaningful way.

Asking questions and adjusting your work so that interventions are manageable for the client can allow you to address very stuck fascia. Such immobilized areas often contribute to pain. A client reporting that an area is painful doesn't necessarily mean you shouldn't work there, it just means you need to be asking more questions:

- Is there anything in the client's health history that is a contraindication to direct work in this area? If so, of course, avoid working here directly.
- Is there an easier way to get the job done? Great, do that instead.
- Is more preparation needed? Yes? Do it!
- Are you working too fast or from an awkward angle? Are you not present in your own body? If so, you know what to correct.
- What does your intuition tell you? Experience is an important teacher. If you have a sense that you should avoid an area, go with your gut.

But if none of these things are the case, it may be time to address that gnarly, built-up fascia between the metatarsals, or spend time fully releasing the interosseous membrane of the leg, or get under that scapula and improve the movement of the shoulder blade on the ribs. For many clients, direct work in these areas is disagreeable, but the increased range of motion may significantly contribute to better function and quality of life.

Rolfing touch spans from off-the-body to downright bossy and everything in between. We endeavor to move seamlessly among these states, and learning how to invite clients to work around the edges of their comfort zones is just another important skill. Working safely and productively with painful areas requires you to ask good questions, elicit client participation, scale back work into doable bits, and sense into tissue to monitor progress. Not all or even the majority of your work should be around the edges of discomfort, but knowing when it's productive and how to engage your client is important and requires you to be a better Rolfer™.

Bethany Ward
Rolfing Instructor

For those of us in the helping professions, the ability to alleviate pain is seductive. When the client comes with pain and leaves pain-free, we feel good. It feeds our souls. It can also satisfy and reward our egos, and encourage the tendency to perceive ourselves as potent "healers." This perception, in turn, can lead to promises or expectations we cannot fulfill. And yet, clients do arrive seeking pain relief, and we want to help them.

For an authentic approach to these clients, we must examine our understanding of pain. Is it broad enough to encompass the connection of the pain to the client's whole being and environment, or the role of the pain in the client's process? Are we acknowledging that the client's sensory experience is subjective, and that each person's subjective experience has unique meaning? After all, the same stimulus produces in each person a different experience, with unique meaning, which is given a different name.

To address pain as Rolfers, we must consider it in relation to the whole person – his/her biomechanics, movement patterns, habits of perception and systems of meaning. And we must consider the pain as a component of the client's entire process, a process that happens within a dynamic environment and over a period of time. The interesting question is not simply whether Rolfing SI alleviates pain, but why and how it does so.

Meanwhile, I'd like to share some incidental data about pain from the research supporting my doctoral dissertation on the psychobiological effects of Rolfing SI (Prado 2006). The data collected suggest that even though Rolfing SI does not aim to address pain per se, its integrative, "third-paradigm" approach often does reduce the intensity and frequency of pain, and can also change for the better a client's subjective experience of pain and perceived quality of life.

The research involved 874 subjects, and investigated their experience of SI through intake and exit questionnaires developed at the São Paulo Ambulatory Clinic (NAPER; see Prado 2009), as well as through the World Health Organization's Quality of Life survey (WHOQOL; see Prado 2010). These tools elicited extensive information about the subjects' experience, and included pain as one among many topics.

Subjects who had pain at the outset also described the pain's duration, frequency and intensity on the standard 1–10 visual analog pain scale. In our sample, the data showed statistically significant reductions of both the intensity and frequency of pain from before to after the process. This was true for both chronic and recent-onset pain.

Despite these positive findings, it would be a mistake to characterize Rolfing SI as a good tool or modality to treat pain. Doing so would encourage a second-paradigm mindset and neglect the essence of our work. Instead, these findings should encourage inquiry into the processes through which a third-paradigm approach affects pain.

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Rolf Movement® Faculty Perspectives

Taxonomies, Vectors, and Neglected Spaces

By Kevin Frank, Certified Advanced Rolfer™, Rolf Movement Instructor

This column addresses four topics: the first is another look at the taxonomies subject – how the Rolf Institute® of Structural Integration (RISI) organizes our work into categories of assessment, intervention, and departments of education, and how it works in practice; second, we take a look at a perceptual approach that uses vectors; third, a brief introduction to the problem of missing space, physiological and phenomenological; and finally we touch on the delicate matter of the energetic dimension within our work. The theme that ties these four topics together is an ongoing inquiry about how we define, prioritize, and teach the work.

The discussion has specific relevance for faculty and students who wish to better define the role of movement in learning and doing structural integration (SI). At the RISI this work is called Rolf Movement work – more usefully defined as the *perceptive*, *coordinative*, *expressive*, and *psychobiological* dimensions of Rolfing® SI. From a "body as movement system" (Frank 2008) point of view, current taxonomic definitions of Rolfing SI pre-judge any discussion about educational priorities since discussion begins with the premise that there are faculty and trainings that are "structural" and faculty and trainings that are "functional." This column continues an inquiry into the usefulness of this premise; the goal being to further nurture holistic education in RISI trainings.

Topic One: Structure and Function

This author proposed drawbacks to the current RISI taxonomies: structural/geometric, functional, psychobiological orientation, and energetic in an article (Frank 2012) that proposed the replacement of "structural" and "functional" with more meaningful terms. The proposals represent a movement-oriented view and link to premises about how Rolfing SI training is conceived. Jeffrey Maitland (Maitland 2012) took up the discussion with kind appreciation and amiable corrections to some of the logic and semantic underpinnings of the earlier article. Still, Maitland did not address how the taxonomic categories affect educational priorities. The current article focuses this issue further, and clarifies as well what appeared to be a misunderstanding of the author's comments about the energetic taxonomy.

The Structure Question, Take Two

The word "structural" in the context of "structural integration" promises the world that SI evokes *lasting* shifts in a client's patterns of behavior – posture, ease of movement, life view, etc. Lasting change is a feature of our work. Secondarily, biomechanics, the study of anatomical structure and function, is also fundamental to this process and could be termed "structural." But biomechanics is not strictly the province of education in fascial mobilization. Rather, it's equally essential to matters of perception and coordination.

The primary meaning of structure – work that concerns long-term patterns, as opposed to work that is palliative or for repair of injury – is the crux of the issue. When we use the word "structure," in the sense of how patterns change slowly over time, physical-tissue properties are

one component of the structures that bind us, but no more or less so than the motor patterns or perceptual or psychological patterns that bind us. We are creatures who somehow become bound. We aspire to become unbound. Structural integrators assist people to recover their freedom to function gracefully in gravity. Structural integrators approach structure in a variety of ways. Maitland (2010, 166, 60), in describing a Zen approach to the body problem, refers to "a profoundly awake, *unencumbered activity of feeling*" that is possible "by transcending the fixations of ordinary thinking" of what he elsewhere terms the "I-am-self." This is not so far away from SI.

Let's drill further into how the word "structure" gets used at RISI. When we make an assessment or an intervention, do we call it "structural" because we are primarily looking at how various categories of tissue express limitation? Or do we call it "structural" because it is an inquiry into the many reasons a person is shaped the way he or she is, so patterns can change in a way that lasts? And, is there, in some instances, built-in presumption that physical pressure on fascia is the more likely avenue for lasting change – the more "structural" one? To be clear: the value of fascial mobilization is not being questioned. It is a fantastic method to help unlock patterns, especially when used by practitioners who embody the work. The author is an enthusiastic advocate for, and user of, fascial mobilization. The question is, rather, do we have evidence that in any given situation fascial mobilization is necessarily the more "structural" approach – the one that has the more lasting effect? Can anyone prove the general case? And, regarding the other sense of the word "structural": is fascial mobilization the approach that requires a greater degree of anatomical specificity? Again, it's debatable. What we do know is that human beings, and their postural habits, are complex. Let's ponder this complexity through an example.

Hypothetical Clinical Example

An athletically active client has knee pain, and a family history of knee failure due to lifestyle and genetic factors. She comes to a Rolfer to receive the Ten Series. The client experiences fascial mobilization as welcome relief, not only from the knee pain, but other aches, pains, and restrictions of movement that have bothered her for years. She exclaims after session one, "Where has this been all my life?" Over the course of the series, the practitioner uses a variety of interventions including: "indirect" joint mobilizations at the knee; fascial mobilization to restore differentiation and adaptability in the feet, lower leg, hip; and explorations to improve adaptability in the upper center of gravity, etc. – a "soup to nuts" offering. Each fascial manipulation includes education in sensing bony articulations, initiating movement from support, and using spatial orientation to enhance palintonicity; to name a few. The client learns that she can sustain sensory receptivity in the feet in order to push, economically. She learns exercises for knee stability. The client learns what it means to evoke change in coordination. The client learns to allow stillness and notice moment-to-moment shifts in sensation and awareness.

Late in the series or, maybe a few months after, the client reports a flare-up of knee pain. The client is understandably discouraged – things were going so well. We don't like these bumps in the road, of course, but they do reliably occur. How does a practitioner meet them? Is it possible to meet the client freshly, noticing what presents now, so something unexpected might reveal itself? How do we teach this?

During this particular visit, the client learns what turns out to be the next lesson: she anticipates knee loading by tensing slightly in the hamstrings and the extensors of the foot. She is now, for whatever reason, ready/able to be curious about this lifelong pattern. Starting from what she has already embodied and learned, she now feels the move from sit to stand in a new way – while imagining femoral independence from the tibia. The client practices this movement slowly. As she presses her femur against the practitioner's hand in the moments going from sit to stand, she rebuilds the motor map of knee extension. Her knee remains less compressed during the movement. The client learns to recreate this movement so she can do it at home: lying supine she learns to imagine the calcaneus expressing a down arrow of intention and the femur an up arrow of intention prior and during flexion and extension of the knee. The practitioner coaches the movement so the client finds ease in the exercise. She learns to use her eyes to help interrupt the former pattern of co-contraction at the knee. The client anchors the new postural preparation – she considers how this new way of moving, from sit to stand, contrasts with her family pattern. She finds a way to be okay with it, and to appreciate the value of the former pattern.

Bottom line: the practitioner gets "lucky" – it's a good day. The client goes home and begins to build a better relationship to the event we call knee extension, one in which there is new clarity about the joint and the manner in which we learn to pre-move in helpful and not so helpful ways.

The Structure Questions, Again

Which of the events in the previous example are more "structural" and which are more "functional"? If we say that the fascial mobilization is more structural, do we know that that is the case? Did fascial episodes, within the package of interventions, lend more to the new equations in the brain? Did the fascial work offer more to stabilize the knee than the coaching of pre-movement and self-care? Did one intervention require more understanding of joint mechanics than the other? Will anyone claim to say for sure? Most of us aren't fond of uncertainty. We often assert certainty in situations where we *wish* we had it. But, is Rolfing SI a craft built on certainty? With time and good fortune we may be able to make general assessments built on statistical data. New data may inform our choices in practice. These questions don't have simple answers. In the meantime, what is important is that we endeavor to evoke and invite structural change in all the ways our craft is able.

There is a further question: What does it mean to step back a moment, from logical determination, and meet a client openly, free of what we "know" from the past? What's important in the example is that a motivated client and an open-minded practitioner found a successful outcome – together. Two people went through an exploration within a taxonomic spectrum, all conceived to evoke postural improvement and better stability under demand – for the long haul.

A bigger question follows: how will RISI continue to improve and enhance what it teaches and how it teaches it? It's helpful (Maitland agrees) to take care with how we use language – specifically our definition and use of the term "structure." Do the terms "structural" in contrast to "functional" really assist students to understand the complexity of postural change? Or does the term "structural" sometimes insidiously suggest priority toward manual pressure; to move something physically with our

hands? Maitland asserts the notion that structure and function are two sides of the same coin. Why would we assume that we know, a priori, that posture is limited more by an apparent tissue issue as opposed to another component of structure?

Let's restate the structural/functional taxonomy issue more directly. There are two major aspects of structural education: one primarily aimed at mobilizing tissue and one more concerned with evocation of perception and coordination – both of these approaches accomplish differing degrees of long- and short-term change. Both involve touch. Both of these approaches lead to both structural (long-term) and functional (short-term) adaptation. Both of these approaches often move seamlessly back and forth to solve immediate and long-term challenges for the client. Revised language removes barriers to learning.

Topic Two: Vectors

What is a vector? A vector is a force with a direction. The fields of physics and mathematics define vectors this way, represented as arrows. How do vectors fit into SI? They're relevant because the part of our brain that conceives movement appears to "think" in vectors. In order to throw or catch a ball, the brain has to anticipate the force and direction of the object and where it will end up at the crucial moment of contact. Our brain uses vectors to stand up. The brain does all this without using math or other symbols. How does the brain do it? We don't yet know. But we can reliably demonstrate that it does so, and the usefulness of the metaphor. One can experience the brain's receptivity to vectors. We can learn to throw and catch; we can improve economy of function over time when we support the brain with the language it likes to hear.

In the previous example, in which a client learns to "unlearn" conflicted habits of knee movement, the client is taught to use arrows of imagination in the session and for self-care. We can call imagined arrows of directionality "vectors," or "vectors of imagination." They represent the ability to imagine a direction in space, which can be learned relatively quickly. Vectors have a directional component, and a force component. The force component is the clarity and strength of one's imagination. Like bodybuilding, our brain can improve the strength of its imagination over time, especially if we learn in a way that is interesting and successful. Unlike going to the gym, however, each client needs support to discover how a vector arises in his or her own meaning and perceptual system. This is where we, as practitioners, meet clients in their moment-to-moment curiosity and availability.

One direction brings immediate improvement. Two or more directions are better. When vectors are evoked in opposing directions, the body behaves like it's eager to respond, to express palintonicity. All bidirectional vectors link to foundational bi-directionality – of weight and space, of up and down. Imagined vectors are a way to shift pre-movement and help restore normal coordination and posture. Vectors are a subset of tools to recover lost or missing access to spatial relationship, a key component for integrated function in gravity. Vectors represent a form of not-doing: we don't do vectors; we allow the vector to do the work in the non-conscious processes of the brain. This brings us to the topic of missing space.

Topic Three: Erased Space

Let's consider two forms of lost capacity to perceive our full range of peripersonal space; that is, lost capacity for the brain to register areas of space around the body. In both cases, the body loses important bearings for postural integrity and function. One form is lost space at the physiological level – *physiological spatial (space) neglect* – meaning the body has physiologically lost the ability to process/receive some dimensions or areas of space around itself. It can be caused by stroke, for example. Another form of missing space is referred to by Godard (2009-2012) as phenomenological space neglect. This form of lost space is not the result of a physiological problem. Rather, someone acquires an inhibition, a block to the available information about some part of the surrounding space. Since structural integrators aren't brain surgeons, it is primarily to this latter form of space neglect that we can offer help: *phenomenological space neglect* is potentially plastic to our interventions, to the tools within the SI scope of practice.

What causes phenomenological space neglect? Many things, but let's start with very simple examples to get the sense of it. Imagine you see something very unpleasant, so unpleasant that your body makes a reflexive choice to avoid seeing it ever again. Can you imagine that? In an actual event, you might instantly acquire an inhibition to the space formerly occupied by the unpleasant sight – without realizing you have done so. A direction or quadrant of space becomes, effectively, dimmed or erased. Or imagine you see something that is highly attractive. You might keep looking for it (subconsciously) long after it has gone away, with the residual effect being a "leaning" toward the side of interest with a corresponding diminution of availability to the opposite direction. This "leaning away" or "leaning toward" is happening around us more than we suppose. Although it might not cause the body to lean physically, nonetheless the perception of space is changed. Other common causes for shifted spatial perception include injuries involving collisions with moving objects, auto accidents, and family dynamics, to name a few.

Why does this matter to structural integrators? We care because we want to evoke postural change. What shapes body posture? A significant influence on the shape of our bodies is the shape of the space we imagine around our bodies. We live in space shaped by our patterns of perception. Some of the ways we build a personal version of space are described by Godard in the interview "Phenomenological Space, 'I am in the space and the space is in me'" (McHose 2006). Godard introduces a view of the invisible forces shaping the human body, and its posture and movement; invisible templates through which we perceive space and anything in it.

The relevance to SI is especially clear when we observe asymmetries of posture that correspond to asymmetries of perception. An example is idiopathic scoliosis. We notice a relationship between the way one side of the body is willing and able to move forward while the other side expresses hesitation in subtle or not-so-subtle ways. We may then notice the difference in how one eye allows the world in, while the other eye blocks the world to some degree. By testing the client around issues of how objects are sensed on one side versus the other, or by tracking a client's capacity to push or reach into space on one side or another, we can begin to build an interpretation of what the client's spatial map looks like, and we may find there are "holes" in that map. Our non-conscious mind reacts to these holes and adjusts movement and posture accordingly.

The examples offered are simplistic. The actual stories behind people's phenomenological space neglect and the manner by which some clients can begin to gain lasting shifts in their spatial perception – and consequently, their posture and function – are more complex. Still, at any stage of SI education, students can start to observe perceptual variations as they examine asymmetrical posture. It's wise to introduce this experience early since it enlarges the possibilities for finding plasticity of form beyond viewing form as held only in the tissue. And it's important to point out that when mobilizing fascial tissue the client's spatial map will shift, at least temporarily, even if we don't know we are doing so. Tissue work changes the spatial map. It's a two-way street.

Topic Four: The Energetic Question – An Inquiry

Maitland's (2012) article implied that this author advocated retirement of energetic work in his proposed retirement of the taxonomic term "energetic." This was not the proposal. What was proposed, and what is needed, is that "energetic" work within Rolfing SI be better defined. The term "energetic" can mean many things. How might we discover terms that tell us more specifically that which is energetic? Could there be a careful inquiry into what energetic means specifically for SI practitioners?

The author has been the grateful recipient of therapies in which, to the casual passerby, nothing happens. Nothing is visible. Those moments have sometimes been life-changing. What are they? Could there be some struggle with this question? Could there also be some struggle with the question: how do these interesting dimensions of work assist postural evolution in the gravity field?

Let's reflect on implicit qualities to good SI: simple listening presence; an absence of reactivity, demand, and judgment; open attention and empathic resonance; stillness. These qualities often release inhibitions in ways that all the things we do, do not. Is energy work predicated on "not-doing?" If so, how might we talk about this? Fundamentally, freed from patterns of inhibition, the body often heals itself – gravity is the therapist. Is this an ingredient to what has been termed "energetic" work? Maitland (2010, 174), in *Mind Body Zen*, offers insight into not-doing and therapeutic resonance, both of which function as the practitioner steps out of the way. He says, "Central to the fourth way [what might be termed "non-dual" healing] is the practice of zero (or unification with the client) in which healing is the result of the healer's *orientation* [italics added] rather than the application of technique or intention." Orientation is fundamental to SI – it's essential to our work (Frank 2010 and 2011).

Bottom line: Energetic work by any other name would feel as sweet. Terms other than "energetic" might fit more meaningfully and respectably within a contemporary model of SI, one that the larger world can relate to. How does work, invisible to the lay observer, relate to conventional models of postural health and performance? How can "not-doing" be modeled and given consideration? What is the role of imagination? (Frank 2010) What shifts occur in client/practitioner relationship in moments of shared attention? Can subtle phenomena be linked to models of biology, physics, or psychology, as are the other parts of the SI package? A working definition would help find the right places to put "subtle phenomena" within the Rolfing SI curriculum.

Whatever the many "system to system" communications that occur between practitioner and client, human beings respond positively to sincere listening and curiosity. Within a resonant field of connection flows the potential for change. A variety of healing traditions purport to codify this potent connection. Each system has its own idiosyncrasies and language. Is there something not particular to any one tradition?

To circumscribe a system or multiple systems of subtle phenomena with the term "energetic" fosters the notion that energetic activity is somehow a separate matter from what we do already. Without calling it "energetic," what is it?

There is an understandable surge of interest about learning and teaching this as-yet-to-be defined category of material at RISI. What needs to happen to ground the conversation, to notice and name the broader phenomena that underlie various methodologies and tools? How do we honor the depth and nuance of Rolfing SI that's here already?

The Space of RISI Education

This column, among other things, introduces the topic of space neglect. Space neglect is another inconvenient element to the "structure as tissue" equivalency that has lived, implicitly, in SI since its origin. "Structure" is a tricky term, a term that eludes attempts, in our field, to establish causal certainty. That keeps SI interesting, if sometimes frustrating. A goal of redefining structure is to invite consideration of the manner in which structure is discussed and defined to students in Rolfing trainings. The broader our appreciation of how physical, perceptive, coordinative, and meaning structures live within us – and the more we have a chance to embody them, to bring these concepts alive in a personal and sensory manner – the more we listen broadly to client posture and movement. As this broader quality of listening is integrated into Rolfing training, it's more likely RISI graduates will offer leadership within the SI field of the future.

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TMJ Disc Mechanics and Correction

By Allan Kaplan, Certified Advanced Rolfer™

Whenever someone comes into my office with temporomandibular joint (TMJ) dysfunction, I can't help but cringe a little. And when I hear practitioners crow about how they always have great luck "curing" TMJ, I cringe a little more, and reckon that either (a) they get really fresh, easy cases, (b) they are extremely lucky, (c) they have a corner on the magic, or (d) they are deluded. For the truth is that the TMJ is an extremely complex anatomical system, subject to many influences both within and outside of the context of Rolfing® Structural Integration, and that using other paradigms sometimes needs to be considered. From my perspective, cranial manipulation often fills the gaps that fascial work can't, because the worst cases of TMJ dysfunction involve derangements of the articular disc, situations that call for more than straightforward tissue work.

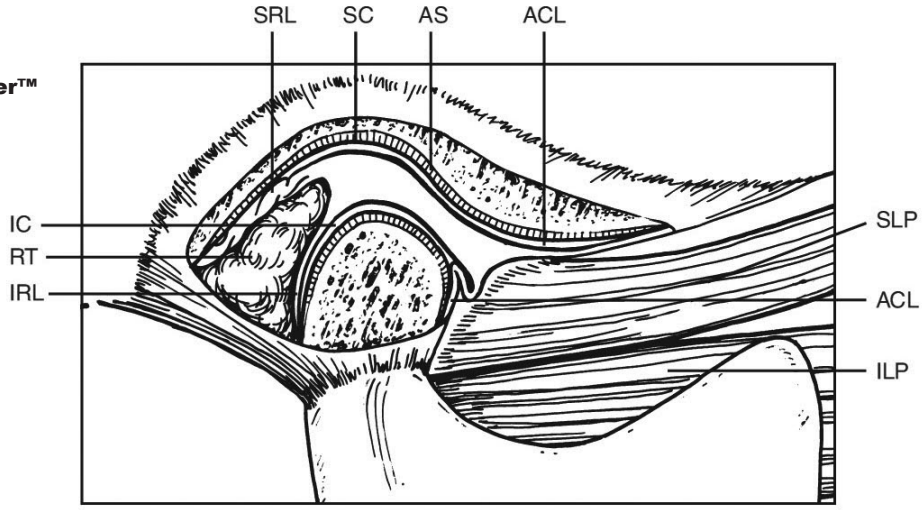

Figure 1: Temporomandibular Joint. Diagram showing the anatomical components: ACL – anterior capsular ligament (collagenous); AS – articular surface; IC – inferior joint cavity; ILP – inferior lateral pterygoid muscle; IRL – inferior retrodiscal lamina (cartilaginous); RT – retrodiscal tissues; SC – superior joint cavity; SLP – superior lateral pterygoid muscle; SRL – superior retrodiscal lamina (elastic). The discal (collateral) ligament has not been shown. *All images used with permission.*

Analyzing all the influences on the TMJ that could emanate from the cranial system would take volumes, well outside the scope of this piece. Simply, they could derive from forces acting upon the mandible, temporal bone, and the intracapsular disc from the other neighboring bones of the cranium, the dura and cranial membranes, and fascial chains extending down the body. Unless these forces are resolved, they can persist in holding the TMJ structures out of balance ad infinitum. If the cranial system is suspected as being a significant influence in the TMJ dysfunction, a referral to the appropriate practitioner may be advisable. For our purposes, we will limit ourselves to an overview of the immediate environment of the TMJ itself. There are several thorough articles dealing with TMJ myofascial influences written by our colleagues Clay Cox (2001), Christoph Sommer (2008), and Peter Schwind (1987), and I won't repeat what they have already said; derangements of the articular disc are a separate entity and a primary cause for the worst cases of TMJ, issues of persistent jaw clicking and locking.

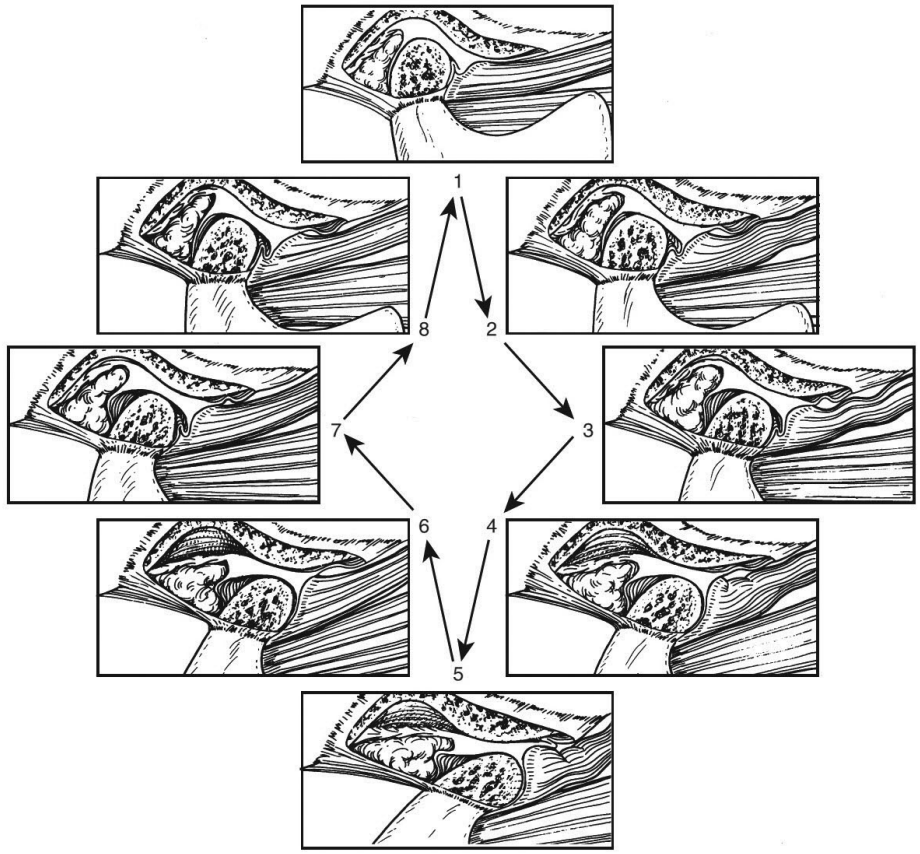

Figure 2: Normal functional movement of the condyle and disc during the full range of opening and closing. The disc is rotated posteriorly on the condyle as the condyle is translated out of the fossa. The closing movement is the exact opposite of opening. The disc is always maintained between the condyle and the fossa.

