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Ask the Faculty Approaches to Psoas Work

Q Could you discuss your thoughts regarding the different approaches and techniques you use for working with the psoas muscle, and its importance in our work?

Introduction

The psoas muscle and its role in human structure has drawn much attention from Rolfing[®] practitioners from the early days till the present time. It has been perceived as a "mysterious" and "emblematic" element of Ida Rolf's work. Historically, it has been identified and held responsible for the perception of how "deep" Rolfing Structural Integration (SI) was. It has always carried an aura of outstanding importance in the work. Anatomically deep in the human structure, it requires special techniques and enhanced skills to be reached and dealt with.

Psoas anatomy and function has generated much speculation by Rolfers[™]. We have seen many articles on the psoas in our periodicals (*Bulletin of Structural Integration*, *Rolf Lines, Structural Integration: The Journal of the Rolf Institute*[®]), and it has been mentioned in the content of many others. Studies and theories about it, as well as new techniques to address it, continue to emerge out of the creativity of our community.

The question posed above, intended to elicit descriptions of various techniques for the psoas, inspired faculty members to write the small contributions gathered here, several of which contain far more than simple practical answers. Besides practical ways to address the psoas, including a description of Dr. Rolf's classical psoas technique, you'll find various theoretical perspectives - from a contemporary explanation of psoas anatomy in the context of the connective-tissue matrix, to a discussion of motility and mobility, direct and indirect techniques, and the role of Rolf Movement® techniques. To broaden the perspective, we have also brought into this column excerpts from other faculty articles on the psoas presented in this issue.

Pedro Prado, Ph.D. Certified Advanced Rolfer[™] Advanced Rolfing Instructor

A The basis for my approach to working with the psoas is founded on a consideration of the interface of mobility and motility. Anatomically we're aware the psoas lies within the category of skeletal muscle, which connects axial skeleton to appendicular skeleton, and as such can create a complex of moves including flexion, extension, sidebending, and rotation in the lumbars. If we include inherent motion and track our psoas intervention at the motile level, we have the opportunity to increase both the efficacy and gentleness of our intervention in this very sensitive and highly charged area.

Here is a description of a psoas muscle release I use, as described by Hugh Milne in *The Heart of Listening: A Visionary Approach to Craniosacral Work* (Berkeley, CA: North Atlantic Books, 1996). Use this technique for clients with low-back pain and lumbar pain, and/or osteoarthritis of the hip joints.

Sit or adopt a long-leg stance to one side of the client. Flex the client's knee; support that knee in your arm that lies nearest to their midline. Place their patella tuberosity anterior to your coracoid process (if you can manage that), or close to it if you cannot. Arrange your contact so that both arms are now free to work with the psoas of your side. Trisect the distance from umbilicus to anterior superior spine.

Now place the curled backs of one hand's fingers at the middle trisection. Reinforce with your second hand. Very slowly "squidge" the small intestine out of the way in order to allow access to psoas major. Sense Position, Field and Wave before you go any further. Begin slow rotatory movements of the client's femur to deepen access. Beginning "Knee Medial, Psoas Lateral" counter rotations in timing with the cranial wave is often a more effective way of introducing softness to the psoas. This may devolve into free unwinding, with no specific pattern of movements. (This is probably the technique A.T. Still used with 'Old Tom.') Intention is to obtain freedom and length in the psoas, and listen to the information coming from its field."

It is helpful to keep in mind that sensuality and sexuality are two basic energetics of the psoas and that sensual movement is the primary dynamic of this muscle as well as the deep potential for movement.

Sally Klemm Certified Advanced Rolfer Advanced Rolfing Instructor

A short psoas can create pain in a number of places. It creates low-back pain, sciatic pain, and puts strain in the back fibers of the diaphragm, eventually causing a shorter quadratus lumborum. A faint pain just above or below the greater trochanter may be present, as may stiffness and other less distinct aches.

Functionally, the psoas, when overcontracted on one side, will visibly sidebend and rotate the lumbars to the same or opposite side of the sidebend. When both are short, it may create lordosis, or it can also lock people down into a posterior lumbar position.

The iliacus muscles, separately or together with the psoas, can also pull the femur superior and prevent its full rotation. Together they sometimes put pressure on the femoral nerve and femoral artery.