A good grasp of the biomechanics of the TMJ is important in having a clear picture of TMJ dysfunction. The most significant aspect is the balance of tensions on the disc. The articular disc is bound

to the mandibular condyle with its head contacting the disc's "intermediate zone," and is sandwiched between the condyle and the articular surface of the temporal bone. This creates a cushioned, sliding contact for the two bones. While there is a degree of lateral/medial motion of the disc, its anterior/posterior freedom is our most significant concern. Posteriorly, the disc is attached to the retrodiscal ligaments, bungee-like structures that act to keep the disc in position, with its intermediate zone centered on the condyle. The ligament tensions are balanced anteriorly by the lateral pterygoid muscle (more specifically by its superior head), part of which is directly attached to the disc, with the rest of the muscle inserting on the mandibular condyle (see Figures 1 and 2).

While there is some controversy surrounding the details of disc and lateral pterygoid function, most sources agree that a hypertoned superior lateral pterygoid can lead to derangement of the disc. The muscle will exert an anterior pull, putting a strain on the disc and the superior retrodiscal ligament when in the resting position. With prolonged tensions, retrodiscal integrity

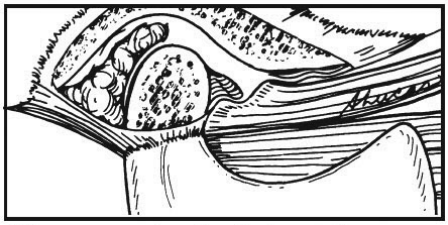

Figure 3: Functionally Displaced Disc. Tension on the disc has shifted its position posteriorly from the intermediate zone when at rest. (This is step 1 in the motion sequence of Figure 2; clicking occurs between steps 2 and 3, with a reciprocal click between steps 8 and 1 as the condyle slides between the different sections of the disc.

can degrade and the disc will distort over time and will slip forward. The net result is a migration of the disc's contact surface on the condyle from its intermediate zone more posteriorly, thereby altering the biomechanics. The degree to which the disc is affected will contribute to whether it develops a click, displaces and repositions (is reduced), or displaces without reduction.

Clicking in the joint is caused when the condyle shifts on the disc during its motion cycle. If the disc has migrated to the posterior zone for a period of time, it

Figure 5: Anteriorly Dislocated Disc Without Reduction. The disc becomes jammed forward in the joint, preventing the normal range of condylar translator movement throughout the entire sequence shown in Figure 2. This condition is referred to clinically as a "closed lock."

distorts and the disc body thins, allowing it to shift forward, forming a "cup" for the condyle to rest in. During opening, a single click will coincide with the shifting of the condyle over the lip of the cup, and sometimes a second click will occur when it slips back to the posterior zone (see Figure 3). A more serious condition will arise when the retrodiscal ligaments are further stretched, with the disc actually being dislocated forward off the condyle during rest. Upon opening, the disc may reduce (reposition), but dislocates again

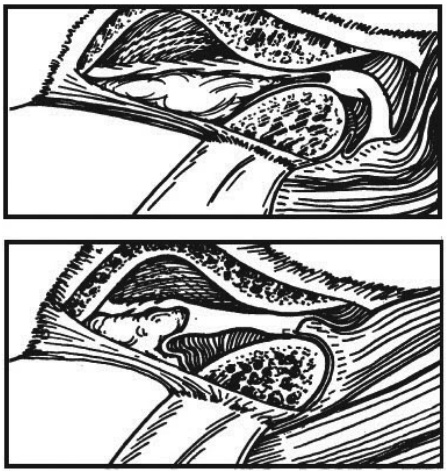

Figure 6: Spontaneous Dislocation of the TMJ. Spontaneous dislocation of the condyle at step 5 (in Figure 2) results in an "open lock" with the disc dislocated anterior or posterior to it. The condyle is trapped beyond the articular eminence.

on closing. The sliding onto and off of the disc will create clicks as well (see Figure 4).

The worst cases are disc displacement without reduction, when the disc slides anteriorly, completely off the condyle, and does not reduce. In such a "closed lock" condition, the disc blocks the condyle from sliding forward. It is not literally locked, but its opening is severely limited on that side (see Figure 5). "Open lock" conditions are likewise serious, and typically occur as a "spontaneous dislocation," when the condyle is forced open beyond its normal range. The condyle displaces off the disc and is stuck forward, beyond the articular eminence on the temporal bone. In an open lock, the disc can be located either in front of or behind the condyle and the jaw won't unlock because it is mechanically blocked by the eminence. The disc and retrodiscal tissues can be crushed between the bony contacts and stretched or torn (see Figure 6).

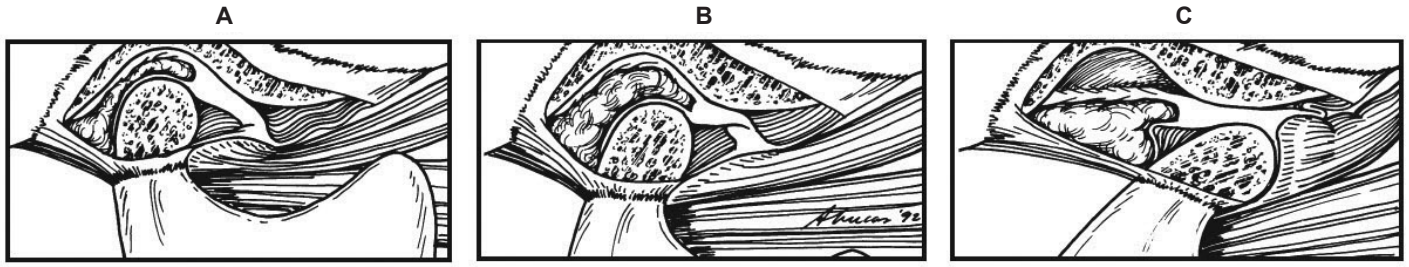

Figure 4: Anteriorly Dislocated Disc with Reduction. A: Resting closed-joint position (step 1 in Figure 2). B: During the early stages of translation, the condyle moves up onto the posterior border of the disc (reduction). This can be accompanied by a clicking sound (steps 3-4). C: During the remainder of opening, the condyle assumes a more normal position on the intermediate zone of the disc as the disc is rotating posteriorly on the condyle. During closure the exact opposite occurs. In the final closure the disc is again functionally dislocated anteromedially. Sometimes this is accompanied by a second (reciprocal) click.

Dislocation without reduction (closed-lock) conditions are liable to create damage that is irreversible over time, because the disc is trapped in front of the condyle and its associated support structures are deranged when the jaw is at rest. The longer the disc stays out of place, the worse the damage to the tissues. The retrodiscal tissues stay under tension and are stretched, and the disc itself gets further misshapen. It is best to reposition the disc with as little delay as possible. Gently gapping the binding there by gently pushing down on the chin or at the molars may un-jam the block.

Assessment is generally straightforward. Note the position of the mandible with the jaw closed. If it is off-center, one side is in open-lock, deflecting the mandible to the opposite side. If the mandible appears centered, have the client open his mouth. If there is deviation to one side and then recovery, there is dislocation with reduction on the side to which the mandible deviates; if there is no recovery, there is typically either no reduction, an adhesion of the disc to the temporal bone, or a muscular spasm on that side.

Prior to any attempt to reposition the condyle or disc, it is important to defuse the tensions on the TMJ as best as possible. From a Rolfing® Structural Integration perspective, this includes all fascial structures related to the mandible, including the hyoid musculature. The lateral pterygoid is primary because it provides the anterior force on the disc. It is then necessary to open the disc space in order to free the structures. Then, the condyle needs to be moved anteriorly in order to reposition itself on the disc.

Sometimes it is possible for the client to self-reduce the problem disc by opening slightly and sliding the mandible to the opposite side. This action translates the ipsilateral condyle anteriorly, engaging the superior retrodiscal ligament, and hopefully drawing the disc posteriorly into reduction. Several tries can be made before the practitioner attempts reduction. If unsuccessful, the practitioner can then try to reduce the disc.

To work with the TMJ, it is important to use a secure position that stabilizes the head and allows good motion at the joint itself. With one hand, hold the mandible with the thumb intraorally along the molars, the forefinger outside along the jawline toward the angle, and the other fingers wrapping around the jaw's edge, giving a solid grip. The other hand stabilizes the head and secures the temporal bone with the middle finger in the auditory meatus, the thumb and forefinger holding the zygomatic arch, the last two fingers resting on the occiput, and flat palm contact. In this position, the joint is literally held between the two hands (see Figure 7).

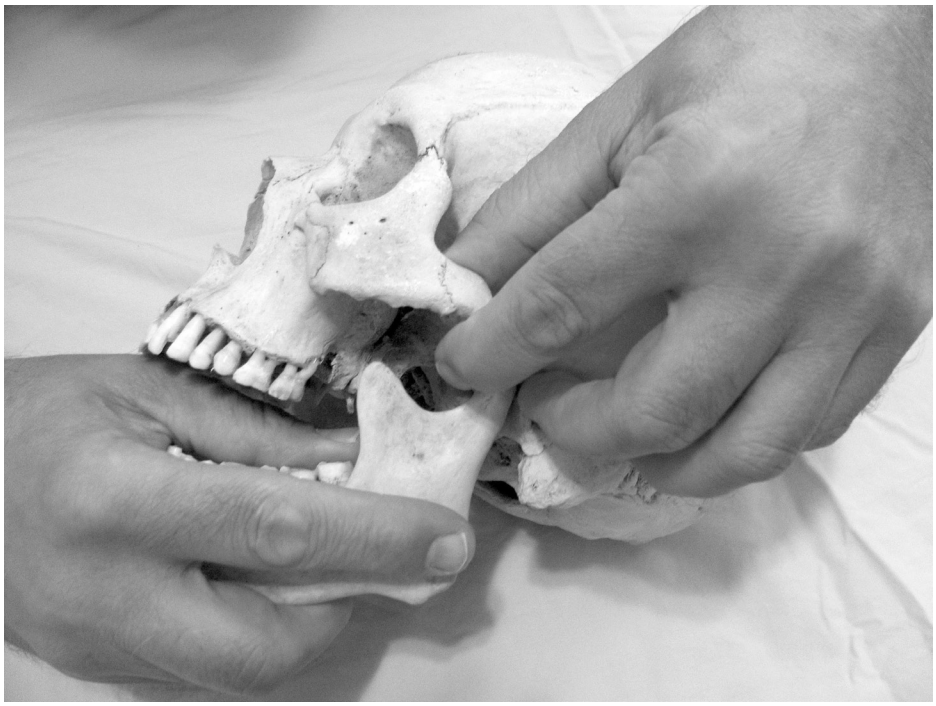

Figure 7: Handhold for Managing the TMJ.

To reduce the joint, the practitioner follows the idea of the self-reduction. The movements should be done slowly and with a gentle but directed force. Initially, distract the condylar head by moving the mandible in a caudad direction and maintain the gapping for fifteen or twenty seconds. It may help to think of pushing with the thumb while slightly closing the fourth and fifth fingers, which slightly lifts the front of the jaw. Then traction the mandible forward and toward the opposite side, tracing the anteromedial motion of the disc's normal motion. The client can help by gently jutting the jaw forward in the same direction, which will help distract the condyle out of the fossa. At the end of the range, the client should relax while the practitioner gently maintains the traction for thirty seconds, making sure that it is not painful; no more distress should be placed on the joint! The practitioner can finish the reduction by gently reapproximating the condyle to the disc (un-gapping the disc space), and holding for thirty seconds. Hopefully, by this point the disc has reduced. Opening and then closing with the teeth meeting tip-to-tip (to ensure that the condyle will still be anterior on the disc) can check the results, being careful not to undo the reduction.

As it happens, just after writing the above paragraph, a client called for a session, suffering TMJ dysfunction. Methodically assessing the situation, I found dislocation without reduction on the left, with soft-tissue spasming stemming from the area of the left mastoid process, along the digastric and stylohyoid to the hyoid bone, and involvement of the entire oral floor to the ramus of the mandible. After releasing the tensions, attempts at self-reduction failed, so the manual reduction was performed and successful. Notable was a "ratcheting" release of tension felt on the prolonged holding of the forward traction phase. Afterward, coaching to maintain a relaxed, anterior "hanging" of the mandible is important, as this will tend to keep the condyle forward, on the body of the disc. Standard dental practice is to combine the manual procedures with an anterior positioning appliance to ensure the appropriate positioning for several days, until the disc and retrodiscal tissues can heal.

As noted earlier, there can be restrictions involved that relate to other paradigms. It is worth mentioning that in this case there was a left cranial torsion present, with the

left temporal bone flexed and out of balance with the right temporal in extension, forcing a torsion pattern on the mandible. Obviously, without specific training, this aspect of treatment would be ignored, with the hope that a successful reduction would release the cranial pattern over time.

Allan Kaplan has been a Rolfing practitioner since 1988. He has studied visceral manipulation with Didier Prat, D.O., and assisted him teaching several classes. More recently, he has studied with Jean-Pierre Barral, D.O. and completed osteopathic studies at the Canadian College of Osteopathy.

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Bones to Fluids: A Path to Understanding Wholeness

By Thomas Walker, Rolfing® Instructor and Rolf Movement® Practitioner

The human egg is 99% fluid and 1% genetic material. Science tells us that 70% or more of the adult body is fluid. Yet, when we touch our clients, we primarily relate to the solid pieces, the bones, muscles, fascia, etc., which make up the 30%. There are a vast number of textbooks written about the 30%. We study, memorize and often describe the changes we see in our clients as the 30%. We are missing much in not learning to actively address the 70%, which is a component of the "fluid body."

In this introduction to the fluid body I will discuss the importance of direct interaction with the fluid body and the potential of this interaction to greatly enhance our goals for structural integration (SI). This introduction is based on my experience, and the related concepts, as I understand them at this time, in my practice. The evolution of the concept of the fluid body has its origins in the discoveries of William G. Sutherland, D.O., who built on the foundations of the founder of osteopathy, Dr. A.T. Still.

Sutherland spent fifty years patiently exploring the subtle movements within the body. At the end of his journey, his ability to interact directly with what has become known as the fluid body has contributed greatly to the understanding of healing and wholeness in the osteopathic profession. This article is a broad overview of how this understanding can contribute to our own Rolfing SI paradigm by understanding how the "fluid system" not only is critical in the development in the embryo but also in the organization, function, delivery of resources, and maintenance of structure in the adult.

Generally, we believe that changes in the structure occur from the outside inward, through our intention and our focused, vectorized touch. We want the fascial interfaces to become more slippery. We want the dried-out scar tissue to become more pliable and soft. We want dense places to soften and let go. We seek and perceive changes. We look for continuity within the structure.

We do three things in SI: hydrate, differentiate/de-rotate, and integrate. The first, hydration, is what we feel when tissues change. We feel the tissue soften and become "gushier." We describe movements as becoming more fluid. There have been different explanations as to why this happens, i.e., pressure, heat, or piezoelectricity. Whatever the cause, as the tissues take on a more fluid quality, differentiation and de-rotation happen spontaneously, or at least become more easily coaxed from the tissues.

Though we value the goal of hydration, we don't study the fluid system, the 70%! We are taught that our interventions within the 30% allow the 70% to emerge. We call this integration – to combine one thing with another so that they become a whole. By this definition it must be wholeness that emerges. Does this imply that a hydrated body is whole and integrated? Could it be that fluids are the vehicle for integration and wholeness? If this is true, could it be that relating directly with wholeness will greatly increase the effectiveness of our work?

> *Sickness is in effect caused by the stoppage of some supply of fluid or quality of life* (Still 1899).
>
> *The object of any physician is to find Health. Anyone can find disease* (Still 1899).

If the body is 70% fluids, does this mean that integration and wholeness are already and always present? If the whole is always present in our clients do we not recognize it because we don't know how to perceive it, we don't know how to evoke it, or make space for it, or support it as a partner in our work? If we follow Sutherland's path of discovery and development of the cranial concept, we will gain insight into the answers to these questions.

Sutherland began his discoveries leading to the cranial concept in 1899 while examining a temporal bone. Its beveled edges reminded him of fish gills and he surmised that the temporals must be part of a respiratory system. He also noticed that the bones of the cranium moved independently of each other and realized that abnormal relationships between the bones produced certain symptoms in his

patients. By manually balancing the bones, these symptoms would disappear. He developed specific techniques that could be used to free the articulations (sutures), allowing the bones to express very slight yet important movements. When these movements normalized, physiology of the whole body could be improved.

In the early 1930s he shifted his focus to the dura and its bi-laminar in-foldings that form the tentoria and the falx. Collectively, he termed these dural in-foldings as the "reciprocal tension membrane" (RTM), and described how its coiling and uncoiling motion determine the motion of the bones of the skull. Sutherland began to notice that the continuity of the RTM from cranium to sacrum resulted in whole-body responses to its movements.

Several years later, Sutherland shifted his focus to the fluctuation of the cerebral spinal fluid (CSF) driven by what he termed the "primary respiratory mechanism" (PRM). He described the CSF as circulating down and around the spinal cord in a rhythmically pulsatile and spiral fashion. Many practitioners have perceived this movement and refer to the pulsation as the "cranial rhythmic impulse" (CRI) which has a palpable rate of 6-12 cycles per minute.

Focusing on the bones, the dura (RTM), and the CRI is the main approach utilized by many osteopaths (of which John Upledger is the most well-known) and lay practitioners today. However, Sutherland moved on. He began to notice that there was a fluid fluctuation ascending and descending from the sacrum to the cranium at a tempo of about 2.5 cycles per minute. This movement, seemingly outside of and yet inclusive of the anatomy, is palpable throughout the body.

In the final years of his life, Sutherland described the motion of the PRM as being generated by external forces. He sensed his patients being moved by an external, ubiquitous force that he called the "breath of life" (BOL). Sutherland perceived the BOL as an incarnate process, inherent in every living being. It passes through the patient's body and the practitioner's hands undiminished, generating a sense of the whole fluid body breathing at a constant tempo of 50 seconds of inhale and 50 seconds of exhale. Because of this "breathing" sensation, he called the tempo "primary respiration" and spoke of his patients as if they were part of a sea of waves, moving rhythmically while a deeper tide moved through them.

Sutherland reasoned that the different polyrhythmic tempos he had been describing through the years were in fact created by the BOL as it passes through the various layers of the whole body. Thus the "long tide" (6 cycles per 10 minutes), the "mid tide" (2.5 cycles per minute), and the CRI (6–12 cycles per minute) are all manifestations of the BOL.

> *Innate wisdom isn't in the body but passes through the body* (Jealous 2001).

The long tide is not affected by the central nervous systems or by external forces. It has been present in each of us since before the moment of our conception. It is an inherent rhythm. Sutherland compared the BOL to the cyclic sweeping of a lighthouse beam that lights up the ocean, but does not touch it. It sweeps through the patient stimulating the inherent healing forces already and always present in the fluids. From these revelations the concept of the fluid body emerged, in which the whole body can be perceived as a single unit of living substance – a whole.

> *Healing comes about when our disease is brought into proper relationship with our health. This is a process of bringing fragmented parts of ourselves back into relationship with the whole and with the deeper healing forces carried in primary respiratory motion* (Kern 2001).

To summarize, Sutherland's studies began with bones, progressed to the fascia (dura), on to the CSF, and then to the entire fluid field. This progression is important to know for our own profession since what we touch every day in our work includes all the elements he described. As he deepened into his experiences he sensed the entire fluid nature of the body, its tempos, fluctuations and qualities, as well as its responses to the all-pervading animating force of the BOL.

> *A successful response from the cerebrospinal fluid . . . is an intensified interchange between all of the fluids of the body. . . . It is definitely evident that the reaction is systemic and includes the whole body even into the bones* (Anne Wales, D.O. in Sutherland 1967).

Sutherland perceived the fluids as the organizing and healing mechanism that delivers "life" and animates the whole body. By interacting with the fluids, profound healing can occur throughout the whole body. He sensed a fluid continuum, containing no anatomy, from within the skin to outside the physical body.

There are three major models of the cranial concept derived from Sutherland's perceptions. The terms *soma*, *fluid body*, and *tidal body* have evolved to describe these three models (see Figure 1).

> *Because humans arise out of a single fertilized egg, our body is never composed of separate systems but rather of Wholeness which is our underlying origin and maintaining force* (Blechschmidt 1978).

At about the same time Sutherland was progressing through his explorations, a German embryologist, Dr. Erich Blechschmidt, was developing a different model of human development than that accepted by conventional science. Genetics were the rage just then, asserting that pre-formation of all living structures is carried only within the genes. Blechschmidt was studying and describing a process called epigenetics. This model states that an embryo develops from the successive differentiations of an originally undifferentiated structure. His observations, based on the physics of moving water, showed that the movement of fluids (the living water or protoplasm in the embryo) were directing embryonic development and that these fluid forces continued through life as the ongoing maintenance and regenerative function of the human structure. Blechschmidt's scientific work would give credence to Sutherland's perceptions.

> *As the embryo differentiates, it is a subdivision of a living whole which is integrated. Therefore cells are totally integrated into the whole and within themselves.*
>
> *We are never not integrated! The human entity is not a higher entity than the ovum* (Blechschmidt 1978).

Blechschmidt discovered that fluid movements were occurring when there were no structures to generate them. His studies of the progression of these movements showed that in order to have movement, some force must be present to cause them. He determined that forces are acting upon and within the fluids themselves. Further explorations showed that there are "submicroscopic movements

Biomechanics Model	**→ Soma**	**→ CRI**	**(6 - 12 cycles per minute)**
Functional Model	**→ Fluid Body**	**→ Mid Tide**	**(2.5 cycles per minute)**
Biodynamic Model	**→ Tidal Body**	**→ Long Tide**	**(6 cycles per 10 minutes)**

Figure 1: Three major models of the cranial concept derived from William G. Sutherland's perceptions.

in the fluids" very much like the metaphoric BOL perceived by the osteopaths. He used the term "biodynamic" to refer to the forces in the fluids that cause order and organization to occur.

Blechschmidt determined it is the flow of protoplasm that produces the differentiations we see in the embryo, and that genes are not the cause of body formation, though they are a necessary condition for it. Genes are a mechanism by which the information in the fluid fields is manifest into physicality. Genes are members of the orchestra, but not the conductor.

> *Shape and form are determined by fluid flow which shapes the limiting membrane out of which comes the anatomical details* (Blechschmidt 1978).

He described a model in which he showed that the interaction between the varying fluid flows within the embryo creates barriers and resistances that influence the genes to create structures. He coined the term "metabolic fields" to describe how these forces of growth compress, shear, stretch and thus affect the metabolism of the cells and, in the end, direct their differentiation into the component structures of our bodies. Blechschmidt described how position influences shape, which determines the expression of the cell nucleus into the formation of embryonic structures. In his view, for the cell to shift from one stage to another, there must be some external force causing the differentiations.

> *The genes are not active, they are re-active in the process of differentiation which is a process from the "outside" to the "inside."*
>
> *Differentiations arise as functions of the whole organism whether it be one cell or many* (Blechschmidt 1978).

A biodynamic approach to embryology is an exploration of the movements, occurring throughout the fluids, which sustain, shape and resource the "whole" person. In other words, fluid movements carry the intention of wholeness, create order, and are the functions that create structures. These ideas are reflected in our Rolfing belief that function precedes structure. To work with the fluid body is to engage the function of wholeness and its ability to organize, shape, sustain, and resource the physical body. We can learn to experience wholeness as a palpable sensation instead of as a concept.

Blechschmidt's scientific descriptions offer a more tangible confirmation of the same phenomena, the often-deistic metaphors, that the osteopaths used to describe their perceptions. Both imply that slow-tempo movements perceived in the fluids are expressions of wholeness that act to shape, differentiate, and organize the pieces of the body. They also state that these embryonic fluid movements are present throughout life.

> *Genes are like the clay that forms a piece of pottery. Clay by itself cannot form into shape, it requires the hands of the artist. And the hands of the artist cannot act without the mind of the artist. Clay represents the genes, the hands represent the fluid forces and the artist's mind represents the Breath of Life – the deific plan or the master mechanic often alluded to by Still* (van der Waal, 2007).

The Fluid Body

The concept of the fluid body is a teaching tool that is both descriptive and limiting, as most models are. It is descriptive because it is experienced as a continuum from "fluid anatomy" (fascia) to no anatomy, with no boundaries whatsoever. It is limiting because the labels *soma*, *fluid body*, and *tidal body* imply that they are distinctly separate compartments. In reality, these are gradations along a continuum from solid to fluid. I describe this continuum perceptually as moving from solid to "liquidy honey" to unbounded spaciousness.

The fluid body is a living continuum and not part of a sequence of events. It responds simultaneously throughout its entire matrix. It is not as if it begins one place and ends up somewhere else. The whole matrix breathes and fluctuates as it directs its therapeutic forces toward specific goals. It knows the priorities of the body. There are thousands of fluid compartments in the body; however, the fluid body doesn't recognize boundaries between these compartments. Ideally, when there is balance in the fluid body, there is one single response encompassing all of the fluid compartments of the body – serous, visceral fluids, lymph, blood, CSF, etc. Fluctuations occur in every drop of fluid in the whole body, in every moment. Sutherland talked about fluid motions by saying that "every drop knows the tide." When one perceives the fluid body, it feels as if there is a single (albeit large) drop that is being "breathed." This can be hard to grasp because our whole medical model is built around compartments (think the 30% anatomy and physiology).

Sensing the dura, the RTM, and the fluid body requires the practitioner to sense and recognize qualities and tissues beyond the physical contact of the fingertips. As we aspire to perceive more than the pieces, more than the bones and tissues, we must learn to "disappear" what is superficial and sense more deeply. Sutherland taught that the fluid body couldn't be contacted in the way one works with the tissues. The dura can't be contacted by pressing harder or deeper. It doesn't respond to direct contact and it cannot be pushed as though it is separate from the whole self.

> *Treat not with techniques but with gentle contact* (Sutherland 1967).

In order to relate to the movements of wholeness in the fluid body, you cannot be separate or think of yourself as apart from them. Wholeness doesn't recognize parts, doesn't have parts. Perceiving wholeness demands that you change yourself. As a practitioner, one becomes a catalyst for its expression by blending with it, and its effects are then multiplied. Dr. James Jealous has said, "Wholeness doesn't appear, you disappear."

The fluid body is highly sensitive. If approached from a spacious perspective and a neutral state of mind, one can watch it do seemingly miraculous reorganizations. Practicing "inclusive attention" (a neutral state of mind having no preference as to outcome, while actively engaged in unbiased listening and having a detached

awareness of oneself, the client, and the room around you) will allow one to get out of the way of the inherent healing intelligence carried in the fluids.

> *You have to hold both the condition and the universal to have transformation* (Jung[1]).

It is important to allow the dualities of giver-receiver/client-practitioner to fade into the background. Duality of any sort is antithetical to wholeness since there are no dualities in wholeness, by definition. To synchronize with wholeness in the fluids one needs to be present in one's own fluid body. Direct interaction with the fluids means that one is not working with anatomy but with the 70% of physicality that has no anatomy. To do this you need to experience yourself as a fully three-dimensional being, a fluid being. You need to begin to perceive your body as more diffuse, to become more aware of the space between your particles and experience your own fluid system.

It is my experience that many Rolfers™ venture into the fluid realm by chance and engage it in the usual ways we learn to work with the fascia. When this happens, the fluids often change and express a pattern that frequently seems to express a repeated swirling, spiral sensation. This sensation may then be misinterpreted by the practitioner as an unwinding phenomenon and they may actively exaggerate the motion with the intention of helping to unwind a trauma. In actuality, the client's system may just be squirming to get away from direct contact. If you begin to sense the fluids and then get curious and shift to a more focused doing or directing attitude, the fluid patterns will also shift in response to your input and intent, just as the smooth surface of a pond shifts when a breeze ruffles the surface. In focusing, you will have lost your ability to sense the client's whole system and so will end up "tracking" your own interference reflected in your client's system.

To contact the fluid body one needs to shift one's focus and the use of one's hands. Your preferences and biases will diminish your ability to sense with expansive perception. Your intentions and focus will also influence what you perceive. You must shift from a doing mode to a sensing/listening/being mode. You need to shift from palpating to sensing, from activity to receptivity. In addition, you need to continually "disappear" your hands and the anatomical boundaries within yourself and your client.

In learning to work with the fluid body, one has to develop more sensitive hands and a much broader spectrum of contact. It is impossible to experience the depth of the fluid body's healing and organizing effects without doing so. Broadening one's contact skills will allow one to experience wholeness as a palpable phenomenon instead of as a concept. It has allowed me to truly "listen to" my clients' systems. As one is able to match the client's pace of change, one can instantly know when one has pushed his pace. One can easily feel the continuity of the fascia and fluids throughout the body and can help to bring balance and coherence to a much broader area with much less effort. Choosing to listen for ease and the perception of spaciousness and hydration expands on what SI practitioners already know about palintonicity and hydration.

Engaging the fluid body described by Sutherland and biodynamics is a simple concept, but it isn't easy to do! It isn't easy because the ability to stay in a neutral frame of mind with unbiased presence and contact is continually interrupted by our mind's impatience with pure presence. Learning to work in this way is really an exercise of mindfulness. What makes presence so valuable, while in contact with another, is that presence allows immediate feedback. Our client's body reflects our level of presence in each moment by the wholeness its system expresses to our perception.

Sutherland's progression from bones to membranes to fluids and the furthering of this work by Jealous and others to include the tidal body demonstrates a continual acquisition of perceptual and contact skills that build upon each other. In our desire to be more effective in our work (*now*!) we often lack the patience to deepen our skills, missing valuable steps with which we can more completely understand the processes of wholeness and its function in health.

There is much interest in incorporating the energetic body into our Rolfing SI paradigm. Those learning to incorporate energetic work will often do their "tissue work" in ways that don't immediately seem to acknowledge a continuum from the soma to the energetic body. The fluid body is the link between the physical and the energetic. By learning to relate to the fluids, we can incorporate a seamless continuity from the physical to the energetic, allowing for a more complete and integrated embodiment. Those learning biodynamics (and energy work) often hold these as a higher form of intervention. This is as limited a view of embodiment as those who relate primarily to the purely physical. We are more effective when we can contact a broader spectrum of embodiment.

Deepening into the anatomical considerations of Rolfing SI has value, and we can also expand into the wholeness aspects of the fluid body with effective results. Moving anatomy to the background while working allows one to have an expanded awareness of the whole person under one's hands. As Still stated, "anyone can find disease." Working with the fluid body has taught me how to clearly understand integration and wholeness and how to engage its effects to rebalance the disorganization we often see and feel in our clients.

As I gained more perceptual skills and sensitivity, I began to experience how the health carried in the fluids can reorganize the anatomy. Now, in everything I do in a session, I have the choice to relate to dysfunction, or to the expression of health in the whole body. I can also choose to relate to the health *within* the dysfunction. To shift from one approach to another, I have to shift myself. If I only relate to the dysfunction, I am much less effective in reminding my client's "being" of wholeness (integration).

Rolfing SI has deep roots in osteopathy. We have borrowed much from that profession and incorporated aspects (craniosacral therapy, visceral manipulation, nerve work, etc.) into our whole-body approach to enhancing embodiment. We can learn much from Sutherland's progression from bones to fluids to further enhance our whole-person philosophy. We consider Rolfing SI to be a whole-body, whole-person modality. If we are to "walk our talk" we may find following his progression a good path.

> *So many therapists are striking at the pattern of disease instead of supporting the pattern of health. Rolfers are not practitioners curing disease, they are specialists in health* (Rolf 1977).

In Rolfing SI, we have limited cranial touch to the axial complex while the progression of Sutherland's studies taught that there is a seamless continuum between the anatomy and the fluids, the axial complex, and the whole body. He demonstrated that the

whole-body responses to this quality of touch offer dramatic and comprehensive results. To learn this quality of work requires patience, both with the time it takes to grow our personal skills and with our ability to change within ourselves, allowing the unerring partnership of the body's inherent self-healing to assist us in our work.

Thomas Walker is a faculty member of the Rolf Institute® of Structural Integration, a Rolf Movement Practitioner, and a Rolfer for twenty-five years. He has studied craniosacral therapy since 1993 and began studying biodynamics in 1996. He has over 900 hours of training in biodynamics. He offers continuing education classes on integrating the fluid body and biodynamics into Rolfing® SI. For more information visit www.explorationsinwholeness.com.

Endnotes

1. Author's notes from a class with Michael Shea.

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A Nonlinear Systemic Journey

By Michael Maskornick, Certified Advanced Rolfer™

Writing an article about a non-linear experience fits the definition of an oxymoron! Just as the description of a drunken sailor's walk must be linear and logical, the event itself is neither. Having said that as an introduction, I now propose to write a story of how in some ways my Rolfing® Structural Integration (SI) practice has taken a non-linear circle back to the beginning. Writing about this journey requires some significant measures of linearity, though the events and thoughts of the journey are not linear. They fit in where they fit, not necessarily in the order they occurred, nor in the importance I now attribute to them.

One of the early stories regarding the development of the ten-session Rolfing format was that Dr. Rolf originally created a series beginning with work below the waist, specifically the legs and feet. This was done to emphasize the importance of our connection to the earth and our relationship to the universal gravitational field. She later became dissatisfied with that beginning and replaced it with a session focused on the chest, upper body, and breathing. Rolf stated that it was necessary to establish enough energy and vitality to help the body integrate the significant changes that would be introduced in the subsequent sessions. This early emphasis on breath and vitality established a systemic basis for my work that carried me through the early times of my practice. It worked well.

Another element that came in was that I had been playing around with neurolinguistic programming (NLP) and Ericksonian hypnosis and was beginning to notice how my work was taking on the feel of nonverbal communication with the body. More importantly, it appeared that the body was communicating to me in ways that were anything but logical, linear, or linguistic. At the time this nonlinearity didn't seem to be getting in the way of the physical manipulation aspect of my work. The work was fun and challenging, and since it was neither verbal nor linguistic, I just enjoyed the nonlinear part of the work as a side benefit to keep me interested. But I was paying attention.

Around that same time, I started hearing more about working with the skull in the way some osteopaths had been doing since the beginning of the twentieth century. I was interested enough to get the training required to be competent in two separate but probably related forms of body work, both systemic with fairly well-defined treatment protocols. Thus, Rolfing SI and cranial work carried me through my mid-practice life, and worked well.

After taking an advanced Rolfing training, I began to think more about non-formulistic series. I was already paying enough attention to the above-mentioned nonverbal communications to have a rudimentary understanding of its vocabulary and syntax. Then in one large conceptual leap, combining attention, nonverbal communication, and the systemic concepts imbedded in energy and vitality, I concluded that all I was doing was one session, over and over. The physical manipulations of the sessions changed in relation to the client's structure and circumstances, but my focus and intention were consistent. I began to use the metaphor that each session was like looking at a gemstone through one of its many different facets (same gemstone, different perspective). I never did get to the point of the bone manipulators who only adjust one bone (e.g., the atlas); my deep intention was not manipulation, but rather the systemic organization of the person in three-dimensional space.

I had some friends and clients who liked what I was doing and wanted me to share what I knew with them. At the time, I thought that teaching the details of cranial work would be more straightforward than teaching the basics of Rolfing SI, and that I could create a small training in that. But by the time I got around to organizing a training, I was disillusioned with teaching based on mastering treatment protocols. Instead, I thought I would introduce the material exclusively through awareness and touch, allowing what you feel to guide what you do. Easy, right?! Just put your hands on the head and notice what you feel. Some of the glib statements that came from my lips included, "Do this and it will change everything that you are already doing with bodies"; "Enter into this learning with a beginner's mind, do not let your prior knowledge get in the way of what there is to learn"; "This is intended to advance your skill level beyond what a didactic training

would." It did all that and more, but mostly to me. My students, on the other hand, were confused and overwhelmed.

You may recognize some of those thoughts coming from the realm of General Semantics (Alfred Korzybski: "The map is not the territory"), awareness meditation, and epistemology (how we know what we know). I was, and am, deeply interested in how our mind filters the raw information of the universe into something that we can make sense of without going bonkers. The problem is: once we become familiar with filtered information, we no longer have as good a grasp of the unfiltered universe. A consequence of familiarity is that we see, feel, and experience what we already expect to see, feel, or experience. Unexpected information is either ignored or, more likely, not even on our radar; it just doesn't exist! The set of blinders we create as we filter raw information gets in the way of perceiving and acquiring new knowledge.

Enter Rolfing SI. Once I began to think about filters of experience and awareness, everything was subject to questioning. What would the stuff under my hands feel like if I didn't already know that it was fascia, it was plastic, and I was in charge? The more I considered this, the more uncertain I became. At first it was easy just to expand the model to include bones, muscles, fluids, nerves, and everything else in the physiologists' handbook. But ultimately it led me to the realms that I think of as multidimensional chaos. What if the stuff I'm working with isn't fascia, and what if it really isn't changing in the ways I've always thought? How dare I have the hubris to think that I know what a balanced, functioning system would look like for this client? In the grip of this confusion, only the solid grounding of my work based in feeling and sensing with my hands and, ultimately, what I call my whole "sensorium" (there is something under my hands; it moves, and seems to be happier in the new position it attains) allowed me to continue working un-befuddled.

Enter cranial work. By this time, in addition to the above questions regarding Rolfing SI, I was having serious questions regarding the cerebral spinal fluid (CSF) theory of movements of and within the skull and began looking for other explanations or theories for these cranial movements. In brief, I no longer accepted that a 0.05 milliliter (0.06%) change in the CSF could overwhelm the 25% output of the heart that was channeled into the skull and back into the vascular system through the cranial sinuses. Then I read about the Traube, Hering, Mayer (THM) waves of the cardiovascular system (Schleip 2002). I knew that John Upledger, D.O. discounted them in his first book, but there are more recent studies that are not as easy to discount. One by Patrick Botte (2010) used Fourier analysis on multi-variable data to show correspondence between TMH waves, breath, and the three primary cranial waves that cranial therapists monitor. (It is not clear how the CSF model can explain the existence of the three tides they talk about.) At this point I am intrigued but not convinced by the THM model. However, I suggest spending enough time with Botte's paper to begin to get a feel for the complexity of the relationships uncovered by his mathematical modeling. Regardless of the theories, I feel what I feel, and use that to initiate changes; it still works well.

A few more thoughts on this topic:

In chiropractic Sacro-OccipitalTechnique (SOT), the generating impulse for the cranial rhythms is the breath. The mechanical gymnastics that convert that impulse to skull movements is not germane to my thinking, but I do think it is a valuable thought.

I recently read some osteopathic thinking regarding the effects of holding the base of the skull and the sacrum. It is considered a calming hold for the autonomic nervous system. (Remember Rolf and pelvic lifts.)

Just as I was editing this article, I was reminded of Rolf's comments regarding Emanuel Swedenborg's theory that the breath was the causal source of the circulation and pulsations of the CSF.

One more diversion and maybe I can get back to talking about Rolfing SI, although I have been talking about Rolfing SI all along. Somewhere in my explorations of THM waves, I was attracted to reading about polyvagal Theory (Porges 2007). In trying to make sense of this dense theory regarding the autonomic nervous system, I was reminded of the vagal effects – heart rate variability (HRV) and respiratory sinus arrhythmia (RSA) – of breath on heart rate. By looking at these effects as relational rather than a causal, I could see how breath, vagal stimulation, heart rate, and, possibly, vascular tone are connected. The feedback loop in these relationships most likely occurs in the brain stem, where changes in the blood flow and blood pressure influence, among other things, the vagus nerve. Thus, variations in our breath are reflected in vagal patterns, which are reflected in vascular tone and heart rate, which most likely are related to pulsations throughout the body, including the cranial system. These complex relationships show no distinct division between cranial movements and those experienced in the rest of the body.

This brings me full circle to where this article started.

Rolfing SI . . . Session One . . . Breath . . . Vitality.

I have returned to the beginning. The first element of Rolfing SI requires the establishment of an environment within the body that is amenable to receiving new information and changing in response to that information. In order to create that environment I began to think in terms of a complex three-dimensional space determined by the shape, fluidity, density, responsiveness, and relationships of its component parts. That space and the relationships among the many components are a reflection of vitality! Every time we put our hands on a client, we are interacting with that environment and his body's ability to accept and sustain change. The effectiveness of that interaction is determined by how well we listen and communicate within that nonlinear systemic space. The success of our efforts shows in the new balance of the system – physical, neurological, emotional, and probably some other undefined (read occult) ways.

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ON PAIN – THE HOLISTIC VIEW OF ROLFING® SI

Integration Versus Fixing Parts

An Interview with Nicholas French

By Anne Hoff, Certified Advanced Rolfer™

Anne Hoff: I initially contacted you when there was a discussion on the Rolf Forum LISTSERV about pain issues and solving pain. A lot of the comments were about modalities and techniques, things like releasing nerves. Then you wrote a very articulate post reminding us of the holistic paradigm of our work, and discussing how you worked. I really wanted this issue's pain theme to include a discussion going back in our lineage, to the core of what we do, which is integration and how that itself can take care of pain. You studied with Ida Rolf, so I thought you would be a good person to speak to.

Nicholas French: I have to admit that often, when I read the Journal and listen to some of my colleagues or run across their posts on the Forum, I feel rather dim as a Rolfer. I've been interested in and studied some of the things they talk about, but I don't have a scientific background and I often find my eyeballs rolling back in my head when I come to grips with scientific papers or dialogues: it's not familiar ground. I've learned not to feel totally deprived because of that, and I've wondered why I have such a different outlook. In part it's that Ida's work and her viewpoint were so striking for me. She was one of the most articulate, really mesmerizing speakers I've known. She certainly demanded we know our anatomy and she referred frequently to scientific protocols, but her main emphasis was on the whole presence of the person – very different from the more medical view. She once said, "look, if you are interested in fixing things and focusing on symptoms, leave here, go to medical school. We're after larger game." She demonstrated the power of holistic emphasis, and it grabbed me, perhaps in part because one of my grandfathers was a homeopath (and surgeon).

My very first client in private practice was a guy who was a roofer and had some impressive injuries. He came in wanting me to fix his back, and I first noticed one of his lower legs [which] had been almost completely severed at the knee, so was not functional. I was thinking, "Is this some kind of curse or test?" Having no one there like Ida or Peter [Melchior], there was nothing to do but follow what I had been taught. The leg had been severed and reattached ten years before, but without nerve function. Imagine his surprise – and mine – when he suddenly noticed after the second session that he could feel the carpet under that foot. And by the end of the [Ten] Series, the lower leg was more functional, had movement and more feeling. That knocked my socks off. I realized this hadn't been a curse, it was more like a gift saying "Think you're smart? Well, just pay attention and you'll learn." I've been a fan of the Series ever since.

AH: Talk a bit about the Ten Series.

NF: It's a difficult thing to describe. As is often pointed out by colleagues I admire, it is not a "list of moves." One guy who attempted to imitate Rolfing® [Structural Integration] was Jack Painter, who called [his system] Postural Integration®. I was told he put out a book that had step-by-step instructions about putting your knuckles or a couple of fingers here or an elbow there, then pushing this way, now put them here and do this and that: a literal recipe. But of course, even if we could have videotaped Ida from various camera angles and printed out precisely what she did that was a brilliant series for one model, it would be an interesting artifact, but it would apply only to that person. It's not follow the dance steps by putting your feet here and there, it's a flow of perceptions and principles, which is what made it such a challenge to all of us. Ida urged us – and she was quite serious –to just follow her "Recipe" for the first five years. She knew that all kinds of other techniques would be very intriguing, especially when we felt confused or uncertain, or simply blank. She said, "Please just follow what I've given you for the first five years. After that, if you want to add stuff, go ahead." I think she knew that if we really immersed ourselves in the Recipe and the principles and the incredible complexity of the human structure, we would recognize that we had stumbled into an infinite realm of discoveries, enough to keep us amazed and busy for a lifetime. Sure, we can learn a lot from others and expand our abilities, but if we are grounded in holistic insight, new methods are much likelier to *extend* our effectiveness instead of confusing – and perhaps reducing – it.

AH: There's the question of *how* something is added. I studied visceral manipulation with an osteopath, and the way he worked didn't look or feel like something that I could readily integrate into what I do. Later I took a visceral manipulation class from a Rolfer – Liz Gaggini – who had studied with osteopaths, but then spent years thinking about how to bring that work into structural integration [SI]. So when she taught, it was grounded in our work – how we see and how we use our hands as Rolfers. That showed me how to integrate that work within the paradigms of structural integration and holism, not add it as just another thing to do. I think that's the challenge with all the other things there are to study.

NF: That's an excellent point, and an important one to me, because the temptation to try and add on our latest love or fascination is probably common to all of us. When I was teaching I noticed how often my fellow teachers and I would be fascinated by some new book or process, which then would influence the next class we taught. In the mid-eighties, a bunch of us on the faculty spent a week in Santa Fe with osteopath John Upledger. He was teaching us his work and we were quite fascinated. His viewpoint was less about changing the structure of bones in the cranium than how one could affect the dura. So he quickly translated from Still's bony emphasis to connective tissue. He got very fascinated with Rolfing [SI], and at one point said that he was seriously thinking of going for Rolfing training. Well, the result was that we were all wildly enthusiastic about what we were learning, and I remember Jan [Sultan] saying it was going to really

transform Rolfing SI as a whole, not only in his practice but also our teaching. I think we were all fascinated by the idea. Jimmy [Asher] was the one who really followed it closest; the rest of us found ways to integrate some of what we had discovered into our own practices. I rarely do classic cranial work; I have great respect for that work and our colleagues who are trained in osteopathy, but I found that mostly it just gave me different ways to listen through my hands to the person I'm working with.

AH: I want to go back to that quote from Ida Rolf, "If you are interested in focusing on symptoms go to medical school, we are after larger game." I think it's a difficult path in many ways to be a Rolfer, to have been introduced in a pressure-cooker training to this wonderful new way of working, and then to go out in a world that really doesn't know what we do. I wasn't a Rolfer back in the late 60s, early 70s, but I imagine that there was a big difference then, as there was much more awareness in the culture of the possibilities for human transformation. Now what drives many people to Rolfing sessions is not that they had a friend who went to Esalen and had some mind-blowing experience, but that they are desperate to get out of pain. We have a holistic mindset of aligning the body in gravity so that wonderful, transformational things can happen, and they walk in saying things like, "My left knee hurts." So to invite that person to think in a bigger way than he's used to, it's a challenge. It's even more of a challenge if we are new and still exploring the Rolfing world and can get sucked into thinking I have to make the person happy and fix his knee, rather than have the kind of trust you had with your first client.

NF: In the 60s and 70s there was a different sense of possibility, but I'm not sure it's made our work that much more difficult now. It's always been a challenge to communicate what we are offering. One of the things that spurred me to write that response on the Forum was a letter from a colleague saying that he had tried the Series, didn't think it worked well, and he had a family to feed. I fully appreciate his quandary, because I had a family to feed, too, and as a new Rolfer used to go over my notes with cold, tense fingers every time before a client came, trying to convince myself that I had absorbed enough information to be effective. Then I began to realize, to my surprise really, that rather amazing, impressive changes were coming from what I, a newcomer, was doing. And before long my schedule was packed – and it stayed full. All simply because of Ida Rolf's rather radical vision of what is possible. The medical world has a lot of brilliance, and fine technical stuff, but they look at patients with a linear view and then try to impose solutions. Ida urged us to understand that the individual being is a very complex, rich source of information, and that the body is *conscious*, so if we engage in a dialogue with it – in whatever way we can – we can learn from that being what will help healing to manifest.

It takes work to educate clients: "Okay, I understand that your back really hurts, and the reason I'm starting up here is that I see a connection to that problem" – even something as simple as that. When I first started to practice and told people "I'm a Rolfer," most would say, "What the hell is that?" But before very long people were saying, "Oh, yeah, I've heard about that" – or, "my aunt tried that," or "my brother was raving about how it helped him," and it's simply because what we do *works*. People who'd heard or read that our work helped people out of pain came to us with these blank looks, and then we had to do this courtly dance of attending to their idea that we were going to help them get out of pain, but we were going to do it in a very different way, and we wanted them to simply pay attention to what was going on in the body and be as patient as possible. I think what's really been remarkable is how much Rolfing [SI] has spread – all over the world - since Dr. Rolf began teaching it. But it still seems to be the tendency of most Rolfers to fall back into the more linear, rational approach, because that is the paradigm of Western culture. Sometimes it takes conscious effort to remind ourselves to think back, to remember what Ida said. Rosemary Feitis' book *Ida Rolf Talks About Rolfing and Physical Reality* is a wonderful resource. I often lend it to clients who are really interested in the work, because that's about as close as you can get to hanging out with Ida these days. (I also reread it periodically.) If they are open to it, I'm glad to tell them stories about her, about what I'm doing and why, and it helps refresh my awareness too, because so many people who come to me are just looking for some sort of quick fix.

AH: What do you say to that client who comes in and says, "I've got this bad shoulder and my neck hurts and I work at a computer and I heard you can fix it" – what do you say to get his mind open to the idea that it's not just about trying to fix things?

NF: First, I tend to recall Dr. Rolf emphasizing the futility of chasing symptoms around, trying to fix them: "If you work on their symptoms, they will gradually get worse. Your job is to find the roots of those symptoms, which are simply the more obvious superficial indications." It's important to address their "help me out of pain," so I might say, "I'll be glad to do everything I can, but here's how I see this process: I don't think anyone has the power to heal another, but I've found that there is something that heals people if they are given the right help – and that's a process that we do by working together." As Dr. Rolf said, "As long as there's life and breath left in a person, there's always the possibility of positive change." Some people are dubious, but you'd be surprised how many people say, "That's really interesting, tell me more."

I can give you an example. I had been [practicing] Rolfing [SI] for about three years and one of my closest friends and colleagues referred to me one of his clients, a large guy in his forties who had really persistent low back pain. Chuck had taken him through the Series, and sent over the Polaroids. I looked at them, and the guy had had really fine work, very nice changes. But the guy was still very concerned about his pain, as it hadn't really changed. So I looked at him, and saw that he had lovely organization from the soles of his feet up through about L1-L3, but something else didn't fit. The usual rational thought is if somebody has upper problems you work on the foundation, like fixing your house, and that's what Chuck had done. In studying with Ida, I was fascinated by the different ways she saw, like, "What doesn't fit?" When I looked, this guy's upper body looked compressed, too short and still. It just didn't fit. He had a nice, graceful-looking lower body, but the upper part looked like it was pulled down and tacked onto it way too tight. So when he laid down I started working on his upper body – either intuition or desperation. Naturally, he said, "You remember that I told you it's my lower back, right?" I said, "Yep, I remember, it's just that I've seen an important connection. Be as patient as you can." I spent the larger part of the hour working on his shoulders and arms and upper ribs, and when he got up from the table he looked about four to six inches taller – and it's the way he felt. He

was happy as a kid; his back all of a sudden felt strong and good, and I was happy, too. I had seen something that had not occurred to me before about the power of accumulated tension in the arms and shoulders to affect the shape of the entire body.

So part of the proof of our work is that people get up with the kind of feeling that man had. Now it doesn't always happen that quickly, and I was riding on some great work that my buddy did, but it's an event I'll always remember. So I'll tell people Rolfing stories and listen to what they've got going on to engage them in the kind of attention that is open to who knows what – a different approach, a happy surprise, or something miraculous. I can't count all the startling improvements I've seen in clients, many of which I didn't think possible but were verified by their physicians – and I've heard plenty of similar stories from Rolfing colleagues.

AH: This is a beautiful example of that quote "we're after larger game." With that guy, everything was going to make you want to go work on the low back, try to make the client feel better, but you were able to hold this bigger picture of "there's something else here, this guy's been worked, it's not as simple as his back's the problem." You had a lot of faith in your training to go for something that you didn't have any guarantee was going to work.

NF: You're right about that faith, but I can't claim that I had a very clear perception of some important principle. I think it was an intuitive hit, and I figure that is an important, even essential, part of Rolfing work. I assume that all of us have that capability if we pay attention to it, or make demands on it, or simply trust that it's there – especially when we are cross-eyed with uncertainty and wondering if we know *anything*. After all, C.G. Jung identified intuition as one of the four psychological functions, which, as he said, ". . . Is capable of seeing around corners." Ida was obviously incredibly intuitive (or as some would say, "psychic"). I hope stories about her are a strong presence in the presentations of all our teachers.

I was lucky enough to have that sort of weird, tantalizing experience one day in my practitioner training, in a class taught by both Ida and Peter Melchior. I was working with my first model. It was an upper session, and as I was working on the right arm and shoulder I noticed Peter was nearby watching me, so of course I wanted to do just the right thing. I put my hands on the guy's arm while I was thinking about it, and then I wasn't sure so I sat back. Then I put my hands on his arm again, and I started seeing different possibilities. I went through anatomy, I went through his history, I went through structural theory. Every time I put my hands on him I was considering a different approach, trying not to overlook anything. After doing that four or five times, I was utterly paralyzed with possibilities and information. I looked up and Peter was just sitting there calmly observing, looking me right in the eye. I confessed: "I'm stuck." He said, "That's funny, you've already put your hands on the exact place about five times." Hmmm. What if there's something in me that knows more than I know consciously? So I went back to that arm – Peter was still watching – and did something that I hoped looked adequately "Rolfish." There was a lovely change, and it not only looked a lot better, the guy said, "That feels so good!" Aha, something else to remember. Now, how can I learn to connect with that information? Peter just nodded and smiled.

I guess that's why I often feel uncomfortable when I see Forum postings asking quasi-medical questions about how to deal with various symptoms and conditions. Believe me, I know that "Help!" feeling, but I'm not sure that the answers given – including the technical ones – are so helpful, because they can also short circuit an important and necessary process in the practitioner. Ida knew we would suffer with such doubts, and she urged us not to discount our training, all the information the client's words and structure presented, or what we could discover if we were patient enough and hung out with the challenge long enough. When we feel "I've gotta be certain," the typical cultural response is to focus on our more logical left-brain support. It can help – or it can blind us to other useful sources of information. She had obviously learned that intuition is an indispensable part of Rolfing work.

One day a student asked Ida for guidance in some important personal issue. She looked at the student in silence for what felt like a *very* long minute, and then said, "Why are you asking me that question? My answer might be perfect for me, but disastrous for you. Also, simply to ask me for the answer implies that I can know what to do and you cannot. That does not respect your own abilities. What I recommend is that you stop being lazy, get up off your behind and work to find the answer you need to discover." No one has *The Answer* all the time, and there are varieties of awareness that are not ordinarily accepted by reasonable, scientific people. Class with Dr. Rolf could feel like being in a pressure cooker, and I figure that was by design. She knew that the human being is a much more complex matrix of systems than anybody has figured out, including the scientific world, and she knew that we would go out and represent her work to the world, her brainchild, and that we would immediately begin to meet with structural and emotional puzzles no teacher ever described. Oh boy. "Here I am, a baby Rolfer, and I am supposed to have the *chutzpah* to work with this person in this moment and actually accept money for it, so I damn well better do something that helps...but *what*?" We had to depend on our training and include all possibilities, including asking for inspiration. So when I see those Forum emails that sound like fourth-year medical students wanting a quick summary of how to fix something, I frequently think the suggestions given are really interesting, but what if they're missing something else really important? Sometimes I'm tempted to point out that even the cleverest answers can interfere with other kinds of learning that would be of real help, the kind that comes only from finding oneself at the edge of the known world and having to call on those inner resources that aren't activated any other way.