There are many ways to locate and lengthen the iliopsoas. Dr. Rolf's traditional way of working the psoas was with the client supine and knees up at a 45-degree angle, and the practitioners' fingers and hands just medial to the anterior superior iliac spine (ASIS), heading in towards the junction where the psoas and iliacus fibers meet. The client would then rock his pelvis slightly anterior and posterior to allow the psoas to fall back and allow the lumbars to lengthen. Combined with a pelvic lift, lengthening the lumbars in the back and rocking the sacrum allows the person to have improved lumbosacral movement and more stable lumbars that are able to move optimally when walking. Dr. Rolf also taught this technique with more focus on the iliacus: your fingers would be slightly more lateral to find the fibers of the iliacus, and you would have the client rock his sacrum.

For the eight and ninth sessions, Dr. Rolf taught seated psoas work, with the client sitting on the bench. The practitioner's hands go in low, medial to the ASIS, finding the psoas; then you have the client lengthen and slightly rock his lumbars posteriorly. Then Dr. Rolf might continue up – slightly – for the same objective: to lengthen the lumbars and create more core movement of the spine.

I still use both of these techniques, but have added a number of nuances that help the client feel the lengthening of the psoas more, and create more length at both ends simultaneously. With the client sitting on the bench, if I go in above the inguinal ligament, I have the client bring one knee slightly medial, then the other. This allows me to find various fibers in the iliopsoas, and I can aim my fingers more directionally. I also have the client slide his foot backwards slightly: this again helps find various fibers of the psoas. I then have him look up to the ceiling (moving his head) and take his arms up overhead, which pulls the thoracic spine upward and allows the psoas and lumbars to lengthen at the top. I find this helps the diaphragm and the mid-dorsal hinge, and the thoracic inlet. Once you've spotted a sidebend in the lumbars, have your client reach up with that arm: this allows the shortest psoas to lengthen the most.

Another technique I employ to lengthen the iliopsoas involves the client laying face up, with legs down. With my hands on the lower end of the psoas below the inguinal ligament, I have the client slowly rotate his femurs medially, then laterally, then medially again.

I also frequently use the sidelying position for the iliopsoas, or prone with legs extended, or the seated position working from the side.

In conclusion, with today's more sophisticated clientele, there may be direct requests for psoas work, and I find these techniques highly useful.

(Editor's note: This is an excerpt from an upcoming paper by Jim Asher.)

Jim Asher Certified Advanced Rolfer Advanced Rolfing Instructor

A My "standard" approach to accessing the iliacus and psoas muscles is the one I learned in basic training – the client lying supine, knees up, and feet flat on the table. I usually start with both iliaci, just behind the ASIS, and have the client rock his pelvis very slightly. While still contacting both iliaci, I then have him slide one leg down onto the table, then the other. I pick one side and have him slightly raise his knee while still working that iliacus behind the ASIS. The work can be done with hands, or gently with an elbow. After doing the same on the other side, I move to the psoas with the client's legs still down. Once I have contacted the psoas on that particular side, I have the client slightly raise that knee. A couple of these movements will finish the work here. If I feel that the psoas needs more work, I will work something else to give both psoas muscles a chance to integrate and settle down. Then I may go back and briefly touch in on them again later that session, or make a note to do some more work later on in the series. With both internal and external types, I have found that the hallmark of a well-toned and integrated psoas is that it is hard to find and contact, even with the client's leg laid out flat.

Obviously, I have tried different approaches to the psoas including standing and seated work, but I find that this basic approach will suffice for almost all of my clients. While this may seem a bit conservative, I have found that I have never "overcooked" a client and have had nothing even approaching a sympathetic response.

(Editor's note: This is an excerpt from John Schewe's article "The Psoas, Musings of a Rolf Institute Anatomy Instructor." See page 28 for the entire article.)

John Schewe Certified Advanced Rolfer Fascial Anatomy Instructor

A Psoas work is a very important aspect of Rolfing Structural Integration. However, it is not always necessary to touch the psoas to be effective. Having an appreciation of the connective-tissue matrix and its relationship to the psoas muscle allows practitioners subtle and powerful means to "work with the psoas." Furthermore, practitioners are becoming more and more sophisticated in the utilization of movement principals, specifically coordination and perception, to enhance their work with clients. Here we will discuss a few strategies that practitioners may utilize to effectively work with the psoas, incorporating an understanding of fascial layers and movement principles.