AH: There has to be a certain tolerance of anxiety on the practitioner's part, a certain openness to not-knowing, to allow intuition to arise. I know for myself, the more I have been able to tolerate a feeling of "I don't know what I'm doing," miraculous things can happen. If I think I have to know what I'm doing, then I tend to work more out of a formula, more rigidly, and maybe I'll still get results, but it doesn't feel the same as when I surrender to the sense of "Okay, I don't know what I'm doing, but I really want to work there for some reason so I'm just going to do it."

NF: Good point: "I don't exactly know what to do now, but I must do *something* . . . oh, how about this?" In the 70s going into the 80s, there was often a sense of a schism [in our community] between the ones who were considered the scientific, anatomical folks, and those who were

the intuitive, metaphysical folks. Peter Melchior, a very bright, perceptive guy, said simply, "The metaphysicians need to learn more anatomy and the anatomists need to learn more metaphysics." It's just a matter of balance. At the time, one of the theories that was going around, at least among a few of the faculty, was that the Rolf Institute® qualified as a "mystery school." So of course I wanted to know what a mystery school was, and was told it was an ancient religious tradition. The idea was that the students who came would be given all kinds of specific work to do, information to absorb, principles and ideas and all kinds of things they must master before they were ready to go out into the world. So the emphasis was on knowledge, but that was simply a way to keep their minds occupied; what was important, the real issue, was whether or not they *wholeheartedly* gave themselves to the discipline, could even find themselves falling in love with it. If the student sensed that there was something of deeper importance than simply following this formula or that strategy, then the heart would open and the spirit could enter – and that's when she or he was actually "trained." The rest was window-dressing, stuff to keep the mind entertained so that the good stuff could enter and elevate the soul. The idea shows up in many ancient cultures. Might not appeal to the scientific mind, but it is an interesting idea, no?

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Resiliency as a Conceptual Model

Bridging Pain and Integration

By Szaja Gottlieb, Certified Advanced Rolfer™

Perhaps is it some consolation to know that when it comes to the issue of dealing with pain from the viewpoint of integration, the first Rolfer, Dr. Rolf herself, confronted many of the same issues. When she presented her work to chiropractors and osteopaths in the 50s in the hope they would champion her work, they appropriated her techniques into their practice but set aside her integrative approach (Feitis 1978, 1990, 13). This disappointment eventually led to the establishment in the 70s of the Rolf Institute®, with structural integration (SI) in its masthead.

Within the Rolfing® SI community we are in profound agreement that the holistic vision of SI occupies a very special place in the field of somatics. In the 90s Jeffrey Maitland formally analyzed SI as occupying the third paradigm of holism, distinguishing it from the first paradigm of feel-good bodywork and the second paradigm of fix-it modalities (Maitland 1992, 46-49). In this he crystallized Rolf's determined intention and establishes ours.

The subtitle of Dr. Rolf's book, *Rolfing: Reestablishing the Natural Alignment and Structural Integration of the Human Body for Vitality and Well-Being* bears notice. Few clients call requesting vitality and well-being. The great majority call because they are in pain. Our response to their inquiries sometimes contains a bit of verbal and conceptual *jiu jitsu* since we, according to our founder and Maitland's third paradigm, are not therapists, but educators. Almost fifty years later, the tension between pain and integration as dialectical viewpoints exists for us just as it did for her, unresolved, waiting for each graduate to find his own way as he navigates through his practice.

Language matters. How we speak and write about Rolfing SI, particularly to our clients, frames our work and its outcomes. Rolf's fascination with Korzybski, a twentieth-century philosopher of semantics, indicates her acute awareness for how symbolic systems have difficulty mirroring reality. Of course, language is such a symbolic system. When the client presents his plaint, when we introduce a potential client to the SI worldview, how do we address that opportunity? I do not mean with our work. I mean, literally – with our words.

In a recent article (Frank 2012, 6-10), in a section called "Who Answers the Phone?," Kevin Frank discusses this second paradigm versus third paradigm conflict that frequently manifests itself in that initial phone call when clients present their problem. Adding urgency to the discussion are recent discoveries concerning fascia, which throw doubt on the sol-gel model on which we have built our work conceptually. He continues with his doubts concerning the taxonomies, particularly structure and function. Though I understand the importance of his discussion, my concern is not with the dialogue amongst ourselves, the practitioners, but between ourselves and the client. Unless they are already familiar with SI, we are left to educate clients who do not have reference points from previous experiences to comprehend SI. "Not massage, not chiropractic . . . ok, well, what is it then?" Responses from the practitioner truly reflecting third-paradigm thinking – that Rolfers do not fix pain, we integrate bodies; that we are not particularly interested in cause and effect but rather relationships; that we are not really therapists but educators; and, finally, that gravity is going to repair their ills, not us – might seem humorous or even bewildering to a client used to an allopathic way of thought.

Clearly, we are a different sort of animal than what the public is used to or expects, and we must consider our exchanges with a client and what the client will deduce from them. SI is a simple yet complex idea, and it takes sustained effort on the part of the Rolfer and sustained concentration on the part of the client to "get it." We may use simplified, plain English versions of our fundamental concepts – such as integration and tensegrity – in explaining our work and how it will help, but to the neophyte without points of reference, it will all seem distant, very complicated, and a roundabout way of getting help.

It would seem logical then that the best way to introduce SI is not to ask clients to make the leap to use our concepts and language, but instead for us to make a leap to concepts and language familiar to them.

The point of this article is that that gap can be bridged, by the concept of *resiliency*: a word readily used and understood by the general population and which speaks directly about health – importantly, the reason for the client's phone call. In the larger frame of SI, the concept of resiliency not only reflects the vision of SI, but adds important new elements to it. The purpose here is to provide a fluent platform for both client and practitioner from the immediate point of contact.

Resiliency

The word "resiliency" traces back to the 1600s and comes from the Latin *resilire*, to rebound or to recoil. *Salire* is to jump or leap; the *re* adds "back," thus to jump back. (Online Etymology Dictionary: "resilience"). The dictionary meanings are both familiar and pertinent: "The physical property of a material that can return to its original shape or position after deformation that does not exceed its elastic limit"; "the tendency of a body to return to its original shape after it has been . . . compressed" (The Free Online Dictionary).

In the Rolfing lexicon, the closest word and concept is "plasticity." In fact, Rolf's definition of "plasticity" sounds like resiliency: "The definition of plastic is a substance which under stress of pressure can be deformed and on release of the stress can be restored to its original state" (Rolf 1979, 4). "Elasticity" is another word/concept that implies the potential of a material to change form (deform) and then go back to its original form (reform). Resiliency resides with plasticity and elasticity within the principle of adaptability and forms a close relation to balance, a mainstay of our conceptual framework. Both plasticity and elasticity, however, do not suggest health, which is key.

Though resiliency is frequently mentioned on many SI home pages and websites as a benefit of Rolfing SI, it usually takes on the role of being a byproduct rather than a goal or an important concept within our work. Resiliency has only had minor inclusion in the Rolfing conceptual universe. This author's survey of articles on The Ida P. Rolf Library of Structural Integration website shows meager usage. Out of the approximately 1,100 articles catalogued, only 32 mention the word in passing reference. Compare this with familiar SI keywords: balance, 547 articles; movement, 717; structure, 701; integration, 578. (The catalogue includes articles since 1969, and shows no article with resiliency in its title.)

Balance

When the potential client calls with his problem, the usual Rolfing reply is that an imbalance exists that needs to be corrected by SI. However, the balance he is visualizing and the one the Rolfer is talking about may be entirely different. In the popular mind, balance suggests equilibrium and stasis reached by equal forces opposing one another. The image of balance for the general public is a stack of stones sitting on top of one another. This image fits very well with a chiropractic one: the "stones" of the body – the bones, particularly of the spine – are sitting balanced on top of one another. When there is a dysfunction, a necessary adjustment to the bones will realign the structure and thus equilibrium and health will be restored. When the Rolfer talks about SI, the client will most certainly fall back on this "stone" model of alignment. For the uneducated client, what else could integration possibly mean? Unfortunately, the Little Boy Logo perceptually reinforces this misconception and the prospective client could easily mistake the balance achieved by "The Line" as an alignment of the anatomical blocks, not unlike that achieved by a chiropractor.

Korzybski's warning about confusing the map with the territory certainly applies here. Missing in the usage of the word "balance" is dynamism. To be more accurate, we should say "balancing" or "balancing/imbalancing" to more precisely describe this ongoing process in gravity. A structurally integrated body is thus not better because it stays the same in gravity no matter what the circumstance – the illusory hope of the client; it is better because it has a superior capacity to adapt and change in gravity no matter what the circumstance. This misunderstanding potentially sets up the tragicomic situation where both parties may nod in agreement, but are actually talking about two different things.

Balance and Resilience

I want to be clear here. I am not trying to eliminate the concept of balance or its importance; I am trying to offer an alternative that fits comfortably in our conceptual framework. The usage of "balance" is problematic on several counts. First, "balance" or "imbalance" does not engage the client immediately with his problem of pain. Secondly, "balance" is insufficient in describing the dynamism and challenge of the gravitational field, at least in common usage. Lastly, "balance" has become an overused word in the field of somatics, rendering it meaningless or inexact in describing specific considerations.

Spatial relations have always been the primary concern in the concepts involving SI. We begin with anatomy and then explore a scaffolding of relationships between parts, first statically and then dynamically in gravity, flexors/extensors, intrinsics/extrinsics, horizontals/verticals. Temporal considerations, which reflect the movement of time (duration), however, are given short shrift. In SI, the concept of balance is, of course, not a fixed point. Nor is it a fixed moment. All this balancing/imbalancing goes on in time, all the time. Unfortunately, the word "balance" implies neither duration nor dynamism.

Resiliency, however, is movement in time. The concept of resiliency is used in many fields to measure ongoing stress and potential breakdown of systems in time. The application of the concept is extremely wide encompassing hard science such as engineering and computer technology, social sciences such as ecology, and softer humanistic sciences such as psychology. Resilient time in ecology, for example, is the time it takes for a system to return to a stable state after a disturbance. It is also sometimes referred to as resilience return time (Carpenter and Cottingham 1997, 6).

Incomprehensibly, at present, resiliency has little role in the field of somatics as a conceptual model, Peter Levine's work with trauma being the exception. Yet, the concept of resilience captures the essence of struggle that all structures take on in the gravitational field: the struggle to remain neutral in gravity no matter what the conditions. If the definition of balance, as it is usually used, is the ability of a structure to maintain in gravity, the definition of resiliency is the ability to maintain a structure in gravity over time. Perhaps this could be expressed as $b/t=r$.

The relationship between balance and resiliency becomes parallel when viewed from the viewpoint of palintonicity. Derived from Heraclitus' "unity of opposition" or "oppositional balance" (Maitland 1995, 172), palintonicity denotes the impossibility of the still point, the frozen moment; all is movement and struggle. As I have stated previously there can be no balance without

imbalance. The concept of resiliency occupies the same territory. The capacity to recoil from resistance is the mechanism of balance. If we remember its Latin origin, to jump back, to recoil from, then resiliency describes this same balancing/imbalancing movement but from the point of resistance or potential breakdown. In a resilient body, the organism constantly adapts to the stresses in the gravitational field without going past its breaking point. Once there is a disturbance the question then becomes whether the system can return to normal function or stability. Therefore we can just as well say, when there is a dysfunction, that there has been a failure in the client's resilience as there has been a failure of balance.

Again, I am not saying the concept of balance should not be used. It is just that, in my view, the concept of resiliency more directly deals with the client's plaint of pain because it comes from the point of view of breakdown. This confluence allows practitioner and client to seamlessly discuss the problem of the client from a third-paradigm point of view, thus bridging what I described earlier as the divide between pain and integration. Additionally, if you believe that the dynamic between practitioner and client is key in the SI process, this confluence is vital. The practitioner can then present integration as a necessity in solving the client's problem on a long-term basis. To ward off present and future problems, the resilience of the client must be amplified, which can only be achieved as a result of a highly efficient, economically functioning system, the hallmark of an integrated body. Simply put, the less stress in a system, the greater its reserves; the greater the reserves, the greater the resilience.

Using the Concept of Resilience in Our Practices

Adding resilience into our conceptual model shifts our point of view, bringing background issues into relief and suggesting entirely new considerations. The implications are manifold and in many directions. First, the reminder that ongoing challenge (stresses) are the norm in the gravitational field. When we get the call from a client concerning a dysfunction, we should be as interested in the client's ability to rid himself of his problem as much as our ability to do the same. In the initial interview there is a need to evaluate the client's resources in terms of resiliency: what kind of gravitational stresses does he deal with daily, how well does he respond to them, and what are his resources in building resiliency? These questions are probably not new for practitioners, but may be seen from a slightly different perspective, particularly time. In my own practice, the essential question in this regard is: how does the client move and what kinds of movement does he do?

When a dysfunction does occur, particularly a reoccurring one – such as knee pain, or back problems – special emphasis must be given to the body's responses. Was it the same as previously? How long did the problem last, and – of special importance – did it get better by itself? In other words, *resilient time*: how quickly a system returns to stability after a disturbance.

Resilient time is a measure for the success of our own work as well. A client with an inherent problem such as a leg-length difference – a constant source of pelvic instability and back problems – often is a repeat client. Though Rolfing SI will probably not be able to "fix" the problem, it might be able to add sufficient resiliency to allow the body to withstand stresses and recover without intervention. Increased time between visits, less incidences of acute breakdown, attest to a higher level of integration and increased resilience. Management, after all, is often the case with clients who have a history of repeated physical trauma, deep structural patterns such as scoliosis, or simply an accrual of dysfunctional patterns (such as forward-head posture) as is often found in older clients. The promise of SI is amplification of adaptive response. In that sense, a resilient system not only moderates the intensity of stressors but also moderates their aftermath, pain (Friborg et al. 2006).

Lastly, perhaps the concept of resiliency, especially resilient time, gives us another way to measure our work empirically. I would conjecture that scientific studies involving SI and resiliency could be designed to test the potential for increase of benefit from our work in terms of adaptability to stress (performance) and recovery from dysfunction (pain).

Resilience and Sustainability

The concept of sustainability is the logical extension of resiliency. If resilience is balance over time, perhaps sustainability is resilience over time. Sustainability stems from the Latin *tenere*: to hold on to; thus the definition of sustainability as the use of a resource so that the resource is not depleted or permanently damaged (Wikipedia).

As educators working in the third paradigm, we have always been concerned with what the client can do outside our practice to support integration. The suggestions have always been informal, coming usually from the practitioners' own preferences, whether yoga, Continuum, Pilates, or CrossFit. With the publication of Müller and Schleip's (2011) article "Fascial Fitness" and the release of their accompanying DVD, that has all changed. It is now clear that when it comes to fascia, specific methods and movements are necessary. Especially interesting from the point of view of this article is the explanation of the "catapult action of the fascia," its elastic recoil action, which sounds identical to resiliency as I have discussed it. Fascia is thus not only the organ of support but also the organ of resiliency. The conclusion that static stretching and even certain forms of yoga have only a limited fascial benefit is startling (Müller and Schleip 2011, 3). With the DVD and the offering of facial fitness training, the SI practitioner, if both parties are willing, suddenly moves into the category of trainer, taking on a greater role in helping the client specifically address the resilience of his facial network and the long-term sustainability of his structure.

Most of the recommended movements in Fascial Fitness will probably seem a bit foreign to the gym workout set, who are a large part of my own practice. The exercises, however, can certainly be adapted and integrated into a regular workout program. The jumping/hopping movements can be, for example, transformed into jumping rope. Given the enormous number of people who are in gyms, trying to improve their level of health, there exists a huge opportunity for the SI practitioner to interface with the public and introduce our work.

One of Schleips's recommendations opens the door perfectly with this potential clientele: use of the foam roller. Teaching clients how to use a foam roller presents an opportunity to introduce them to their own fascial network, derive benefits, and expose them to some of the fundamentals of SI such as fascial chains and fascia's felt sense. With the ascension of the evidence that fascia is water-based, hydration becomes a critical issue for the health of the connective-tissue

system (Zorn 2004, 10). Hydration of tissue, in fact, is an essential ingredient when we contact the fascia with our hands during an SI session. Under the pressure of the foam roller, water is squeezed out of the fascia like a sponge, and then upon release, refills, which resuscitates the tissue (Müller and Schleip 2011, 9). I have been using the foam roller myself and in my practice for several years. I introduced it in my practice in a desperate attempt to get my clients to do something outside their visits that would hold on to the gains made during sessions. The results were better than expected. Used on a daily basis, clients reported less problems and needed to see me less. I call the foam roller the "first tool for fascial fitness."

Foam rollers are now in widespread use at gyms. Simple though it may seem to us, many clients do not know to use them or have no idea of the objective. They either quit quickly because of the pain or roll too quickly over the surface, rather than breaking up fascial adhesions. They are done with their whole bodies in five or ten minutes rather than spending a lengthy twenty to forty minutes getting a fascial squeeze in terms of hydration and exploring fascia at a motile level. Though it may seem absurdly simple, teaching clients how to use a foam roller is, in a sense, to teach self-myofascial release. As a coach or guide, an SI practitioner can take on his appropriate role as educator and empower a client to become more responsible for his process. Embodying our concepts even at the crude level of foam-rolling fascial tissue can have a powerful effect. Who needs words when they can feel process in the flesh? And thus their journey may begin.

Conclusion

As practitioners we span between two poles, our work and the client. We dwell in palintonus. The territory is marked by challenge, dynamism, and perhaps struggle. Our model is not the stasis of bone but the fluidity of water. It is dangerous to take refuge in the activity and concepts of one pole and lose engagement with the other. Without both poles working in oppositional balance, there is a danger of a reification of our concepts and a loss of resiliency in our work. Our clients are not just the end receivers of our work; they are needed as part of our own continued adaptation and response. They are as important a part of our creative challenge as our principles and taxonomies. The almost fifty years of development of SI is breathtaking, except in one regard: our clients. In our trainings and in our somatic explorations, though our work is "relational," there is very little conversation as to how to engage the client, beginning from where the client is situated rather than from where we sit.

Resiliency and sustainability are the vocabulary of potential crisis and breakdown. In this article I have tried to use these terms as a way of creating a different conceptualization other than balance / imbalance for client and practitioner to participate in, in the hopes of creating new meeting ground for both. My emphasis was on the client's point of view and not necessarily the rightness of my ideas. My emphasis was on creating more fluid, more adaptive responses to potential clients seeking out our work.

Resiliency as a concept belongs in the house of Rolf and in the SI pantheon. We can lay claim to it better than any other somatic modality because SI practitioners work with resilience on both on the local level of fascial tissue and on the global level of resilient integrated structure. And perhaps most importantly, resilience provides a coherent viewpoint situated firmly in the third paradigm of holism, whether we are dealing with performance or dysfunction.

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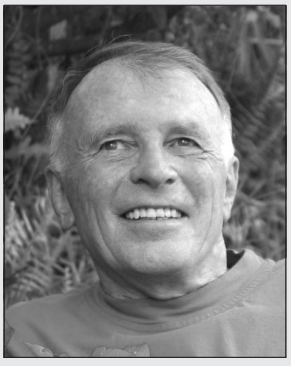
In Memoriam

Richard Stenstadvold 1935-2012

Former Managing Director of the Rolf Institute®, President of the Guild for Structural Integration



Requisecat in pace (rest in peace)

Pain Relief – A Side Benefit of the SI Disposition?

By Heidi Massa, J.D., Certified Advanced Rolfer™, Rolf Movement® Practitioner

What does *pain* have to do with structural integration (SI) – and why should an issue of *Structural Integration: The Journal of the Rolf Institute®* be devoted to pain? How is the pain theme relevant to SI in particular; i.e., can anything be said about pain here that would not be equally well said in a publication devoted to physical or occupational therapy, chiropractic, acupuncture, orthopedics, or any other field whose practitioners treat musculoskeletal pain? Though some SI practitioners have developed fine and even occasionally brilliant pain-relief methods, discussions of the same should be welcome in any publication whose readers' work is the treatment of pain.

The work of SI, however, is something other than this; and structural integrators are something other than perhaps enlightened but still unlicensed physiotherapists. Though many who come to us want to stop hurting, and despite the notion that if we accommodate them the world will beat a path to our doors, *pain* is not the point of SI – not in many of our practices and not according to the largest research study ever made of clients' motivations for seeking SI and their experiences having received it.

In 2006, Rolf Institute faculty member Pedro Prado analyzed the reports of 874 recipients of the Ten Series: 160 clients of trainings in the U.S. and Brazil and 714 clients of the São Paulo Ambulatory Clinic (NAPER). The data included the clients' responses to intake and exit questionnaires, which addressed their motives for seeking the work and the results they perceived.

Contrary to what many would expect, these data show musculoskeletal pain to have been anything but the clients' overwhelming motivation. On the intake questionnaires, though about 80% reported pain, only about 29% identified relief of musculoskeletal pain as a goal for the process. And, of those that did, more than half identified other goals, as well – e.g., better posture, heightened body awareness, and personal growth. In fact, *for only 14% of the entire sample was relief of musculoskeletal pain the sole reported motivation.*

What's more, according to the exit questionnaires, pain reduction was far from an overwhelming measure of success:

- The 29% who were motivated by pain expressed about the same overall satisfaction with the process as did the group as a whole.
- Of the 29% motivated by pain, about 2/3 (or 19% of the entire sample) identified significant improvements *other than pain reduction* as reasons why they were satisfied with the process.
- Only about 10% of the entire sample expressed satisfaction with the process *specifically because of reduced pain*.

Conversely, for over 70% of the clients, pain relief was *not* a motivation; and because this subset was also satisfied with the process, it seems that they sought and received benefits other than pain relief. Adding to that subset the 19% who were motivated in part by pain but reported benefits other than pain reduction yields *nearly 90% reporting benefits other than pain relief*.

At the risk of sidestepping the rush of humanity beating paths to the doors of others, many of us don't aim or claim to fix pain – though during an SI series, lots of pain does come out in the wash. Claiming or attempting to treat acute pain is especially problematic on many levels: I myself address acute pain only as first aid – usually the only available aid – to someone who will not be paying me. In other words, for many of us, our work is *not* the treatment of pain.

That said, it's a fact that even those of us not in the pain-relief business are often surprisingly successful at it, managing to relieve even acute pain with rare or non-obvious etiology. How can that be? Is there something about the SI training or viewpoint – or something about what an SI practitioner *is* – that makes us effective at doing something we don't make a career of doing? If the answer is *yes*, the possibilities include:

- The importance of the therapeutic relationship.
- The pain-mitigating effect of grounded and coherent hypotheses for why the client is in pain.
- The ability to entrain with the client's nervous system to modulate the client's autonomic responses.
- Recognition that the origin of the pain is often remote from its site, and the ability to intervene at some distance from the site.
- Knowledge of anatomy, and the habit of thinking anatomically rather than systemically.
- Comfort with ambiguity and with not having answers.
- The mindset of not identifying with the outcome.

An acquaintance of mine, a gifted mechanic, was working brutal hours over Labor Day weekend to complete the ground-up reassembly of a 1962 Ferrari. The car carrier was picking it up Tuesday, and the engine wasn't in yet. His boss phoned me: "Can you come to the shop right now and fix Mike's neck?"

"I can try," I replied. "Set up a lunch table in the back room." Though Mike is a stoic, he and I had worked together in the past with some success, so at least he was not afraid to let me give it a shot. Besides, on Saturday of Labor Day weekend with two more days of grueling overtime ahead, who's he going to call?

Mike was in considerable pain and having trouble walking around. To my alarm, he couldn't turn his head without sending shooting pain into one leg. Mike explained that he had awakened that way, having been attacked by a giant squirrel and then fallen backwards off a ladder – *all in his dream*.

Skipping any body reading on this modest and now very crabby introvert, I put him on the table fully dressed, tuned in, and calmed down his autonomics. During that time, I explained that as far as his nervous system was concerned, *he really was attacked by a giant squirrel and really did fall backwards off a ladder*. What's worse, because he was sleeping when all this happened, his system was poorly defended against it. I also reassured him I believed he was going to be okay.

Unfortunately, nothing I tried – not even remote work at the heels or the sacrum – did any good at all for his neck. Even

small passive rotation caused a huge convulsive jerk in response to the stabbing pain shooting all the way to his left toes. Wondering what could be happening, I asked Mike for his take on it. The mechanic and I reasoned it out together – how turning his head a few degrees could possibly grab his toes and everything in between with such violence. We agreed the most likely culprit was interference in the electrical system: maybe in the course of twisting to brace his "fall," Mike had put a kink in his dural tube. But even assuming the validity of that hypothesis, I knew nothing about how to un-kink a dural tube. So I faked it. Mike and I *imagined* that using the head as a handle, I could access that territory and encourage it to unwind.

Who knows what worked – but something must have because Mike's coordination and demeanor were much improved. Later, one of his colleagues observed, "You must have had a good talk with Mike. He's acting human again!"

When these little miracles happen in our practices, we'd learn something by asking why, whether due to a particular technique or something else – and if the latter, then what?

A Pained Process

By Kerry McKenna, Certified Rolfer™

> *"About suffering they were never wrong, the old masters: how well they understood its human position; how it takes place while someone else is eating or opening a window or just walking dully along."*
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> (W.H. Auden, "Musée des Beaux Arts")

In my favorite movie, *Amélie*, the main character's love interest is trying to follow a path she has laid our for him, and he is stopped in front of a statue that points up to the next hill and clue. A child chides the dim hero with an old proverb, roughly translated as "When someone points at the sky, only a fool looks at the finger.". Pain is the finger that points at the sky. The Rolfer is there to help the client examine the sky and relate it to the finger, not to simply remove, nor to be mesmerized by, the finger.

The Finger

Talking about pain itself becomes a verbal model of the complications existing around pain. Let me illustrate. When clients ask me what is causing a pain symptom (and they ask, because they don't presume to know) – "Is *it* my old knee surgery scars?" "Is *it* my herniated disk?" "Is *it* the way I sit at my desk?" – I always ask *around* the *it*, instead of try to answer specifically. *It* is a trap. "Do you have an idea?," I ask back. "Well, it hurts here . . ." they'll begin. My usual follow-up is to ask about the pain, to gather as much information as I can about how the client uses language and gestures to describe his experience. I try to avoid coming to conclusions on the causes. It is my experience that once people's minds reach a conclusion, new information has less of a chance to penetrate. For example, a client is convinced he has one short leg, and concludes that the discomfort in his back will always be there because he'll never change his legs' lengths. We may not change the leg length, but we may affect the discomfort anyway. How about them apples? We can make dangerous or obstructive assumptions about pain like "probably a nerve impingement," or "sounds like a muscle tear," and lose the trail of a more complete system—a system that maintains the pain symptoms. I am wary of being distracted and losing the clues that will lead me to great heights.

Pain is not the enemy. Why are we taught to try and rid ourselves of it?

As a Rolfer (with no other field of practice per se), my scope of knowledge revolves around the physical sensations that anchor the experience for us both. Relating the pain to the body brings us back around to talking about sensations again, where our information is. It's the safe spot of *paying attention* again, and in due time, I am leading the questioning solidly out of the pain locale and into a general realm. "What else do you feel?" This new line of questioning is meant – in short – to lead us away from the distraction that pain can be, and relieve us both from the duty of fixing the problem, away from the cause/effect model and away from coming to conclusion. Some clients are gifted at feeling a banquet of other sensations and some need our gentle prompting.

Primarily, we focus on the release of constricted tissue. In practice, I spend Ten Series after Ten Series following the logic that if I can help a body balance its tensional forces, people's pain will either release its hold as we proceed, or it will eventually, with patience, lose the war of attrition to better posture in the long run. At the threshold of considering advanced training in Rolfing® Structural Integration (SI), naturally I feel the squeeze to know how to handle one-off appointments, where clients legitimately hope for immediate relief. Rolfing SI as a system does not lack the agility to address pain directly, but even if "relief" is realistically understood, and the client will forgive its brevity, is there not a larger responsibility, to address the mind/body and to respect the role of pain in its family of experience?

Back to the Sky

While I endeavor to pay attention to the whys and wherefores of a specific injured tissue, I also need to remember that a client's pain is an intimate experience. Each person has an intimate, sometimes complicated, relationship with his pain. That relationship is as much part of the maintenance of pattern as it is key to relief, equal to other factors. The relationship he has with *pain in general* is a very interesting question. This question trumps all healing attempts and excursions off the bat. Clients may not know the nature or sensation in detail, or want to be too curious. The answers to "How do you feel about pain in general?" will be the basis for their whole experience, facilitate and block, spread caution or trust in proportion. They came to us, presumably to be free of pain, without ultimate awareness of how "pain-free" can be achieved. That's what we're here for, whether we lead them to ultimate freedom from pain, or lead them to their own acceptance of pain among the relationships of the mind/body family.

Recently, I have had a string of clients who had just "had enough" of their pain. Acute or chronic, pain had plagued them for months and years to some degree. I'm sure

we have all had our share of clients with pain that we have wanted to instantly make vanish with the wave of a magic wand. And we have all held off, in the better judgment, to find a way to enable a body to support itself more ideally. Through Ida Rolf's principle that gravity is the organizing factor, we instead encourage ease within gravity, which will, I presume to say, transcend pain, and enable the alleviation of it, at least as long as postural alignment can be judged a major contributor.

The Sky

Obviously, the pain of a broken leg should stop a body in its tracks. But even the dull pain of depression can be described as a way to slow down, alerting a sufferer to pay attention to his body/mind in a new way. The act of paying attention ideally brings enough information to find a way to generally and specifically adjust the system – a system that has, in effect, supported the painful condition – to shift it to support a resulting pain-free system. In other words, the relationships around the pain shifts focus away from the locus of the sensation of pain on to a host of other information.

But *relationship* is still the main issue. For one facet, a client's relationship to his or her own pain is a point in the tensegrity model of the mind/body. One cannot work without it, whether attempting to deny, or attempting to relieve the pain. Other basic facets are the client's relationship to his body, judgments about pain, attitudes about relief (e.g., never sees the doctor, takes lots of medicines, or "walk it off, sissy"), patience, trust, the perceived skills of his helpers, and more . . . all of these things hold place in the mind/body system, just as any bone holds place and relates to a structural model of the body.

How do we know how a client deals with these factors? The questions we ask about a client's body are the most obvious opportunity to demonstrate real respect for how he feels about pain. But first, and frequently forgotten – how does the Rolfer feel about pain?

I'll be honest. Like most practitioners, I'm afraid of not relieving the pain. I'm afraid of re-injuring someone when he needs healing the most. Without examining these attitudes, I run the risk of unconsciously imposing my fear or agendas onto my client. To sincerely put away my fear, acknowledging it and releasing it each time it arises, I can be responsible for the task at hand, and endeavor to remain as neutral as I can for the sake of uncovering the client's attitudes, which are supremely pertinent.

Another major factor in my relationship to pain in general is my physical history with pain and injury in my own body, which can also be a silent participant in the healing room if I don't acknowledge it. My story began with the migraines I had as a baby and that continued my whole early life. I was strong and athletic but these headaches put me down twice a month for twenty-four years before my first Rolfing series cleared the relationships that led to the pattern. Before Rolfing SI, though, I learned to pay attention to how I felt because of the pain itself. Warning signs, triggers, pressure points – the pain was motivating me to figure out how to relieve it! In addition, "my headaches" became part of my identity, how I got attention and was forgiven weakness, even as I was miserable with it. Long story short, my relationship with my pain became one of detailed curiosity, patience, "specialness," and resignation as well. I can't expect every (nor any) client to have the same tensegrity model of pain attitudes as I have. I have to listen and interact with what *the client* is reporting, applying my curiosity, patience, and acceptance to his whole system.

While pain legitimately takes up a lot of attention, if a client is encouraged to feel what *else* is present in the body, change can take hold perhaps better or more confidently. I ask questions that leave space for the acknowledgment of the discussion, letting the client fill in the blanks. As I was taught, I use statements of validation to prompt trust and confidence in whatever language or gestures the client uses to explore and describe his experience. I keep my language neutral, free of any of my own associations to pain and to not trigger any associations the client may have. I try to pick up nonverbal cues to the client's acceptance or rejection of my touch or information. Questions that occur to me frequently include:

- Is the client not wanting to pay attention to sensation?
- Is he paying deep attention but not talking about it?
- Is he never taking suggestions of exploring on his own?
- Is he coming in with discoveries despite the presence of persistent pain?

Keeping open to answers to these questions and more are all ways of clueing in to the client's approach and attitudes. And as always, having patience and respect for the wisdom of the client's mind/body models. The truth is that we can't speed up or impose the results we'd rather see, nor can he.

Clouds Move Slowly – A Bear Becomes a Bunny

I had a mechanic in Atlanta who was absolute gold. I could bring my car in and it'd be perfect in a day, never costing more than necessary. But while he could fix the car as soon as he looked at it, he always asked me the questions that led me to detail my experience, which was an indispensable quality when I had a real mystery to solve. "Its brake pedal becomes soft sometimes, and then I smell chemicals and then the brakes give out, but only every six months." It was an improbable problem to have. "When the brakes cool down a while the problem goes away and it's fine." Of course he could take it from there. But he asked me about the smell some more. And what did I mean by soft, and how long did it go soft before the smell came, and the giving up? Did any of these things happen independently of the others? He couldn't find anything mechanically wrong. But he believed me. And when my brakes really fried out in a scary episode, I limped it into Mr. Clarke's and we replaced them. Twice in two years.

His ability to tap into my relationship with my car gave me the trust in him that I needed to eventually get the dangerous problem solved. And even if the brakes weren't to be immediately fixed, I maintained patience and dedication to it because he valued and respected my relationship to my car when other experts did not. Eventually, it was only my close attention to the patterns after the third brake failure that led to a discovery that the pin got stuck open or closed at random times, doing damage that had little regularity. A car is a machine, but there's also the driver's relationship with the car that can save its self-destruction.

Pain as a Trust Process

So far, I've written about the pain of injury, stuckness, and misalignment in gravity. But pain is relevant to the client and Rolfer by way of the pain of healing itself. SI has deserved its historical reputation as a painful process, though it is no longer necessarily so. Still, in any modality, we

can acknowledge the discomfort of a body's healing process, even to speak of a scab over a cut beginning to itch as it knits.

In training at the Rolf Institute®, I learned to ask clients to let me know when the pain they feel under my hand feels like a four out of five or higher, so I could gauge my pressure. After a time, I have retired that practice, because I found that it made more of my clients nervous under my touch. (Maybe putting the question out there touched on my inner fears, but I've noticed positive results in not asking the question this way. *But*, I would like to emphasize that I'm not recommending this to anyone who may find the one-to-five model useful for clients.) My experience is that in asking clients to gauge the working pain:

1. I'm telling them I may go too far, which they will look out for with a preconceived vigilance in the nervous system.
2. I'm telling them that I'm afraid of hurting them, which sets up the idea that I may not be trusted or confident in my approach.
3. I'm suggesting that pain is not acceptable. Some clients are led to pay attention only to volume of pain, not quality of sensation.

In regards to number three, paying attention to sensation is primary in integrative work precisely because integration means we accept a certain amount of all sensations, including pain, and find their appropriate messages. Most clients do not have much ambiguity around pain and do not feel shy about expressing its presence (if nonverbally sometimes), but still I prefer to ask clients to describe any "sensations" as we work together, and to let me know what they need from me as we go along. I find that this encourages them to say, "I need less pressure" or "I need to stop you" if that is the case. When encouraging a client to expand his personal awareness, it is often more successful to trust him to feel more subtlety before he even has the confidence to do so – like asking a leg to bend cleanly when we know it will twist on the way, but we work to make "cleanly" the goal.

Pain is part of life. In another of my favorite movies, *The Princess Bride*, there is a great line: "Life is pain, Highness. Anyone who says differently is selling something." One of the motivations in a long and happy life is to be as healthy as possible, to enjoy pain-free days and nights. Too often, our chief complaints as humans revolve around the aches and discomforts that denote chronic misalignments, and indeed Rolfing SI can take a huge chunk out of the discomfort levels of our clients. At the same time, we also attempt to make sense of things that are not pointed out from the actual pain of the client. It is our job, as agents of integration, to help humans to move from the rejection of pain, and the medical model that pain must be relieved as quickly as possible (and sometimes at great future cost), into a clearer understanding of the part that pain plays in the whole – which of course is a matter of individual meaning: like clouds in the sky, the viewer sees what she sees.

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ON PAIN – TECHNICAL MATTERS

The Rossiter System®:

Extending Ida Rolf's Teachings for Immediate Relief of Structural Pain

By Richard Rossiter, Certified Advanced Rolfer™, Founder of the Rossiter System

The Rossiter System® is a method for targeted relief and prevention of structural pain – i.e., pain created by overuse, injury, trauma, abuse, or stress – in which practitioners coach clients to resolve their own pain by restoring normal joint range of motion in space. The techniques employ the client's weight-assisted, active, vectored stretching of painful tissue, in the context of a pre-stressed whole-body fascial net. Structural pain, which usually resides in the connective-tissue system, often alters that system to the point where simple massages, chiropractic adjustments, and analgesic medications no longer work. At that point, sufferers seek more drastic measures.

Thirty years ago, I was one of them. Refusing to believe it should take months of adjustments or massage to get results, I turned to Rolfing® Structural Integration (SI). Like so many clients, I fell in love with it from the first session. By the third session, I had decided to become a Rolfer. As a new Rolfer in 1983, I landed on a strange planet – Little Rock, Arkansas – where the inhabitants weren't especially interested in becoming more aligned with their gravitational field. What they wanted was pain relief – and they demanded immediate results.

After I'd been in practice about a year, I was fortunate enough to begin to work with a neurosurgeon, Jim J. Moore. He promised me that if I could fix his back, he'd send me his patients. After I fixed his back with old-fashioned Rolfing SI, he sent his "basket cases" to me for the next five years. Dr. Moore was thrilled to have a referral alternative to the chiropractors, physical therapists, osteopaths, and massage therapists: he felt he was finally getting results. Though Dr. Moore seemed satisfied, there came a time when I wasn't. Results to me are about pain resolution, not human evolution. Wanting even better ones, I asked Dr. Moore's permission to expand what I was doing. He agreed to let me try working differently, with parts of the Rolfing series; and from that experiment grew the work I do and train others to do today.

Currently, our sixteen-member faculty has trained 1,525 Rossiter practitioners worldwide. The Rossiter System is taking people out of pain in fourteen countries – from North America, the U.K., and Western Europe to Israel, South Africa, India, Japan, and Guam. Most coaches are in private practice, and many focus on athletes.

How the Rossiter System Was Developed

My time with Dr. Moore gave me the freedom to go into untapped and unknown areas of connective-tissue work. I was looking for better, quicker, and longer-lasting results. I took chances. The first step was deconstructing the Rolfing Ten Series. I wanted to know cause and effect – the exact result of each thing I did; and I created a database to track the outcomes of my techniques. The second step was verifying that 1) without client involvement, nothing happens; and 2) without movement, nothing happens.

The work was challenging for clients; but while some disliked the process at first, they got over it once they felt the results. In fact, many clients wanted to stay ahead of the pain enough to return for preventive care. These were the ones who would have been hard pressed *not* to continue the job or activity that had created the pain, and rather than getting to a point where drastic measures such as surgery or retirement would look like good options, they used Rossiter work for prevention and maintenance. These clients were also the inspiration for what became the industrial and athletic applications of the work.

Eventually, the techniques were organized into tool kits to address specific body areas, such as the elbow, shoulder, knee, or low back. Each tool kit has several techniques, which, if applied in sequence, address most of the pain problems commonly encountered in that body area. The assortment of tools in each kit also provides a range of challenge or difficulty so that the work can be tailored to each client's abilities and tolerance. Today, the tool kits have been converted to iPad and iPhone applications, with an Android application now in development.

Premises Underlying Rossiter Work

The Rossiter System addresses just one thing – pain. Pain is why people show up. In thirty years of practice, never have my clients asked to be realigned with gravity to further their personal evolution. Pain is why we go to doctors, chiropractors, massage therapists, physical therapists, and finally to structural integrators. Because the source of most structural pain is the connective-tissue system and structural integrators have been trained to understand connective tissue more than anyone else, structural integrators readily grasp the logic and methods of the Rossiter System. But – the look and feel of Rossiter work is nothing like that of traditional SI.

A Rossiter practitioner is a *coach* – not a therapist. Rossiter coaches do not cure or rehabilitate anyone. We do not focus on the etiology of the client's pain. Instead, we provide firm guidance to help the client unravel what is almost always a body-wide pattern of disorder. A Rossiter coach does not necessarily understand how the techniques work, but that understanding is largely unnecessary to relieving pain. What is necessary is to get the client to follow instructions. Not every client is willing at first. However, once they've experienced significant pain relief in only a few minutes, they start listening.

The analog to a Rossiter coach is a personal athletic trainer who watches the client perform exercises and knows how a particular exercise or stretch should look when performed correctly. The trainer recognizes when the client is either cheating to make an exercise easier or endangering himself. Part of the job is to perceive when the client should advance to harder exercises and then to push the client to work harder. The coach needs to watch the client's eyes, palpate the quality of the client's movement, and assess the client's degree of participation. The greater the client's awareness, the greater the client's willingness to participate.

The first task of either a personal trainer or a Rossiter coach is restoration of mobility. For the personal trainer, only after mobility is reestablished should strength be addressed because, in the absence of adequate mobility, strength training or even daily activities can injure the client. The Rossiter coach addresses mobility by getting the client to restore space in the body's connective tissues. The client might not understand exactly what is happening, but still feels the result of immediate pain relief. If a technique fails to produce results – i.e., if the pain is still there – the coach knows the work is needed elsewhere and moves on.

The Client – the Smartest Person in the Room

When it comes to the client's body, the smartest person in the room is and will

Figure 1: An example from a typical Rossiter workout. Note the PIC's locking action.

always be the client – or the PIC (Person in Charge), as we say. The PIC's connective tissue has the innate ability to recover from injury and abuse. PICs get results in their connective tissues as a result of their own work. If the coaches were to do the work, the work would stay in the workout room with the coaches. If the PICs do the work, the power of doing it themselves lets the work go with them.

What does the coach do? To help PICs get out of pain, the coach shows them how, gives them the tools, and then gets out of their way. Coaches control the environment, the room, the floor, the field. The coach cannot and does not control the PIC, but should inspire the PICs to work their hardest to get out of pain. Yelling and cheering are tried and true ways to get people beyond their comfort zones to achieve the best results possible. A well-timed shout of encouragement at a difficult moment can make all the difference in a session – or "workout," as we call it.

Execution of a Rossiter Technique

For any Rossiter technique to be effective, the *how* is as important as the *what*. The general sequence is this:

- The PIC is positioned on a mat on the floor.
- The coach steps on the painful body part to transmit weight, through the foot and with precision, into the PIC's connective-tissue system.
- The PIC pre-stresses the connective-tissue system with a full-body stretch we call *locking* (see Figure 1).
- The PIC moves the painful body part, according to directions, against the resistance of the coach's weight.

Performing a technique correctly requires attention to four elements:

- **Time** – urgency, immediacy and pacing.
- **Power** – how much energy is directed to the PIC's connective-tissue system.
- **Dimension** – restoring enough space in the PIC's body.
- **Movement** – having the PIC do the work.

Time

The first element, time, is about condensing the duration of recovery to a minimum. It's about getting results *right now* – in minutes, not months. Recovery from chronic pain doesn't take a long time; it takes the PIC's concentrated effort within a short time. This means never procrastinating. If the PIC takes a shortcut, the coach makes the PIC backtrack *immediately*. If the PIC misses something, the coach makes the PIC go get it *now*.

Time is also about pacing. Because a technique is only as effective as the PIC's level of involvement in the process, its pacing should be slow enough for the PIC to engage fully in a deliberate movement.

Time is *not* about how long the PIC has been in pain: with the PIC's hard work, almost any structural issue can be resolved, no matter how old it is.

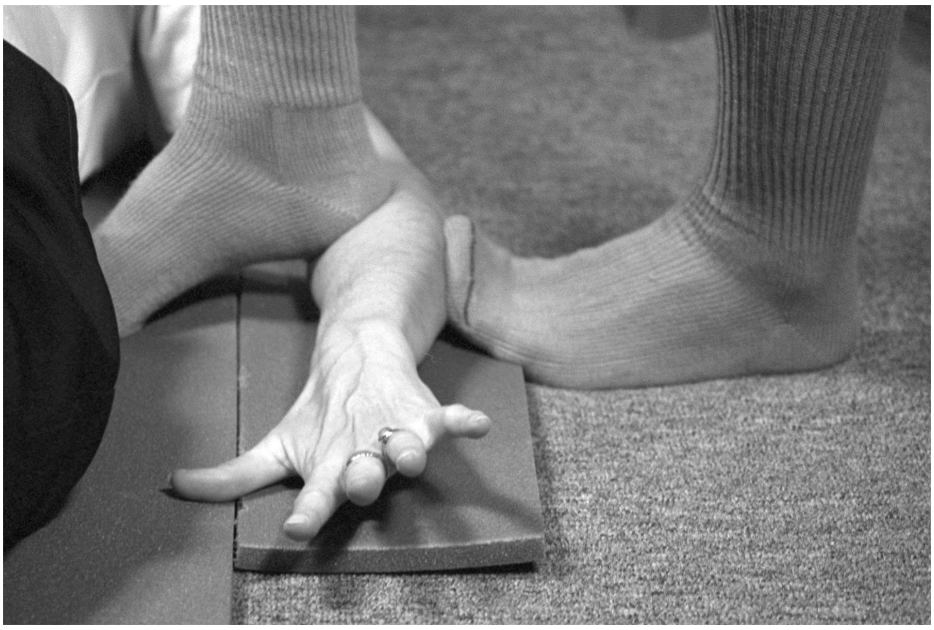

Figure 2: The coach contacts and stabilizes the PIC with his feet.

Power

The amount of power put into the technique determines the speed of recovery. Power comes from the coach's weight, as well as the PIC's efforts. The addition of weight maximizes the impact of the PIC's connective-tissue stretch. Weight delivers pure energy to the PIC's body, and that body knows best what to do with it. How much weight? As much as the PIC can tolerate and still be able to execute the move. For best results, the coach should use body weight only and never *push on* the PIC.

To contact the PIC, the coach uses a foot – not a hand (see Figure 2). That's one reason the work is done on the floor instead of on a table. I started using my feet twenty-four years ago. (How I learned to use my feet was a complete accident.) Now, I teach using my feet only. It's much easier on both the coach and the PIC if the coach transmits weight through a limb designed to bear weight.

Dimension

We live and move in three spatial dimensions. The element of dimension is about reclaiming the space the PIC could occupy before the pain set in. Rossiter work uses a testing system to identify with specificity those spaces that the PIC cannot occupy without pain. Keeping the PIC moving at a slow and deliberate pace, the coach directs the PIC to occupy currently painful spaces in order to reclaim them.

This is where *locking* comes in. Locking is the PIC's active full-body stretch of the connective tissue away from the body area being worked. This makes the rest of the body a fixed point against which the PIC can move. Locking anchors the painful body area from the inside, with every fiber of the being, while the area is being stretched and stabilized from the outside by a combination of the coach's weight and the PIC's movement. The combined actions blow open restricted boundaries and can disrupt aberrant patterns that have been in place for months or even years. It's as if the PIC is ironing from the inside out the wrinkles that living has formed in the connective-tissue system. It reestablishes the PIC's naturally accessible space almost immediately, and the PIC reclaims the full pain-free dimension of movement and being.

By contrast, without locking there is no engagement of the body beyond the painful area being worked. There is no fixed point against which the PIC can work *hard*, no place for the rubber to meet the road. Without locking, the disengaged 95% of the body will quickly re-establish whatever connective-tissue dents and wrinkles the PIC is working locally to remove; and whatever results the PIC achieves will not last long.

Movement

The PIC does the work by stretching to the limit of a reach, assisted by the coach's weight. The vector of the reach is precise and targeted, while the extent and duration of the action are governed by the PIC's immediate limits. As the coach encourages the PIC to challenge each day's and each minute's limit, the PIC regains the connective-tissue length and range of motion required to reclaim dimension. Often, the PIC will need to work with multiple vectors in order to regain normal and natural movement.

If we stretch any connective tissue hard enough or long enough, it will eventually become painful. In Rossiter work, we are looking for that limit. It doesn't take long to see who is serious about getting out of pain: serious PICs test their own limits often.

Applications

The Rossiter System organizes individual techniques into short protocols – workouts of ten to thirty minutes' duration – for PICs who came to be in pain from activities they are not going to stop doing. Some protocols are designed for use in factories and other workplaces, while others are for athletes. However, these same protocols may be used in the traditional clinical practice setting.

Relief and Prevention of Pain from Repetitive Stress in the Workplace[1]

Many workers develop structural problems as a result of the work they do. Occupationally induced carpal tunnel syndrome, shoulder pain, low back pain, and hip pain are endemic in industries such as poultry and meat processing; parts manufacture and assembly; cutting and sewing; data processing; furniture manufacture; and virtually any kind of assembly-line task. Warehouse workers, retail clerks, and others who walk or stand on concrete all day are also vulnerable, particularly to back or hip pain.

Unfortunately, the usual remedies are shots and surgery; and despite the high cost of these treatments, the workers are not pain-free for long and are prescribed increasingly invasive and damaging treatments. In most industrial facilities, this story plays out not with a single worker, but with a substantial percentage of the entire work force. When workers' symptoms recur, absenteeism increases, and productivity declines. Eventually, those workers with the most skill and experience are forced into involuntary early retirement – to the economic detriment of themselves and the employer alike. Of course, the individual workers suffer more than economic harm. They suffer diminished quality of life for years, as they take the pain of their jobs home to their families and out into their leisure and community activities.

What's worse, in the smaller or rural towns where industrial facilities are often located, the usual approach to occupational repetitive stress injury (RSI) has the potential to cripple not only a plant, but a once-thriving community. After fifteen to twenty years' operation, the employer, undoubtedly drawn to the town in the first place partly because of its healthy labor pool, discovers that the local hospital's bottom line is improving at the expense of his own. And, the plant has disabled so many bodies that fresh workers are increasingly hard to come by. Preferring a healthy work force to a thriving hospital, the employer relocates and takes his jobs with him.

The safety officer of one furniture manufacturer felt as if he were accumulating a huge bone pile out back out of folks who could never do their work again. He hated seeing his friends and neighbors drop out of the work force. His company, like employers everywhere, was losing maybe five to ten of what should be workers' most productive years. The problems would start small, as things that should be very easy to recover from; but the "cures" of shots and surgery eventually made them all worse until people too young to retire could no longer handle their jobs.

None of this has to happen – not the human suffering, not the economic losses, not the community degradation – and none of it should happen ever. There is no excuse for it. My twenty-three years' experience in the field indicates that the vast majority of occupationally induced RSI can be relieved and prevented from recurring through techniques that can be executed right at the workplace in only a few minutes per session.

For a sense of the economic benefits the Rossiter System has brought to the work place since 1990, consider the results from one of the world's largest manufacturers of ready-to-assemble furniture, which had experienced major increases in workers' compensation claims despite having instituted positive ergonomic changes. The company instituted an on-site Rossiter System program, and in the program's second year, the company's claim costs were 70% lower than they had been the year prior to the program. This was true even though the company had grown nearly 45% – from about 1,900 employees to nearly 2,700. Lost work days went from 685 to 30 – down 96%. Finally, claim cost per hour worked went from 12 cents to 2 cents.

Relief and Prevention of Pain in Athletes[2]

Once athletes start down the grim path of shots and surgery, they're on borrowed time, risking perhaps years of competitive activity. Because athletes are disciplined and motivated, they should be among the easiest clients for anyone to help recover from injury or overtraining. Unfortunately, however, residual pain often prevents full recovery – either by continually recurring or even by getting worse. On the whole, trainers do not have the proper tools to address the pain and rest does not resolve it. For the professional athlete, this pain signals the end of his career.

This Too Does Not Have to Happen

Tennis enthusiast Cathy Gorbett attributed her 2010 singles and doubles championship in Steamboat Springs, Colorado to Rossiter Coach Ruth Nottage, who fixed Kathy's knee just before the tournament. Ruth reported, "Cathy was blown away by the quick and remarkable results she had." Sometimes it's just that simple – fixing a recent problem the day of the event.

Other times, the Rossiter System is a means for the athlete to regain full mobility following a longstanding problem. In the golf world, distance hitters, called "long drivers," are the heavy lifters. Professional long driver Jeff "Critter" Crittenden, one of golf's best, had not fully recovered full arm rotation following a bicep tendon injury – even after a year of physical therapy. He was unable to use his left arm effectively and was in pain when he got to Rossiter Coach

Chuck Lubeck. Two moves later, out of pain and his arm rotation restored, Critter won the Dixie Classic Long Drive tournament, and he credited the win to Chuck and the Rossiter System:

> I [had] yet to regain full rotation in that arm until I allowed Chuck to introduce me to a Rossiter Workout. He applied weight to my arm and directed me to move it around in specific motions and voilà. I was suddenly able to do what I had not been able to do since before my injury. I was able to fully rotate my arm and went on to win the Dixie Classic Long Drive event that very day. I'm sure Chuck had everything to do with my winning that event and I can't thank him enough.

Rossiter work can be used preventively in athletic training, just as it is in the workplace. As reported in *The Professional Skater* in 2011, maintaining competitive figure skaters' flexibility and mobility is key to injury prevention and better performance, and the Rossiter System has proven itself an invaluable component of off-ice conditioning. Similarly, for two different high school baseball teams, the Rossiter System was used regularly for six consecutive years as a means to prevent injury. In those six years, no pitcher on either team was ever injured. Ask any baseball coach if that's not amazing!

Conclusion

Whether coaching a whole assembly line, a struggling athlete, or an ordinary SI client, the most rewarding moment is seeing the look on the face of a person who gets up and can't believe the pain is gone – that the pain the person expected to have to live with forever and take meds for to boot is actually gone! Someone who'd been forced to give up a job, sport, or hobby gets to go back to it. Relationships that were under stress because a spouse couldn't even bend over, much less help with the chores or participate in travel and play, can recover. People who had stopped being able to make love because of the pain, now can. People who had to stop exercising or even walking can shed the excess weight they gained.

Liberated from the fear of doing things that had caused pain before, folks who had lost interest in life suddenly have the confidence, as well as the ability, to get back to doing things they'd given up on. Why? Because even if the pain returns, they know how to get out of it. The emotional distress of feeling left out of life doesn't rear its ugly head any more.

Though the Rossiter System is *not* Rolfing SI, it is derived from my training and experience as a Rolfer. This body of work enlists the traditional SI premises of 1) working with the whole fascial net; 2) using gravity (i.e., weight and the client's sense of it); and 3) tapping into the client's capacity to self-organize. It also affirms some truths familiar to Ida Rolf's heirs: without movement, not much happens; and without client involvement, not much happens. Though Rolfing SI is not second-paradigm work, its teachings underpin the Rossiter System's powerful second-paradigm pain-relief methods.

Endnotes

1. In the parlance of the Rossiter System, the series of workplace protocols are called Quantum Pain Relief®.

2. In the parlance of the Rossiter System, the series of athlete protocols are called PainSlayer® and the PainSlayer Series.

For general information on the Rossiter System, to find a Rossiter Coach in your area, or to learn about becoming a Rossiter Coach, visit www.therossitersystem.com.

A Rolfer's™ Pelvic/Lumbar Joint Restriction Algorithm

An Interview with John deMahy

By Mollie Day, Certified Rolfer™ and Rolf Movement® practitioner

For ten years prior to training in Rolfing® Structural Integration (SI), Certified Advanced Rolfer John deMahy worked as a nurse in an emergency room (ER) trauma center. This experience gave deMahy an acute understanding of how to create order in the midst of chaos. Later, as he began to study spinal mechanics through Rolfing SI, it was deMahy's ER experiences that led him to develop an algorithm – a chart of ordered tests and procedures based on the body's flow – for the treatment of joint dysfunction in the pelvis and spine.

Mollie Day: Before we discuss the details of your algorithm and its techniques, would you tell me how the method came about? What's the relationship between what happens in the ER and in a Rolfing session?

John deMahy: When someone is rushed into an ER in critical condition, there are a vast amount symptoms and information about the patient that have to be assessed and analyzed before you take action . . . now! In an auto accident you might be dealing with fracture, lacerations, bleeding, head injury, as well as a cardiac emergency. Life and death can depend on how fast assessments are made and treatments delivered. Algorithms, such as the Advance Cardiac Life Support algorithm, bring order into the chaos. These are sets of specific assessments, "yes" and "no" type questions, usually set up in a flow chart, to guide you quickly to the most effective treatment. As we know in Rolfing [SI], there is a hierarchical relationship in the body's structures. If you try to put someone's head on his shoulders without organizing the support in his feet and legs, it's not going to work. In the ER, you treat the wrong thing first and the patient might die. In Rolfing [SI], you treat the wrong thing first and you're not as effective in organizing the structure.

MD: So understanding the ER triage system helped to you to understand a system of order for joints in the pelvis and spine?

JdM: During my advanced training in 1989, Jan Sultan and Michael Salveson introduced me to the world of spinal mechanics – how the joints function. Watching them work, it was easy to see how this was going to radically change my Rolfing [work], which involved strictly fascial work at that time. I became totally engrossed in studying the spine and pelvis. Spinal mechanics can seem very complicated. I found myself spending more time of my session trying to figure out what was going on in my client's spine, than actually working. That was about the time I started remembering my ER experience, thinking that all my patients would have died had I worked this slow.

I realized that I needed an algorithm to navigate the spinal mechanics. I needed a tool to quickly organize specific assessments and treatments so I could get on with the business of structural integration. So I combed the literature for information, broke it down to digestible chunks and applied Rolfing principle to what I found.

MD: Why are the joints so important to the work? Why not just follow the "Recipe"?

JdM: The majority of acute low back pain is cause by or exacerbated by pelvic or lumbar joint movement restrictions. These restrictions are caused by a neuromuscular reflex, which occurs when the joint is pushed beyond its physiologic barrier. You might say the joint locks to keeps it from dislocating, but also from returning to its functional range of motion. These alterations in joint function not only cause pain but also a constellation of compensations, which can greatly alter the structural pattern. So a strategy that first addresses the cause of these compensation makes the goals of the Recipe easier to achieve.

MD: What is the hierarchical order of the algorithm?

JdM: *Foundation precedes mobility and mobility precedes locomotion*. So first we address [issues of] the foundational joints, which are the pubic symphysis and innominate shears. Second, when those joints are functional, we go to joints of mobility: lumbar facets and sacral-iliac joints. Finally, we address locomotion through the innominate rotation in the walking cycle, at the ilio-sacral joint.

MD: Would you give a clinical example of how a Rolfer could manage pelvic joint mechanics in this ordered way?

JdM: Let's use the example of a yogi with habitual low back pain. You discover that her sacrum is torqued and one leg appears shorter that the other. But, no matter how many times you try to balance it through fascia in the legs and pelvis or through sacral manipulation, it's torqued the next time you look. The sacrum appears to be completely unstable. In yoga there are many *asanas* that can put uneven stress on the pubic symphysis. With this setup, when an aggressive stretch pushes the pubic symphysis joint beyond its physiological barrier, the joint locks. So, a poorly trained or over-zealous yogi can easily find herself with a superior or inferior pubic symphysis restriction. In the algorithm-based principles of the body, foundation comes before mobility: The pubic symphysis comes first. But, in this example, the Rolfer [was] trying to solve a problem of mobility without establishing foundation, namely a functional pubic symphysis.

MD: What you're saying is that you can normalize sacral movement – the sacroiliac joint for example – but if the pubic symphysis is out then the sacrum will de-stabilize again?

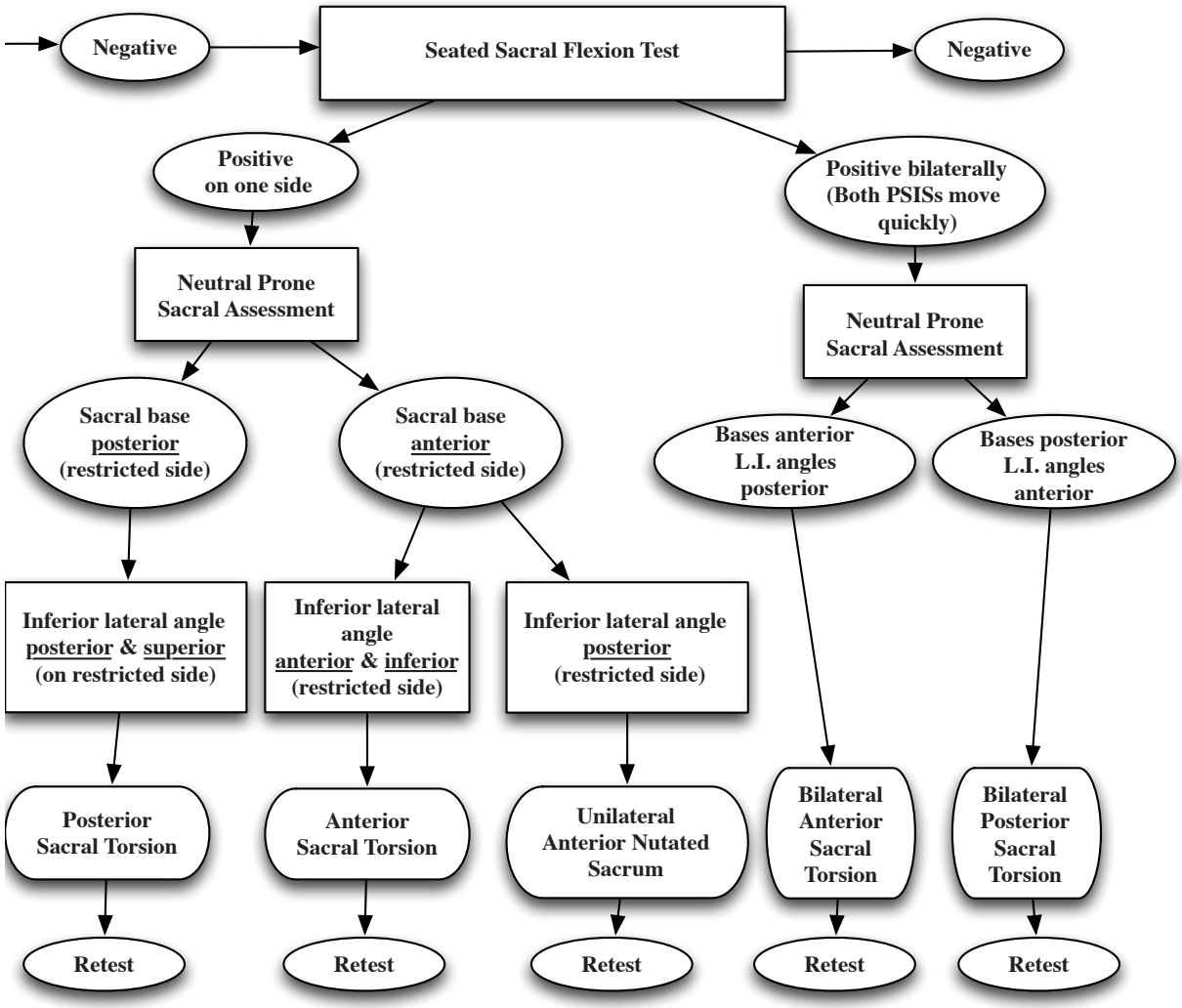

Figure 1: The sacral section of the Pelvic/Lumbar Joint Restriction Algorithm.

JdM: Correct, and sometimes it happens before your client leaves the office. Before the mobility in the sacrum and lumbars can be addressed, the foundation must be stable. The algorithm moves you quickly through assessments and treatments. Then you still have time address the Fourth-Hour line, the abdominals, piriformis, et cetera. Then you would want to do movement education to improve core stability to reinforce the symphysis.

MD: How do you fit the algorithm into a Rolfing session or series?

JdM: If I suspect pelvic or lumbar joint restriction, I will go through the assessments of the algorithm. If there are no joint restrictions, I will know in three minutes, the amount of time it takes to test the joints. If there are restrictions, it will take me fifteen to twenty minutes to bring a client through the whole algorithm. And I still have forty for the rest of the session. And I will get more accomplished in the time remaining: once the joints have returned to their normal movement pattern, the neural reflex is gone; joint inflammation and pain are quickly relieved or greatly reduced.

If someone comes in to your session, no matter what "hour" [of the series], if he is having joint restrictions in the pelvis or spine, what you're seeing is not the primary structural pattern. Compensations stemming from restrictions in the axial skeleton overlay the primary pattern. This could include things like leg-length discrepancies, rotations, and side-bends. If this is the case, and you go into your session without addressing the restriction, then you're wasting time chasing compensations rather than primary pattern.

MD: Would you give an example of how you look at the sacroiliac joint and how you present that in your manual?

JdM: The manual is designed as a resource to use during a session, while you are learning. The algorithm chart (see Figure 1) lies open on your desk, as a road map, guiding you through tests and results. It guides you to the specific restriction and suggested procedure. There is a page number at each step so that if you can't remember how a step is performed you can quickly go to the appropriate page. There you will find an image of the dysfunction, and/or a photograph and detailed description of the diagnosis and treatment.

Sacral-illiac restriction is detected with a seated flexion test. With the client sitting on the bench you place your thumbs bilaterally on the PSIS. Instruct the client to roll forward starting at the head with the pelvis moving last. Remember that the sacrum is part of the spine and should be able to move with the spine before engaging the ilium. So if one PSIS begins a superior movement before the other, the SI [joint] on that side is restricted. Then you would ask the client to lie prone on the table, to palpate the sacrum. Compare the sacral base in relation to anterior and posterior for rotation. Then compare the inferior lateral angles for rotation, then caudal and cephalad for side-bending. With this information in your hands the algorithm points out the name of the specific restriction and an effective procedure.

MD: What is the technique you use to mobilize the joint?

JdM: I use muscle energy techniques first developed by Fred Mitchell Sr. D.O., and I reinforce these techniques with principles of Rolfing [SI]. The technique works by stimulating a different reflex to temporarily override the reflex holding the joint. The client is moved into a position just before the joint restriction is engaged in every plane; flexion or extension, rotation, and side-bending. Then the client is asked to gently pull away from the restriction against an unyielding hold from the practitioner. When the client lets go a post-contraction relaxation reflex is stimulated. At that point there are a few seconds in which you can freely move the joint back into normal range. Once in normal range of motion, pain and inflammation are quickly reduced.

MD: You teach this work, so you obviously believe other Rolfers can benefit from it.

JdM: When you first start studying spinal mechanics, it can be overwhelming. You start looking at the sacrum or spine and think: *there could be anything wrong in there*! But when you learn the architecture of the joint, you see that there are only certain movements available in each joint. And when you study the architecture of the skeleton, you learn that there is a hierarchical order to the way joints function in relation to one another. To learn a strategy for handling that information, I created the algorithm. For me, it is beneficial in that it saves time and prevents confusion. I've tested it myself for eighteen years, and I've taught it to other Rolfers who are also using it effectively. One of the standards of scientific research is: "Can what you've done in your laboratory can be reproduced in another lab?" This is a reproducible strategy.

There is a sense of confidence that develops as you become able to understand and explain why the client was in pain and what you are going to do to get [him] out of pain. I always ask my clients, "You have seen lots of practitioners, has anyone explained to you why you're in pain?" The answer is usually no. So I pull out my models and explain it all. The sense of relief that you see in your clients' eyes, when they finally understand why they've been hurting and how it is going to change, is very rewarding.

MD: You and Jon Martine have taught together. What is the relationship of your algorithm (joint manipulation work) and his neural manipulation work?

JdM: Neural and joint work dovetail together perfectly. This is really seen when there is pain or paresthesia along the lumbar and sciatic dermatomes as in sciatica. After the spine and sacral movement is normalized and the area is fascially decompressed, there is sometimes still pain and paresthesia along the dermatomes. The effect that neural manipulation has on pain, parasthesia, and motor function is simply amazing. And besides, it is really fun teaching with Jon.

John deMahy, R.N., Certified Advanced Rolfer, began his career in emergency and orthopedics nursing. He has had a robust Rolfing practice in New Orleans since 1989. Greatly influenced by the work of Philip Greenman D.O., John is the author of Joint Restrictions in Structural Integration. *This text presents his simple and effective algorithm for the assessment and treatment of joint restrictions in the lumbar spine and pelvis. He is a graduate of the Rolf Institute® (1985) and Louisiana State Nursing School (1978). John taught kinesiology at the University of North Carolina Charlotte. He continues to teach continuing education in manual therapies as well as anatomy and kinesiology at various yoga teacher trainings.*

Mollie Day practices Rolfing SI and Rolf Movement® work in New Orleans. She is also educated in visceral, neural, and joint-manipulation techniques through the Barral Institute and in craniosacral therapy techniques through the Upledger Institute. Mollie's practice stems from her education and experiences in medical anthropology, manual therapy, yoga and qi kong. Alongside the healing arts, Mollie facilitates other transcendental experiences through writing poetry and meditating in wilderness places.

Thawing Frozen Shoulder:

Addressing the Imbalances that Drive the Dysfunction

By Matt Hsu, Certified Rolfer™ and Egoscue® Certified Posture Alignment Specialist

Debbie had originally come to me with some knee and hip problems that she had been experiencing while hiking. Her knee and hips were now feeling fine, she told me, but she had a new problem. A fall off her bicycle resulted in a diagnosis of "shoulder encapsulitis," and now, after six months of rest, massages, and two bouts of month-long physical therapy (PT) regimens, her range of motion (ROM) had improved only slightly. She was frustrated and wondered if there was anything I could do for her. After fifteen minutes, her ROM increased dramatically – she was both shocked and thrilled. Over the next few weeks, she regained the rest of her ROM. What helped her shoulder "thaw" was a perspective on frozen shoulders that I'm going to share here.

It seems that every few months, someone walks into my office with "frozen shoulder." Sometimes it's a self-diagnosed case (i.e., "I can't move my arm past here"), and sometimes it's been diagnosed as "true" encapsulitis by a medical professional. Regardless of whether the client has bothered to get a medical professional to give the shoulder dysfunction a rather grave-sounding name, the two-stage approach I present here has generally proven quite effective for the majority of clients who report having some version of "frozen shoulder."

Stage 1 - Focus on the Symptomatic Site

The first stage involves straightforward manipulation on the areas directly related to the shoulder. The majority of Rolfers are already familiar with this approach, so a quick summary will be presented here (for a more in-depth exploration, Erik Dalton's "Fix Painful Shoulders" blog post[1] is a good start). Depending on the individual's specific ROM limitations, you address the fascia of the relevant musculature. For example, a shoulder with limited internal and external rotation will benefit from work on the rotators. Rotational capacity can be enhanced with assisted movements with targeted work on the antagonists (e.g., gently bringing the shoulder into external rotation and attempting to relax the internal rotators). Frozen shoulder sufferers often have limited ROM in pretty much all planes of motion, so it's common that you'll find that you are working the entire rotator cuff and the other muscles that have not been given the privilege of entry into that much maligned group of four. Work on the pectorals, on the trapezius, along the lateral border of the scapula where the serratus anterior can lock the scapula to the ribs, and into the axillary region can all be useful.

I've found that working around the shoulder in this way can often yield significant ROM improvement (a few clients of mine and others have reported 80% improvement from manipulation alone). However, there appears to be a limit to how much ROM improves at this stage; and there are times when this stage of intervention provides almost no benefit whatsoever. Based on my observation of postings to the Rolf Forum LISTSERV; emails from other Rolfers; and massage, PT, and medical literature, this is a common barrier to success. I have seen many solutions to busting through this limit offered from Rolfers and across various fields. Some are not particularly palatable (unless you consider hanging mercilessly from the affected arm until the soft tissues simply "give in" and allow for better ROM to be an option). Some require a significant investment in technological gizmos that do not approach an efficacy rate that satisfies me. So these are not things I generally do. Since Debbie had already been through PT and had described receiving numerous manipulations all around the shoulder from her physical and massage therapists, I decided that doing more of the same was unlikely to produce any different result.

Stage 2 - Address the Rest

Germane to this stage is the old quote: "Where you think it is – it ain't." Just because a shoulder is frozen does not mean the shoulder is the problem. The name "frozen shoulder" traps us mentally into thinking the problem is the shoulder. The lack of motion there is certainly a quality-of-life problem, but the source of that problem need not be found right where the symptom lies.

At this stage, having already exhausted your manipulation options around the shoulder itself, you must look beyond the shoulder restrictions and assess the rest of the client to tease out the source of the client's issue. Remember, you've already spent time manipulating the fascia and affecting the musculature directly related to the shoulder, so you can basically rule this out as "the cause" of the problem. Almost invariably, I have found that frozen shoulders most improve by paying attention to the rest of the body: specifically, what's happening around the spine (and, by extension, the pelvis).

The following are two quick tests you can perform to begin the investigation process. If these tests are positive, you have a couple intervention options to explore.

Test 1: Static Paraspinal Prominence

Stand behind your client, as she stands however she normally stands. Palpate the paraspinal musculature. It's very likely that you'll find one side of the paraspinals is clearly more prominent. Typically, the paraspinals on the ipsilateral side of the frozen shoulder will be much more prominent in the lumbar and low thoracic spine, though I have seen the prominence make it all the way up to the medial border of the scapula. If you find this clear difference in the stiffness and prominence of the two sides, your interest should now be in the coordination of the kinetic chain as your client abducts at the shoulder.

Test 2: Standing Arm Abduction

Your client can do this with or without a shirt on, but it is helpful to see it without the shirt. Stand behind the client as she stands with feet parallel to each other a fist's width apart. Have her raise her hands and arms out to the side, instructing her to tell you when she feels pain or discomfort in the shoulder. As she raises her arms, pay close attention to the orientation of the rib cage and shoulder girdle and to the prominence of the paraspinal musculature at lumbar and thoracic levels. What you will typically see is that even before the client reaches the painful part of the motion, the paraspinals on the ipsilateral side of the frozen shoulder will be much more prominent, indicating that they are far more active than the muscles on the contralateral side. This activity pulls the rib cage and shoulder girdle into rotation and makes it impossible for the humerus to articulate properly within the glenoid cavity.

You can replicate this experience for yourself by doing the test on your own with a little exaggeration. Follow the same instructions as above and see what your natural range of motion is. Now, drop your arms to your sides and twist your torso 20 degrees to the right so that your sternum is facing a bit off to the side but keep your face and shoulders squared up facing forward. Now abduct at the shoulders again and see what happens to the ROM. Unless you have some very flexible shoulder joints or are a particularly good compensator, you'll find that your right shoulder lost many degrees of motion as a result of that twist. Try turning to the left and repeating the experiment to see what happens.

The importance of what you just learned cannot be overstated. A twist in the torso will affect the function of the shoulder joints.

Once you have confirmed that the paraspinal musculature is functioning asymmetrically, your next step is to find a way to restore symmetrical function that does not compromise the shoulder. This can sometimes be easy, and it can sometimes take a few months. However, for the sake of your client, you want to be able to see if there is a "quick fix" that not only relieves some of the shoulder symptoms but also clearly demonstrates the interrelatedness of the paraspinals and shoulder function.

Debbie's left shoulder was the frozen one. Her torso was visibly rotated. Her whole upper body was twisting to the left (right shoulder and chest more forward than the left). The paraspinal muscles of her mid and lower back on the left side (ipsilateral side to the frozen shoulder) were much more prominent than those on the right, indicating a big, big muscular imbalance.

Intervention

"A-Position" Paraspinal Work

At this stage, putting someone into the "A-position" and performing some asymmetrical work on the paraspinals to encourage a release of the holding pattern will be useful. Position the client in a way that forces the spine to rotate in the direction opposite her usual pattern. If your client has a frozen right shoulder and paraspinals that are tight and prominent on the right side, you would have the client lie down on the left hip with the hip and knee flexed to 90 degrees and the chest and arms down on the table. This puts the spine into left rotation, counter to the usual pattern. (This positioning for a frozen right shoulder with prominent right paraspinals is what is shown in Figure 1.) You now work slowly and methodically on the prominent paraspinals, getting assistance from your client's body position. The twist you have put your client in encourages the stretching and relaxation of the paraspinal muscles you're working on.

After as little as thirty seconds and as long as five minutes, have the client stand up again and reassess ROM in her shoulder. If she notices improvement, you have now made a solid connection in her mind (and yours) that the twisting in the spine is limiting the shoulder. If there is

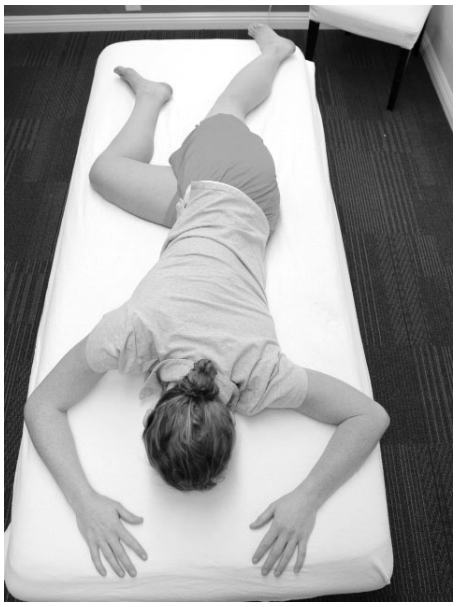

Figure 1: The "A-position" is a modified sidelying position that puts a twist in the spine. It can become uncomfortable in the neck after a few minutes, so it's best not to have a client in this position too long.

no improvement or you reach a plateau of improvement from manipulating the paraspinals in this position and in other positions (as you deem appropriate for your client), then it would be a good idea proceed to a different mode of intervention to see if the paraspinal disparity can be eased with positions/exercises that gently demand symmetry. Below you'll find two that I often use to restore some symmetry.

With Debbie, the A-position manipulation produced an immediate improvement in her shoulder ROM. After another few minutes of prone back work, I had her stand up, and she had still some more improvement, but not a significant amount. Her paraspinals did not feel like they were going to suddenly go back to symmetry, so I proceeded to the exercise phase.

Air-Bench

The "air-bench" is an exercise that athletes from various sports have experienced and many Asian Americans know as a punishment parents hand down for getting a B on a test (not mine, thankfully). It is also known as the "wall sit" or the "phantom chair." It's typically cursed as a horrific killer of the quadriceps group, but for our purposes, it will be a useful way to try to remove the rotational pattern in the spine and restore motion to the shoulder.

Have your client stand with her back against the wall. Have her keep her butt against the wall as she slowly walks her feet away from the wall. She will be sliding down the wall until her hips are bent to about 100 degrees and her knees are bent to about 100 degrees; her knees should be directly over the ankles or a little bit behind them (see Figure 2). Instruct her to keep her lower back pressed into the wall and the majority of her weight on her heels. Have her hold this position for one to two minutes. If that's not possible, go in small increments up to a minute. This position makes it very difficult for the spine to maintain rotations and gives the back and body a quick taste of what it's like not to be rotated (or to at least try not to be rotated).

Once she has completed the allotted time, have her stand straight and then repeat standing arm abduction. Very often, you'll find that she will be able to be abduct higher than before. Should the air-bench fail to provide any noticeable improvement, you can try the next exercise to see if you can get any ROM improvement.

For Debbie, this exercise produced more dramatic results. The shoulder wasn't perfect, but the underlying back issue was clearly being addressed.

Upper Spinal Floor Twist

For the "upper spinal floor twist" (see Figure 3), have your client lie so that the side with the more prominent paraspinal muscles is down on the floor. Have her bend hips and knees to 90 degrees, and position her arms straight out from the chest with palms together; her head can relax on the floor (A in Figure 3). Keeping the knees together, have her bring the top hand up toward the ceiling, then all the way over toward the floor (B in Figure 3). Do not allow the knees to slide apart through the entire ROM. If her knees do slide apart,

Figure 2: The air-bench exercise.

have her reduce how far she's reaching so that the knees can stay together. Instruct your client to breathe into the lower back and into the ribs. The muscles and fascia of the lower back will gradually allow her to rotate fully through this exercise. Have her hold this position for sixty to ninety seconds then switch sides. Once the other side has been done, switch back to the first side and do that one more time. Then have her stand up and repeat the standing abduction test.

If there is still no improvement, there is a host of other exercises and positions to attempt, but presenting them all is beyond the scope of this article and, without further training, is likely beyond the scope of many Rolfers' practices.

Discussion

If there is marked improvement from the paraspinal work you've done in the A-position and/or from either or both of the exercises, you have very strong evidence that more work to restore symmetry of function to the paraspinals will help unlock the shoulder, and that should become your focus. Your efforts can focus on restoring balance to the paraspinals, as well as to the hip stabilizers that may be holding the pelvis in a rotation that forces the paraspinals to begin a counter-rotation. If you find that manipulation over the course of a few sessions does not continue to provide any benefit, referring the client to someone with expertise in restoring muscle balance with proper, targeted exercise is advisable.

For Debbie, addressing the paraspinal asymmetry helped unfreeze her shoulder noticeably. She was able to move her shoulder much better, and careful progression into exercises that challenged her shoulder mobility (without allowing for paraspinal compensation) over the next few weeks got her to the point where she could do the yogic "reverse namaste" position without discomfort again.

A Final Story

When Lorna walked in, she was unable to lift her left arm out to the side beyond about 30 to 35 degrees from her body. She physically couldn't do it because of the pain. She also couldn't lift her arm out in front of her beyond about 40-50 degrees without more pain in the shoulder joint. An MRI by a doctor showed an old rotator cuff injury – which he deemed too old to repair – as well as signs of bone spurs within the shoulder joint. The doctor told her that if physical therapy didn't help, she should consider surgery to clear out the bone spurs. After four weeks of rotator cuff strengthening exercises and some painful attempts to restore ROM, she was no better off than when she had started. The surgeon's blade drew ever nearer. In her fifties and still wanting to be able to work on upholstery projects and do volunteer work with horses, she did not consider this great news.

She came to see me on the recommendation of a friend of hers who had finally gotten relief from her back and leg pain after enduring two failed surgical attempts. Lorna was skeptical that anything could be done given the medical diagnosis, but was willing to see if something could help.

By addressing the paraspinal asymmetries and retraining her body to coordinate different regions, it took about forty-five minutes for her to be able to move her arm through almost the full ROM. It took another month for her to fully regain motion and control.

Remember: "Where you think it is – it ain't."

Endnotes

1. Available at http://erikdalton.com/fix-painful-shoulders.

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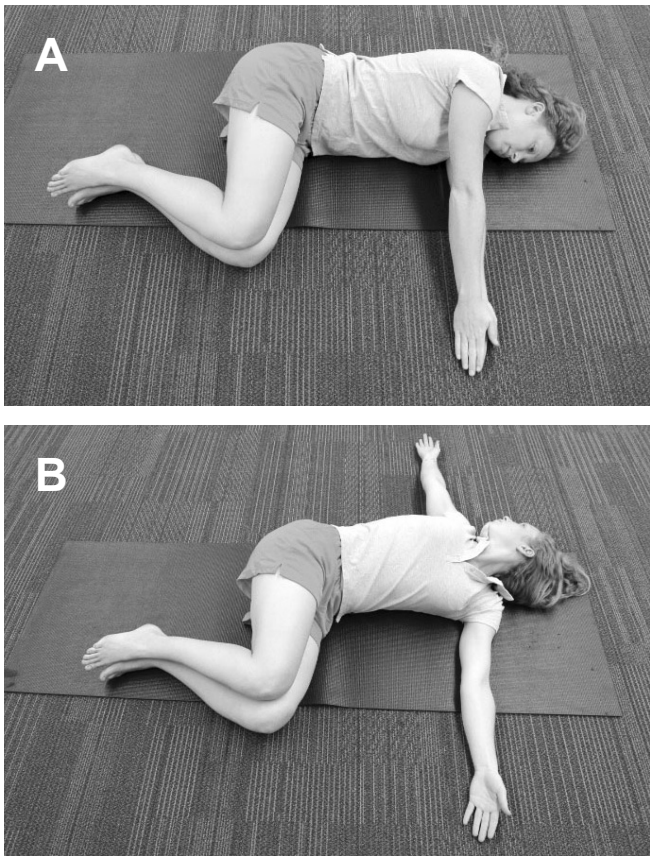

Figure 3: The upper spinal floor twist, with A showing the starting position and B the ending position.

Third-Party Payments

By Clay Cox, Certified Advanced Rolfer™

You can't always get what you want.

The Rolling Stones

Overview

A "third-party payment" (TPP) is where someone/some entity, other than the client, pays for the client's treatment. More often than not, it will be a workers' compensation fund, the defendant's attorney in a motor vehicle incident, or an insurance company in a personal injury case.

Workers' Compensation

We will look first at workers' compensation, or the TPP systems that handle treatment for injuries that occur on the job. These include state systems (for subscribing employers and state employees), county systems, and federal systems, as well as private corporate systems. In most cases necessitating treatment, it is held as common wisdom to allow the injured person to choose his own practitioner. The thinking behind this is that there will be a quicker response to treatment.

Laws and procedures will vary state by state, and differ again for federal cases. Providers must generally apply to the system and have an assigned provider number before beginning TPP work in these systems. Further, pre-approval to treat may be required, and payment will usually be determined by a fee schedule of allowable amounts, covering sessions of no more than sixty minutes. The information you need to start with should be readily available at the relevant Department of Labor website. This author has been paid for services by workers' compensation systems in Pennsylvania, New York, and California, as well as Arizona.

In Arizona, the state where I work, the first person to treat the client, after the emergency room physicians or the first responders, is designated the treating physician/practitioner. If a client comes to you who is already seeing a physician, you will have to get that provider's permission and referral as well as that of the workers' compensation agency that you will be dealing with for payment. Cumbersome, but doable. Because of the state's large population of Native Americans and their reluctance to get treatment from traditional allopathic physicians, nontraditional practitioners are often chosen. As a result, more alternative and complementary practitioners are given provider numbers with little bureaucratic complications. Workshops are given to all interested parties to bring them up to speed regarding compliance with forms and language particulars. Most of these practical aspects apply to most other states systems as well.

In dealing with the federal workers' compensation system (administered by the Department of Labor and mostly concerning benefits for federal employees), the administrative caseworker nurse will refer the client to you at the client's request. After becoming an approved provider, the process is pretty similar to most TPP processes: submit appropriate billing and treatment notes. With the Feds, payment will be rendered through direct deposits into your bank account, and will again be determined by a fee schedule.

There is a special category of workers' compensation cases called "long-term care awards" or "lifetime care awards." These cases come about when a workers' compensation hearing officer determines after the client's attorney has presented the case that the specific practitioner should be awarded special consideration in this case to treat the client on a long-term or permanent basis for a given frequency. These cases have been in the system for a significant amount of time, usually years, and the record shows that the practitioner's work is the most efficacious treatment available for the client's long-term condition. This decision is usually based on several factors – primarily long-term intractable pain, historical levels of pain medications contraindicated for long-term use due to organ stress/risk for failure, or the practitioner's work being the most cost-effective long-term care for the patient given the circumstances of the case.

Personal Injury

Personal injury (PI) cases are another form of TPP. These are cases where someone has suffered an injury that was not work related. Most common are "slip-and-fall" and motor-vehicle-related injuries.

Slip-and-fall type injury usually involves a private party being injured, somehow, through no fault of his/her own in/at a business setting. The company's liability insurance company usually pays the case pretty quickly unless some sort of fraud is suspected. A simple receipt will usually suffice for you to be paid.

Motor vehicle accidents (MVAs) are the bulk of PI cases. It is important to investigate the particulars of these cases carefully. *Whiplash Injuries* (Forman and Croft, 1988) and *Motor Vehicle Collision Injuries* (Nordhoff, 1996) as well as others will be very helpful references.

It is very important to evaluate all PI/MVA cases for any evidence of misrepresentation of the facts of the incident and/or the extent and type of the injuries claimed to be sustained. Medical reports, tests and imaging reports, as well as police accident reports all provide information that will help you through this maze. In most cases where fraud is suspected, attorneys will be involved, and if you are to be compensated it will often take a year or two for these cases to be settled. (It is very rare for workers' compensation cases to involve fraud as they are usually well-investigated by agents of the company involved.) Attorneys are not usually involved in TPP cases unless the bills are not getting paid by the insurance company. If you are getting paid and the client retains an attorney, the bills stop being paid until the case is settled. Most insurance is for the state's required minimum. If you have exhausted these funds, more often than not, there were broken bones or blood loss involved in the case. Often, "pain and suffering" will become an issue in settling the case. Most of the time these considerations are evident at the onset of the case and its evaluation. These cases will more often than not involve attorneys, but this is not the bulk of our cases.

What Care Does TPP Cover?

TPP is very rarely made for palliative care. These entities pay for actual, measurable, positive change such as improvement in the client's ability to perform activities of daily living, increased range of motion, functional restoration, reduced need for prescription medication, and reduced need for allopathic medical intervention. These changes must be documented throughout the treatment duration. Documentation starts with the

client completing a case history form from your office. After reviewing this form with the client at his/her initial office visit, a relevant physical examination is performed and the results recorded.

Compensation is paid, as a matter of course in Arizona, for brief reexaminations to note and measure changes made as a result of treatment. This is the only objective tool to determine if your case plan is appropriate or if the plan needs to be modified. When there is a lack of expected progress made with a given treatment plan, a modified treatment course is then detailed. SOAP notes are written on each treatment appointment and a reexamination is performed at the end of the course of treatment relevant to the case.

Billing

When billing for TTP cases, treatment notes will generally be requested (you will need your client's signed authorization to release the notes). The SOAP format is standard. (A web search can quickly bring the reader up to speed.) A variation in this format is where a "Treatment" section is added. This is especially valuable for complementary and alternative practices whose modalities may not be as well known in the industry as traditional treatments.

In billing, the standard is the Health Insurance Claim Form or HCFA-1500 format used currently. (This form and instructions are also available on the internet or from office supply stores.) To use this form, the reader will need to familiarize him/herself with the Current Procedural Terminology or CPT codes as well as the International Statistical Classification of Diseases and Related Health Problems or ICD-9 codes. (Both of these code books come with instructions and are available for free on the web.) The CPT code helps describe what you are doing to help the client. The ICD-9 helps describe why you are doing what you are doing.

Only physicians may diagnose. The emergency room or previous physicians will have rendered one or more diagnoses that practitioners can work with. In many cases, practitioners can simply record the client's complaint and give the ICD-9 code that best describes it; for example, neck pain (cervicalgia) 723.1 or low back pain (lumbago) 724.2. (Commonly accepted lay terms are not seen as clinically derived diagnoses and have always been accepted in my filings. For example, my coding would read: 723.1 Neck Pain or 724.2 Low Back Pain as described by the client.)

You will do an initial examination, usually moderate in duration, billing under CPT code 97001 or 97002 for follow-up examinations. Structural integration is best described as Manual Therapy (CPT code is 97140) and is measured in fifteen-minute increments for a maximum of four units (one hour). The fees for these services are based on what is usual, customary, and reasonable for your individual locale. (Some third parties or states may not accept a Rolfer using some or all of these codes. In some cases, Rolfers may only bill under 97124, the CPT code for massage therapy. Again, consult with the third party or with an experienced practitioner in your area if you are new to TTP.)

Finances

Workers' compensation cases and cases where the "Med Pay" component of the client's automobile insurance policy is in effect are paid upon presentation of appropriate billing forms and treatment notes in the traditional SOAP format. It is common to include a "Treatment" section in the daily notes delineating just what treatment was rendered.

If the client did not have Med Pay, then the other party's insurance company will receive the billing and the treatment notes. In this case, payment is rendered after all treatment has been completed by all practitioners and physicians and the client is released from further care.

If there are contested issues in the case, then the client, his/her attorney, and the defendant's attorney receive the billing and notes. Payment is rendered after the case is settled. Frequently cases are settled without the added expense of a court hearing.

Fees for Service

If your client has chosen the "Med Pay" option on his/her auto insurance policy, you can be paid as you bill. When the incident is serious but there are "no broken bones and no blood," usually the case is settled for the limits of the defendant's policy, which is usually the minimum required by state law.

You will also need to stay on top of the amount of money paid out on the case. The client can usually keep you in the loop as to how many and what type of practitioner is involved in the case. If you are the sole practitioner, there will be little to be concerned about policy limits. There is little chance that you will run up $15,000 of treatments for a "no blood/no broken bones" case even with multiple clients in the same vehicle.

If the client has a number of practitioners involved in the case, be in good conversation with your client and approximate moneys spent on the case to be safe that the policy limits have not been exceeded. (The insurance company will not give this information to you, only to the client.) One way to attempt to avoid these situations is to ask the client to make partial payments on each visit. There are many benefits to this practice in all PI cases. The remaining balance for the treatment visits will be billed to the insurance company.

There are other ways, as well, to handle payment for services with PI cases. A medical lien or letter of protection can be drawn up by commercial entities for a nominal fee and filed with the county recorder's office. This process does not guarantee payment in a contested case. If your client loses the case, there is no money for anyone on your side: client, attorney, or practitioners. It does, however protect you from the hassles that are inevitable when dealing with attorneys who may ask you to reduce the amount you are owed for a variety of reasons.

When a PI case goes into litigation, the time between treatment and funding often increases to two to three years. In litigated cases, the client's attorney generally asks for an amount calculated as three times the loss (i.e., the cost of treatment, physical losses, and time off work). In settlement, one third goes to the client, one third to the practitioners, and the remaining third to the attorney. In working the case to get more money for the "pain and suffering" of the client, attorneys are willing to cut their share by a percentage and often ask that the practitioners do the same. The problem is that what the attorney is cutting is often bloated billable hours, while practitioners are asked to reduce their fees earned for direct services to the patient (i.e., time spent bent over the treatment table).

Also note that both attorney teams as well as the defendant's insurance company have a right to access all of your treatment and billing records. All of these records must be identical. All parties get identical copies of the same information. (When records are requested, you can charge for the cost of copying and mailing them.)

You do not have to agree to an attorney's request that you reduce your share, but, you do need to establish a working relationship with all parties involved in the case for a more satisfactory outcome for all involved. You do not know when you will be working with this attorney again on another case. You want to make it as possible as realistic for the client to come back to you for more treatment after the legal case has been resolved. One way around this other than flat denial – I never flatly deny working with other team members: not professional ethics in my opinion – and to also be compensated for having to wait to be paid for your services is to require clients in PI cases to sign an "account service fee agreement" where they agree to pay out of the settlement a 1½% monthly fee on monies due, compounded monthly until the case is settled. This fee is compensation for the extra paper work, phone calls, and accounting necessary in these cases. In a year this fee will add up to 18%. With this money you have some room to negotiate with the attorney. It is strongly suggested that you do not negotiate with your fees for direct client services. Remember that only banks and lending agencies can charge interest. The account service fee is the amount of money needed for the treating office to keep the case open by office staff, compile notes, coordinate treatment with other practitioners, handle attorney phone/correspondence time, and manage accounting for the case.

Treatment Overview

It is beyond the scope of this paper to address how to manage the client's more complete recovery through the blending of formal structural integration work and direct and specific pain-management efforts. That being said, some overview of the matter is offered.

A functional understanding of the client's overall need is paramount throughout the duration of the case. You have been invited into the case because of the client's pain and suffering, but at some point in the course of treatment overall progress will be limited by the lack of order in the client's structure. It will become necessary to begin a reciprocating strategy where you begin to integrate establishing order in the client's structure with corrective and restorative pain-management efforts. Your efforts should not be palliative nor aesthetically oriented.

It is important to remember what you are being paid for in TPP cases: issues that were the direct result of the original insulting incident. It will always be a judgment call as to where to draw a finite line in this vein of thought, but remember that the further you move into formal structural integration, the further away you move from direct pain management. This will increase the probability that you will unnecessarily complicate the case with your philosophy, and this will reduce the chances of a more favorable judgment.

Pitfalls

There is one major pitfall in a managing TPP cases: malingering. Sometimes, the client can get very comfortable being paid to stay home from work and/or receive treatment without having to pay for it. This may mean that the client was not injured to the extent that he/she initially reported. It could be that the client has recovered faster than anticipated. It also could be that the case as presented was fraudulent from early on – though your case history taking and initial physical examination will usually ferret out cases of malingering.

This situation provides a conundrum: in order to have much success at all in treating clients in these types of cases, you must first believe in what they say. The pain is genuine. The stated losses are real. The amount of suffering experienced is the difficult parameter to deal with in these cases. Once you start doubting your client's word, you have started losing the safe vessel for treatment. How to avoid this pitfall? Training, treatment, and documentation is the answer. Learning how to test for the presence of pain generators, treat them efficaciously, and test for the progress in treatment, and documentation make the difference in understanding your case. They can also make the difference between getting paid and not.

MVAs that have the fewest complications are "rear-end motor vehicle accidents" (REMVAs), where the potential client ("target" in the MVA) is a licensed and insured driver who was legally stopped and wearing a seat/lap belt at the time of impact, and where the "bullet" vehicle driver was also insured at the time of the incident. It also helps the case if the other driver was cited as responsible for the incident. If these cases are selected carefully and properly secured, treatment fee recovery should run near 100%.

Another pitfall when the client is not paying for treatment is that it may be hard for him/her to see the true benefit of the treatments. To help the client understand progress, I take measurements during the initial examination and during re-exams, and share this with the client. The felt sense of the client's stated progress will be solicited and reported as well. We are monitoring progress in subjective reporting as well as objective findings.

Summary

Why get involved in TPP work at all? There are many reasons. First of all, you will be offering your unique services to a group of people who might not be able to afford them. (Most of our clients pay for our services with discretionary moneys. It is a select group who has that money available.) Second, it will expose you and your practice to another level of professionalism. Often, you will be coordinating treatments with other professionals and providers in the community. You will be dealing with companies and agencies regarding care and compensation. You will become more educated as to the workings of the healthcare world of which you are already a member. Through this, you will be educating a large group of professionals about your life's work. You will be creating a professional network for increased referrals and providing a matchless set of services sorely needed in the healthcare field. Finally, you will be providing a component of help and healing to people in need.

Clay Cox received his basic and advanced Rolfing training from Jan Sultan, Peter Melchior, and Emmett Hutchins. He has been practicing Rolfing SI since 1979. He subsequently trained with Mary Burmeister, John Upledger, and Jean-Pierre Barral.

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Who Moves?

By Jeffrey Maitland, Ph.D., Advanced Rolfing® Instructor

I would believe only in a God who knows how to dance

Nietzsche

Abstract

This paper is a phenomenological investigation into how we, as self-movers, experience ourselves moving our bodies. Through an examination of walking meditation, its purpose is to understand how an activity as mundane as walking can provoke an experience of human freedom. Describing how we move our bodies is surprisingly more difficult than one might imagine. When we look at the commonly accepted way to describe our moment-to-moment movement, we find confused descriptions that are too narrowly conceived to capture our experience of movement. To make matters worse, closer inspection of our experience also reveals that we cannot even locate the mover of our body. Many of these confusions can be cleared up by employing a distinction from phenomenology between reflective and pre-reflective consciousness. As a result of clarifying these issues, new insights and more illuminating descriptions of how we move become possible. These gains in clarity, in turn, provide us with a way to understand how walking can be a portal to experiencing the depths of human freedom.

The Enigma of Self-Moving

Of all the things that inhabit this vast universe, nothing is more enigmatic than what is closest to us – our own nature. We know ourselves to be conscious beings, capable of both abstract thought and complicated emotions. But as soon as we try to say what consciousness is or how it exists, we quickly find ourselves embroiled in a morass of philosophical confusion. Things are not much different in our attempts to understand our emotions. But perhaps the most surprising capability that slips through our fingers when we try to grasp it is our ability to move. Everything moves. But we are self-movers who have no idea how it is that we move.

For the most part, we move through space, appropriating gravity, each movement flowing freely into the next, without ever giving it a thought. Generally we do not have to think about how we move, we just move when and where we want to. But have you ever wondered how you move your body, how you actually experience moving your body? To answer this question you must contemplate how you experience your movement as you live, breathe, and accomplish it. The question is asking for your point of view as the one who is moving, not for the point of view of an observer who is watching you move. Hence, for example, a neurological explanation of how you move is not an answer to the question.

This question is surprisingly difficult to answer. When we make the attempt, we discover that not only do we have difficulty describing how we move our bodies; we are also at a complete loss as to where to find the mover. We say with great confidence, "I move my body." What could be more self-evident than the knowledge that you are the mover of your body? But where is this mover? Can you locate the self that moves your body? If you cannot locate the mover, is it even possible to describe how you move your body?

Upon first hearing these questions, we are frustrated and have little idea how to answer. But if you stay with your initial puzzlement, drop your thinking mind, and open yourself to really experiencing who moves and how you move, you could experience something truly remarkable. Like similar numinous questions, their answers have to do with realizing our freedom – not through words, but in direct experience. There are many ways to experience true freedom. But, as we are about to see, one of the more surprising ways is found in the Buddhist practice of walking meditation.

Since Zen Buddhism is not a form of faith-based monotheism, strictly speaking it is not a religion. It can better be understood as a practice or discipline designed to awaken us to the true nature of what is. The fact that Buddhism is a practice and not a religion means that it tends not to be subject to religiosity, filled with unverifiable claims, or steeped in dogma. As a result, an examination of the Buddhist practice of walking meditation (in Japanese Zen, *kinhin*) is especially well-suited for understanding how freedom can arise during the simple act of walking. If we want to catch a glimpse of the extraordinary in the ordinary, we need only recognize what is always and already so: right here, right now, as we are moving through our world, in the always ongoing free flow of one movement into the next, the simple act of walking can become a portal through which we come to realize our freedom and place in all of this.

How to Run Down a Mountain

In order to catch our first glimpse how liberation can arise from the simple moment-to-moment free flow of everyday movement, let's look at a familiar experience. The following description of running down a mountain comes from a person who was just beginning to explore Zen. The simplicity of his experience reminds us of other similar kinds of experiences. The universality of these experiences also suggests that we are closer to realizing our freedom than we might have suspected. This description of running also provides us with just a hint of what is possible when we are able to transcend the confines of our limited human self.

> *The first time I saw the Colorado Rockies, I was an out-of-shape graduate student. A friend took me on a hike into the mountains. When we finally reached the top, my legs ached and my throat was on fire with my breath. After a short rest, we started down. To my surprise, my friend began running down the mountain. Being so uncertain on my feet and unsteady on the sliding gravel, I cautiously, and with what I thought was great care, placed one foot in front of the other, simultaneously probing each rock and pebble to make certain it would not slide. As a result, I repeatedly fell down. Finally, I gave up all caution and decided to follow my friend's example. With complete abandon and at the same time perfect precision, I ran down the mountain. When a rock slipped under my foot, I was able to leap in precisely the right direction so as to never fall or break my stride. Without there being time for calculation, my body knew exactly, with unerring awareness, what to do. When I reached the foothills, my legs no longer ached and my throat and lungs were no longer on fire. I was exhilarated. A few years later, when I began jogging, I was able to find again*

this joyful freedom that resulted from abandoning myself to movement.

Although this example is a somewhat shallow experience of how freedom can arise in the mundane activity of running, it does give us a tantalizing taste of what is possible. Notice, the more the student thought about how to move, the more he fell. His thinking-self was too present. Finally when he let go of all caution, he simultaneously let go of the confines of his self. He stopped thinking, and just ran. He was suddenly free of self. He was no longer running – he was being run.

Looking more closely at the description, we also discover two ways of moving: one that is bound up with thinking too much and another that is free of the self and its fixations. The transformation from thinking too much to dropping the self is the transformation of the one who moves, or, what is the same thing, the realization of freedom. What is the difference between these two ways of running? Who moves?

Unfortunately, the most common understanding of how we move our bodies does little more than confuse an already confusing topic. It turns out to be much too narrowly conceived to grasp how liberation can arise from the simple moment-to-moment free flow of everyday movement. Since the most common answer is the most confused, we need to see through how it informs our thinking before we try to understand walking meditation.

I Will It to Move and It Moves

When asked, most people say that moving is simply a matter of willing yourself to move and then moving. This answer amounts to saying that all movement occurs in two phases: first, willing our body to move and then moving it. For the purposes of our discussion, we can call this answer the *I-will-it-to-move* theory.

To see why this description does not apply to all movement and why it cannot grasp the appearance of freedom in walking meditation, let's look at a simple example. Imagine we are eating a meal together. With your first bite you notice that your food is in need of salt. You have the idea, or perhaps just feel the urge, for more salt. You ask me to pass the salt. My decision to pass the salt and the act of passing it occur simultaneously as one and the same movement. Without thinking about what I am doing, my eyes find the salt and my hand follows. Without giving it any thought whatsoever, without first willing my arm to move, my whole body participates in a fusion of flesh and intention as I simply move my arm to pass the salt. Without first willing your arm to move or thinking about it, saturated with the intention to receive the salt, your whole body participates in the movement of your arm. Your intention to receive the salt and the act of receiving it occur at the same time in the same movement.

As our example clearly demonstrates, our typical everyday way of moving does not take place in two phases. At the moment of receiving the salt, your reaching for it and your intention to receive it are one and the same action. In actuality, intention, flesh, and movement are not separate. Rather, they are fused together in one unified action involving the entire body in our attempt to achieve a certain result. The decision to act and the resulting action occur at the same time in the same movement. In our everyday way of moving, the two phases of the I-will-it-to-move theory are collapsed into one unified activity in which the will to move and the act of moving occur at the same time as the same action.

As a way of adding authority to their view, some are tempted to dress up their account with a little neuroscience and claim, "First, I desire to move my arm. Then the brain and nervous system take over and move my body." But no matter how much detail you fill in about how the brain and nervous system take over, you cannot escape the fact that this answer is just a slightly more complicated variation of the I-will-it-to-move theory we just looked at. Throwing a little science into the mix adds nothing to its explanatory power, because the theory is based on the very same one-sided description.

Not convinced by the I-will-it-to-move answer but unable to say why, many people defiantly throw their hands up and declare, "I just move!" While such a response is not really an answer, it often expresses the suspicion that there is more to moving than is stated by the I-will-it-to-move description and the frustration that comes from trying to describe a whole-body orientation and movement in which intention and flesh are somehow fused into an inseparable unity.

The I-will-it-to-move view probably seems suspicious to many because it also suffers from the unspoken assumptions of metaphysical dualism: mind and body are two separate and distinct entities and that moving our body can be understood on the model of moving an object. Nothing could be further from the truth. For example, picking up our arm is nothing like picking up a shovel. When we move an arm, we do not experience it as picking up and moving a separate isolated object. Rather, our entire body participates in the movement and we experience the arm's moving as both the fulfillment and manifestation of our intention. Our arm moves in such a way that it orients our whole body unified in an action saturated with the intention to accomplish something. We clearly do not experience our arm as an isolated mere thing that we mysteriously sling into moving by means of our will. Movement, flesh, and intention occur simultaneously as one unified action involving the entire body as it orients toward accomplishing something. Movement is the visible activity of mind.

But when all is said and done, the most telling argument against the I-will-it-to-move description comes from the simple recognition that it ignores our typical experience. Our experience shows us, again and again, that the way we typically move minute-to-minute is not a matter of first willing our body or some part of our body to move and then moving it. We simply do not always find two distinct phases: an act of will and then an action that follows. Just think how peculiar we would look if our walking were dominated by having to first will each step and then moving. We would look like some sort of herky-jerky marionette. Or perhaps an even better example is Jacques Tati's lovable character, Mr. Hulot, whose stop-and-go, haltingly indecisive walking seems to go in multiple directions at once, as if he were being driven by seemingly contradictory intentions.

Thinking about Moving

Normally, our minute-to-minute ways of moving are performed as a seamless fusion of intention and flesh where the desire to move and the resulting act is one and the same movement, and where each movement flows freely into the next. This way of moving only happens when we are not attending to it or not trying to make ourselves move in new ways. The exquisite free flow of movement disappears the minute you think about it. Furthermore, attending to our movement while moving is usually an indication that something is wrong or that a movement is new to us. Consider how much we have to think about what we are going to do before we

do it when we are recovering from injury or learning a new dance step.

Thus, the kind of movements partially captured by the I-will-it-to-move theory are, for the most part, performance difficulties that require our thought before movement. What the I-will-it-to-move description also brings to light is that movements that involve performance difficulties have two phases. The first phase is about the intention to move in a new way, and it usually involves planning and thinking about how we are going to move. Although there is a tendency to construe the first phase as the cause of movement, a moment's reflection reveals that it is actually the reason for it. The second phase is practicing and trying to move in the new way.

Oddly, even though the moment-to-moment, free flow of one movement into another is our most common experience of movement and the one closest to us, it is also the movement we have the most trouble recognizing and describing. Part of the reason we have trouble getting a handle on it is because it is the kind of movement that only appears when we are not attending to it. You cannot think about this kind of movement and do it. You can only live it. The moment we attend to it, it disappears and becomes an object of scrutiny for reflective thought, and the more we think about it, the less free our movement becomes. Unlike performance difficulties (such as learning how to dance or walk after an injury) that require thinking about how we are going to move, the ubiquitous free flow of movement that fills our days requires just the opposite – that we do not think about it. For the most part, however, we are only vaguely aware of the unified free flow of the whole body in movement. As a result, we tend to miss just how exquisite our moment-to-moment flow of movement can be and how much of our days are alive with it.

It's Not Unconscious Either

Interestingly, our rather circuitous investigation into the experience of self-movement has revealed two ways of moving. One way requires thinking about how we are going to move before we actually move, and the other more ubiquitous way of moving occurs in the absence of reflective thought. The observation that our free minute-to-minute movement does not involve thinking suggests to some that it is unconscious. But as it turns out, the reflective/pre-reflective distinction from the discipline of phenomenology is much more suited to the job of understanding these two forms of movement.

Consider some examples. Suppose you are completely engrossed in a game of basketball, or in the midst of giving an inspired performance of a piece of music, or lost in the beauty of a flower, or frightened by a loud noise. In each of these experiences you are orienting pre-reflectively. You are not thinking about what you are doing, yet you are not unconscious. You are conscious and aware and can easily recall your experience. Even though you are not thinking, you are consciously participating with what is unfolding.

Later, in reflection, when you separate from lived-experience, your self appears and you think about what happened. Your descriptions usually take place in the past tense and the words "I" or "me" typically show up in your descriptions. Reflecting on your experience, you might say, "That was the best performance I have ever given. Did you hear the quality of tone I was able to achieve?" About appreciating the beauty of the flower, you might comment on its color or fragrance. You might describe in some detail the most exciting moments in the basketball game. When you think about or reflect on pre-reflective experience, you step out of the flow of lived experience and objectify it.

The word "object" means "that which is thrown before" and the word "subject" means "that which is thrown under." In reflection we become a subject contemplating an object. We find ourselves no longer participating with what is unfolding, but rather separate from and thinking about our experience. We find ourselves "thrown under" the dominion of an object that is "thrown before" us. Pre-reflective experience, therefore, is both pre-subjective and pre-objective. In reflection as we separate ourselves from lived-experience, the participatory understanding of pre-reflection falls apart into the subjective and the objective.

The pre-reflective/reflective distinction is a philosophical distinction. It is not, therefore, the same as the psychological distinction between the unconscious and conscious. The pre-reflective is not the unconscious mind and the reflective is not the conscious mind. The psychological distinction is more narrowly conceived than the philosophical. The unconscious is that aspect of our pre-reflective experience that we, either through self-deception or lack of interpretive skill, misinterpret to ourselves and others in reflection. Self-deception is a willful reflective misinterpretation of pre-reflective experience that we convince ourselves to be true over time.

The pre-reflective/reflective distinction does not just apply to what we call mind. Properly considered, it applies to the orientation of our whole being, body and all. We can reflectively think and act on our experience. We can also pre-reflectively assess our present situation and move toward or away from whatever is coming our way, and never give it even one thought – except later when we reflect on what happened.

At this point in our discussion, it is probably already clear how the pre-reflective/reflective distinction applies to our two forms of movement. Our ubiquitous experience of the free flow of moment-to-moment movement is properly understood as a pre-reflective experience. The two-phased movement that we uncovered through investigating performance difficulties is a clear example of reflective experience.

Moving without Self

Many of us spend so much of our days thinking about this and that that we completely miss the flow of pre-reflective moment-to-moment freedom of movement that is, for the most part, our constant experience. If you dig yet deeper into the kind of movement that does not involve thinking, you will also discover that there is no enduring self or entity that moves your body. As we make our way through the world dealing with the obstacles and difficulties along the way, nothing *seems* more certain than that I am the mover of my body. But if you try to locate the mover of your body, you cannot find it. The more we consider this question about who moves the body, the more ridiculous it seems. How can it be that there is no self that moves my body when it is so obvious that I am the mover of my body? Who is the mover, after all, if not me?

Even when faced with the inability to find a continuous self-subsisting self, the claim that there is no continuous self that moves the body still seems wildly counterintuitive. But look again. Nowhere in your pre-reflective experience of the free flow of moment-to-moment movement do you find a continuous self-entity that moves

your body. There is just the pre-reflective orientation of your body, fully aware, assessing and negotiating its way through the obstacles, joys, and difficulties of its world. There is no separate self-subsisting self doing the movement. There is only the inseparability of intention and flesh, where the intention to move and the act of moving are simultaneously manifesting in one and the same movement.

Our movement mostly occurs at a pre-reflective level where the intention to move and the actual movement are experienced as one and the same action. At the pre-reflective level, there is no reflective self in play: there is only pre-reflectively conscious, intelligent, purposeful moving. Later when you think about or report on what you were pre-reflectively doing, you introject a self into your experience. You say, "I moved," and falsely believe your reflective self was there all along. But clearly, a reflective self cannot be present in pre-reflective movement.

Your self is neither continuous nor any kind of entity. Other than where your body is, your self has no specific location. There is no internal control center where it sits and moves your body. Instead, your body is saturated with mind and intention. Mind and body are implicated in each other. Even at the pre-reflective level your bodily orientation and movement is infused with an awareness of your surroundings as you make your way through our shared world.

Thus, the answer to the question "Who moves?" becomes more transparent. On the one hand, if you mean by "self" a continuous self-subsisting entity, then there is no such thing that moves your body. On the other hand, if all you mean by "self" is the non-continuous sense of identity that only appears when we reflect on our movement or experience, then the manifestation of a reflective self when we are having performance difficulties or thinking about our movement is how self primarily appears in movement. Otherwise, there is very little in the way of a reflective self involved in moving our bodies.

We easily recognize how we structure our day-to-day activities by means of reflective thought, but are mostly oblivious to the role the pre-reflective plays in our day-to-day activities. As a result, we almost entirely overlook the kind of bodily intelligence that is always at work in our daily life. Although we do not normally associate thinking with the body, our body is a psychobiological intentional whole. It is not a thing we inhabit, but a condition for inhabiting things. Because it is deliquescently graced with mind it is capable of assessing, negotiating, and making its way through the world without engaging in reflective thought or presupposing a self-entity. When all is said and done, you are not other than your body. And, of course, it is you who moves your body – it's just not by means of a self-entity or any kind of continuous self.

KABOOM!

With the recognition that there is no self-entity moving our body, we seem to have arrived at a fundamental insight of Buddhism concerning the existence of the self. But let's look more closely. The Buddha's discovery actually goes to the very origin of self and world and, hence, to the origin of the pre-reflective and the reflective. As a result, pre-reflective experience and the Buddha's experience cannot be the same. But, as we are coming to see, sometimes something as simple as pre-reflective walking can transform itself into a numinous experience of the source, thus demonstrating how pre-reflective activity can be a gateway to freedom.

Whether we realize it or not, we and the totality of what is are always returning to zero, dissolving into oneness, and being reborn. Imagine you are leisurely walking down the street. Suddenly and without warning, a car backfires behind you. *KABOOM!* For an instant, you and the *kaboom*, time and space, subject and object, become one. At zero, there is no self in place to record the passage of time. Then, just as suddenly as everything became one, your self reappears and you begin thinking about what just happened. "Oh man! I thought that was a gun being fired."

In the same way you died and resurrected with *kaboom*, throughout your day, in the very first moment of meeting the things and people of your world, you instantly become one with them and then just as quickly separate. When you were strolling down the street you were sometimes orienting pre-reflectively and sometimes reflectively. But when the car backfired, all sense of self, identity, as well as your pre-reflective world simply disappeared in oneness and love.

Whether we realize it or not, it is the same when we first meet anything. For example, in the very first moment you see a tree, you and the tree become one. As a result, there is no distance and no difference between you and the tree, and there is no pre-reflective or reflective orientation. But, in the next instant when your self resurrects commenting on the magnificence of the tree, a distance and a difference manifests between you and the tree. Even when you are looking at the tree pre-reflectively, a sense of a distance and a difference still exists between you and the tree. But when we return to zero, we are completely one with the tree, the reflective and pre-reflective have disappeared, and there is neither distance nor difference.

Unfortunately, we all too easily lose track of how we become one with everything and mistakenly believe that our self is an enduring entity that is the essence, center, and foundation of what we are. Just as we mistakenly perceive our self to be an entity having duration, we also we mistakenly perceive our body and all existing things as having a self-subsisting nature that endures. This mistake is at the heart of our suffering.

Why Did Bodhidarma Walk to China?

When our everyday pre-reflective movement is practiced as a form of meditation, it can grant us access to the Zen experience of freedom and allow us to know that we are dying and resurrecting in love moment by moment. Zen Buddhism is not a faith-based religion or a philosophical system. Since it is a non-dogmatic, practice-based discipline that emphasizes first-hand experiential verifiability, it is an ideal practice for studying walking meditation. Zen is an intense course of study involving a number of practices, including long hours of sitting meditation (*zazen*) punctuated with walking meditation.

The practice of Zen is not designed to provide the practitioner with a comforting set of beliefs or an alternative explanation of the nature of reality. Rather, it is designed to offer an *alternative to explanation* by allowing the practitioner to solve the riddle of life based on his own direct experience of reality.[1] In a sense, the practitioner wakes up to the way things truly are and his place in all of this. The practitioner develops the ability to know the love that permeates the cosmos and manifest the wisdom that knows the activity of the source. He knows it not because he believes it or has theory about it, but because he has a direct experience of it. This kind of knowing sets him free.

Walking meditation is an important part of everyday practice in the Zen monastery,

and was also incorporated by the Buddha into his daily practice. How far back before the time of the Buddha this practice goes, nobody knows. What we do know is that this simple practice can often have profound results, especially when it is combined with other practices, such as sitting meditation.

There are many benefits that come from walking meditation. Zen retreats are usually seven days long, with each day often beginning at three o'clock in the morning and ending around nine or ten o'clock at night. After a few days of this daunting schedule your legs, back, and other structures can start to ache, spasm, or fixate. Walking can help to alleviate or ameliorate these kinds of problems. It also can help keep the joints of the low back (lumbar spine and sacroiliac joints) mobile and free of pain. But one of the more important purposes of walking meditation is to bring the experience of sitting meditation into action.

As a way to take our second tentative step toward understanding how freedom can manifest through walking, let's look at how it showed up for a beginning Zen student:

> *After twenty five hours of travel and a sleepless plane flight, I arrived in Japan at seven o'clock in the morning dead tired. My good friend was there to meet me. We had to run errands all over Tokyo and arrived at my friend's house late that night. I was so depleted that I could not form words anymore. I fell in bed totally exhausted.*
>
> *We rested the next day and on the following day set off for my first Zen retreat. I was still quite exhausted and somewhat worried by the thought of getting up at three o'clock in the morning for seven days. The retreat turned out to be more difficult than I had ever imagined possible. The pain in my legs from sitting cross-legged was intense and it was all I could do to stay awake.*
>
> *Even walking meditation was difficult. This particular temple supplied straw sandals that we were required to wear during walking meditation and walking in the temple. Unfortunately for me, the largest were half the size of my foot. Walking in them was quite painful and awkward. As a result, I had trouble staying in step with the kinhin line. Exhausted and in pain, I kept at it.*
>
> *On the morning of the third day during walking meditation, quietly and without warning, something shifted in me. Up until that moment I felt as if I were confined in a completely oppressive space, burdened with numerous aches and pains and emotional traumas and so exhausted that I could barely see straight. Then, suddenly I was wide awake, feeling as though I were completely at home, unburdened and alive, full of peaceful clarity, and luxuriating in the expansiveness of the softest, most spacious energy imaginable. I felt free for the first time in my life. My mind was like the great expanse of the sky. My consciousness was no longer dominated by thinking. There was no me doing the walking. It was as if something much vaster had taken over and was doing the walking. I was enraptured by the mere act of walking. I was not walking – I was being walked. How could I have passed over this way of walking in my day to day life? I remembered similar experiences when jogging. But that was nothing compared to the freedom I was experiencing now.*
>
> *Walking free of the fixations of my self brought with it the most delicious sense of freedom I had ever experienced. Moment by moment, step by step, the in-here and the out-there turned out to be the same here. Step after step I was being walked free of all cares and troubles at every level of my being. I felt clear and bright, as if my entire being had undergone a profound cleaning, and was subsequently filled with the greatest sense of freedom imaginable. Instead of resting during the breaks, I spent every remaining rest period in walking meditation, allowing myself to be carried away by being walked.*

Right here, within our everyday way of moving, is an ever-arising, utterly simple way to realize our freedom and place in all of this. Even though this experience was just the beginning for this Zen student, it rather dramatically demonstrates how the mundane activity of walking can be transformed into a profound experience of freedom. He had the advantage of beginning his retreat exhausted, and at the end of his rope. The retreat pushed him beyond his limits, he held on until he couldn't any longer, and then he simply let go and surrendered his limited human perspective – thus demonstrating how something as simple as walking can profoundly open the doors of freedom.

It is useful and instructive to realize how this description differs from our usual ways of walking. Clearly, the I-will-it-to-move description does not even begin to capture *being-walked*. But even our pre-reflective consciousness can be so swamped with feeling that it obscures the potential for freedom that lives in the heart of our everyday ways of moving. To make the point with an extreme example, consider the plight of a paranoid person who is condemned to feeling his paranoia pre-reflectively.

Whether we walk by ourselves or with others, whether in the city or hiking a mountain trail, instead of just being walked, we find ourselves occupied with endless concerns, ideas, plans, worries, anticipations, and random thoughts. We are often so caught up by the flow of thoughts and concerns that we barely even register the fact that we are moving with utter freedom as each movement flows unencumbered into the next. Whether we realize it or not, moment by moment, one step after another, we are appearing and disappearing, dying and resurrecting with the totality of what is in the free flow of one movement into another.

Gateway

It is possible to wake up to the wonder of what is always happening – provided you are willing to surrender to your everyday way of walking so completely that you perceive how the true state of affairs comes to presence in the ordinary. You will not find this freedom in pre-reflective action alone. But as we have repeatedly seen, pre-reflective action can be a gateway to the freedom of being-walked. If you give yourself over completely to pre-reflective action, then, right here, right now, in the simple act of walking you can become the effortless peace of being-walked and know the boundless freedom and unencumbered love that appears when you become one with the numinous activity of the source.

Endnotes

1. The idea of providing an alternative to explanation comes from Henri Bortoft's explication of Goethe's qualitative science of nature. I appropriated his phrase in order to make an important point about the nature of Zen practice. In so doing, I have changed its original meaning. See Bortoft's *The Wholeness of Nature: Goethe's Way toward a Science of Conscious Participation in Nature*. New York: Lindisfarne Press, 1996.

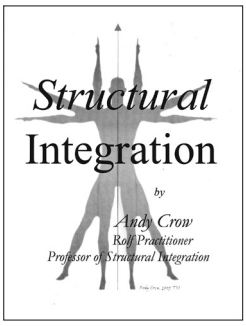
Reviews

Structural Integration

by Andy Crow,
Certified Advanced Rolfer™
(Crown-Omega Publishing, 2005)

Reviewed by Allan Kaplan
Certified Advanced Rolfer™

When I did my basic training in Rolfing® Structural Integration (SI) back in the 1980s, we students amassed binders full of photocopies of notes and outlines of the "Recipe" from previous classes. At that point, our canon consisted of typewritten notes from a few classes by Emmett Hutchins, Peter Melchior, Tom Wing, and Stacey Mills, as well as other miscellaneous cheat-sheets that were floating about. The next generation of fledgling Rolfers referred to Clinton Kramer's "A Searcher's Handbook," another oft-photocopied document of class notes from the era. And now, there's Andy Crow's *Structural Integration*.



Crow has produced a nearly two-inch-thick brick of better than five hundred pages that is born of the halcyon days of Rolfing SI, back in the late 60s and early 70s when today's senior guard was a bunch of young devotees of the master, Dr. Ida P. Rolf. From testimonials by others who were there, Crow's eyewitness account gives an accurate, honest feel of the times and teachings in the Rolf community of the era. His book is chock-full of the words of Dr. Rolf and a spectrum of the old-timers, as well as relevant quotes from a multitude of others, such as Newton, Einstein, Confucius, Aristotle – you name it.

At its heart, *Structural Integration* is a teaching tool, a great addition to any basic class. As Crow puts it, "This book is not a 'how to do it' book. It is not a manual. It is more than that. This book is a process." Indeed, it is his version of the Gospel of Ida, with his own impressions added for good measure. The bulk of the book is an outline of the Recipe, with repetitions of its protocols, session goals, and hallmarks; analysis of methodology and relationships; details of structure; questions to ask; things to do; encouragements and admonitions. It has long asides covering various aspects of anatomy, physiology, body systems, fascia, gravity, energy and mass, thixotropy, symmetry, and even chapters on business and ethics. The book is massive in its scope.

In reality, it would take far more than an hour to cover all Crow suggests in a session: that's where the art and experience come into play, discerning what is actually necessary and appropriate for that client at the moment, and what will be evoked and evolve with what Peter Melchior called "the element of time." So, while the book is not a substitute for experience, it can be a useful tool for the novice or experienced Rolfer.

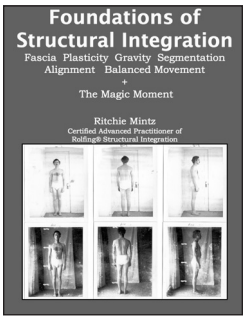
Crow's style is unique: it's a mixture of tongue-in-cheek humorist, evangelist, and carnival barker (sometimes reminding me of the label on a bottle of Dr. Bronner's Pure-Castile Soap shouting "18-in-1 Uses! We're All-One Or None!"), which might not be for everyone. Don't get me wrong – *Structural Integration* really is bulging with valuable info, but the author's obvious enthusiasm for his subject, embroidered freely with "Rolfian" dogma and myth, may be overwhelming to some (excerpts from the book on his website give a feel of its flavor). Speaking from the standpoint of a technical editor, I think *Structural Integration* would benefit from a round with a keen editor who could condense, clarify, and focus some of its repetitiveness, still pounding away with Crow's points without sacrificing his personal voice and intention. But as it stands, it's still a wealth of info and a reminder of the origins of our work. (*Structural Integration* is available from www.andycrow.com.)

Foundations of Structural Integration

by Ritchie Mintz,
Certified Advanced Rolfer™
(self-published, 2012)

Reviewed by Wiley Patterson, M.D.
Certified Advanced Rolfer™

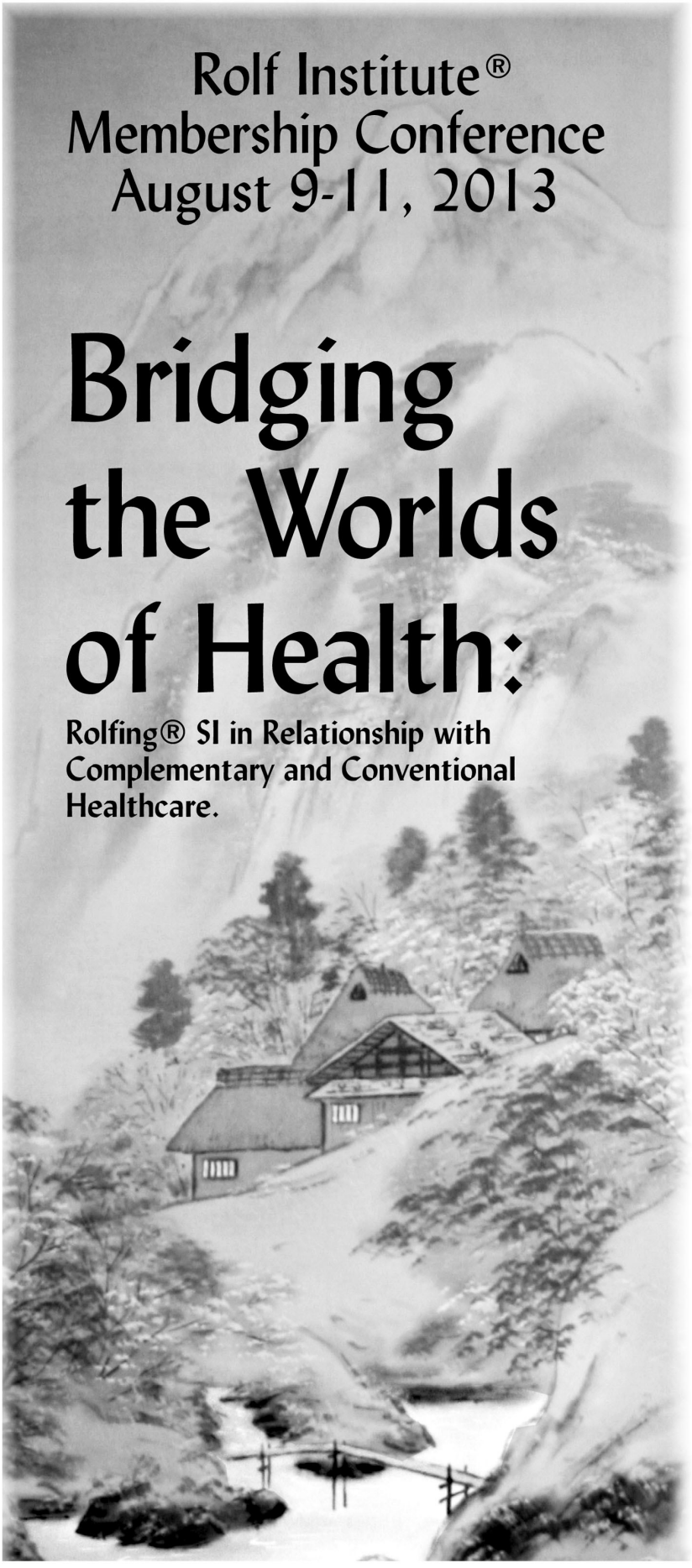
Ritchie Mintz' *Foundations of Structural Integration* is designed especially for beginning structural integrators. It talks about basic Rolfing Structural Integration (SI) theory and covers in-depth many of the mysterious *koans* that baffle beginning Rolfers, such as *gravity buoys us up* and *lumbodorsal hinge*. It is quite powerful in its simplicity. Rolfing SI requires a profound understanding of the normal, and Mintz discusses the realities that make Rolfing SI such a formidable healing process. Removing all other influences on the work, it makes it quite clear why Rolfing SI is not osteopathy, not craniosacral work, not physical therapy. It demystifies "mystery school" concepts.



This book is very logical in its organization. Numerous arcs get launched that neatly wrap up. It builds nicely from one concept to the next, and it has a profound conclusion. Mintz has clearly thought fundamental Rolfing concepts through to a very deep level, indeed to a masterful level. I was familiar with the concepts, yet he deepened my understanding. Many of the ideas in the Rolfing world that I previously thought of as frustrating and incomprehensible mythic lore are now usable in my Rolfing room because of his lines of thinking and simple explanations.

You may not agree with all of the ideas in the book. I didn't at first, but soon felt compelled to rethink each contentious idea. As the logical progression played out, each idea made more sense. I was very moved by the discussion titled "The Next Generations" (starting on page 115), about Ritchie's version of how the work might be taught.

This book is also for the SI community as a whole – beginners to advanced practitioners. It has the potential to heal philosophical rifts. It does this not by arguing a philosophy but by presenting in depth the basic phenomena that allow SI to occur. In whichever camp you have pitched your tent, you will see that as you do your style of SI, you are doing what is described in this book, truly the "foundations of structural integration." There has been a long-standing lack of clarity regarding these concepts, and I believe it has led to decades of contention within our community: there's nothing like the truth stated clearly to clear up misunderstandings. (*Foundations of Structural Integration* is available from www.RitchieMintz.com.)



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Saturday, August 10, 2013

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Cathy Ulrich, DPT, CAR
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Brooke Thomas, CR
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ABR-Bali – December 2012
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USA – March 2013
Faculty: Ray McCall (Instructor), Robert McWilliams (Assistant)
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ERA – March 2013
Faculty: Giovanni Felicioni (Instructor), Fuensanta Munoz de la Cruz (Assistant)
Students: Alberto Almazán Tavero, Abdelghafour Ben Brahim, Peter Bollinger, Martin Egeberg, Satomi Furukawa, Cathy Heitz, Wojciech Karczmarzyk, Richard Loiseau, Tiziana Lunardi, Janine Margelisch, Fabio Palma, Juusi Pellonpää, Marta Pichardo Rodriguez, Laurence Tison, Ruxandra Tomescu

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Phase I: Foundations of Rolfing® Structural Integration

June 10 – July 22, 2013
Coordinator: Adam Mentzell

September 2 – October 14, 2013
Coordinator: Michael Polon

Phase I: Accelerated Foundations of Rolfing Structural Integration

July 28 – August 10, 2013
Instructor: John Schewe

Phase II: Embodiment of Rolfing Structural Integration & Rolf Movement® Integration

April 1 – May 23, 2013
Instructor: TBA
Principles Instructor: Jane Harrington

April 1 – May 23, 2013
Instructor: Thomas Walker
Principles Instructor: Mary Bond

August 19 – October 10, 2013
Instructor: Thomas Walker / Michael Murphy
Principles Instructor: Carol Agneessens

October 21 – December 19, 2013
Instructor: Bethany Ward
Principles Instructor: Jon Martine

Phase III: Clinical Application of Rolfing Theory

June 17 – August 9, 2013
Instructor: Kevin McCoy
Anatomy Instructor: Jon Martine

October 21 – December 20, 2013
Instructor: Larry Koliha
Anatomy Instructor: Michael Murphy

Advanced Training

May 20, 2013 – June 7, 2013
August 19-30, 2013
Instructor: Ray McCall w/Jon Martine

Rolf Movement® Certification: Cranial Sacral, Neural Remapping and Rolf Movement Integration

October 14-19, 2013
Instructors: Jane Harrington/Suzanne Picard

HOLDERNESS, NEW HAMPSHIRE

Rolf Movement Certification: Rolf Movement Teacher Practicum

July 16-22, 2013 (no July 19)
Instrutors: Kevin Frank/Gael Ohlgren

Rolf Movement Certification: Orientation, Perception, and Resonance

August 22-28, 2013 (no August 25)
Instrutor: Kevin Frank

LOS ANGELES

Advanced Training

November 4-21, 2013
March 10-27, 2014
Instructor: Jan Sultan w/Lael Keen

BALI

Phase II: Embodiment of Rolfing Structural Integration & Rolf Movement® Integration

May 6 – June 27, 2013
Instructor: TBA

Dual Training Phase III: Clinical Application of Rolfing Theory & Rolf Movement Certification

October 7 – December 12, 2013
Instructor: TBA

BRAZIL

Unit III w/ Rolf Movement Integration

March 4 – May 9, 2013
Instructor: TBA

GERMANY

Phase I

July 7 – August 17, 2013
Instructors: Rita Geirola, Konrad Obermeier, Giovanni Felicioni

Phase II

October 7 – November 29, 2013
Instructor: Pierpaola Volpones

Phase III

February 10 – April 3, 2014
Instructor: Harvey Burns

SOUTH AFRICA

Unit I

September 9-27, 2013 & October 7-25, 2013
Instructors: Marius Strydom/Michael Polon

Unit II

April 7 – May 30, 2014
Instructor: TBA

Unit III

September 1 – October 24, 2014
Instructor: TBA

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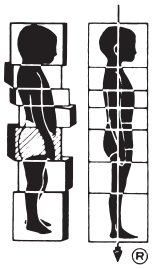

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