Position 1: Hook lying. This is a position where the client is supine with the knees up, feet flat on the table. Movement concepts related to this positional strategy for psoas work include calling for movement (coordination) and inviting body awareness (perception). Begin by inviting the client to feel his feet on the table (perceptual awareness) and to gently press into the table with the whole foot (coordinative pattern). This may help the client and practitioner to begin feeling activation of transversus abdominis. As the client engages the transversus, the practitioner may now invite a slow gentle movement through the axial complex by asking the client to curl his tail toward the ceiling. This needs to be a slow and easy "call to movement." The practitioner is now assisting the client to discover new possibilities of coordination involving psoas in balance with rectus femoris, rectus abdominis, and piriformis. These types of explorations of micromovement can be seen as assisting the client to develop a new anticipatory postural activity to support further motor programming. As the practitioner and client are able to perceive a degree of success with this movement pattern, more complex movements may be added such as slowly raising one foot off from the table or sliding the foot down the table, movements involving contraction of the psoas. Practitioners can look for pelvic stability during these more complex movement patterns. If the practitioner notices a lack of stability through the pelvis - for example, tilt, shift, rotation, or torsion of the pelvis – during this movement invitation, it may be best to go back to the prior step to establish better activation of transversus.

Position 2: 1/2 Hook Lying. This is a position where the client is supine with one knee up, foot flat on the table, and the other leg stretched out. The movement pattern would be the same as above – however now the activation of transversus will come primarily from the foot in contact with the table, and the activation of the psoas will come from the leg that is lying straight on the table. The call for movement will consist of a small invitation for knee flexion of the

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straight leg. Again, if there is a lack of pelvic stability the practitioner may wish to return to the activity described above in Position 1, and assist the client in his ability to perceive pelvic stability prior to proceeding with Position 2.

(*Editor's note: This is an excerpt from Kevin McCoy's article* "The Connective-Tissue Matrix and the Psoas Muscle." *See page 31 for the entire article.*)

Kevin McCoy Certified Advanced Rolfer Rolfing Instructor

A Here is an exercise for perceptive core stability in the context of SI, the straightleg raise supine, which is central to our discussion of psoas function.

Base line: the client is asked to raise one leg, with extended knee. The client is invited to feel what happens. How does the body respond to this demand? The client is asked to do whatever he/she can to keep the pelvis from rotating in the transverse plane while doing the leg raise. This is a good opportunity to speak about primary, secondary, and tertiary stabilizers, and to review the anatomy of the psoas, transversus abdominis, and multifidi.

Intervention: the client is instructed to induce a small demand by pressing the contralateral heel into the table or the entire calf against the table, perceiving the directionality of the press, and maintaining perceptions of directionality in the space and weight on the table. The client is asked to sustain a downward press of the contralateral foot, then to feel upward directionality of the foot to be raised, a directionality toward the ceiling, and then to follow that direction in movement.

(Editor's note: This is an excerpt from Kevin Frank's article "Structural Integration Psoas Intervention Considered in Terms of Normal Stability Response for Hip and Trunk Flexion: A Perceptive/Coordinative View." See page 33 for the entire article and for an image related to this exercise.)

Kevin Frank Certified Advanced Rolfer Rolf Movement Instructor

A My first experience of receiving work on the psoas is now some thirty-six years back. I trust that I can rely on my memory concerning the first sequence of Rolfing SI sessions, but as we know that the brain is permanently "coloring" or actually changing the contents of memories within a new experiential context of our presence, I am happy that I took detailed notes right after my first Fifth Hour of the Rolfing series. According to these notes, the "old style" psoas work was done very carefully. I felt that the hands of my Rolfer found their way towards the inner space in front, and beside the vertebral column, passing slowly through several layers - sometimes waiting for the opening of an inner gate. Sometimes the hands moved very slowly, without coming to a complete stop. It was as if the practitioner's hands were sinking into me, using a different speed for each layer they were passing through. At the end of this journey toward the inside of my body, I sensed that the quality of touch changed; the Rolfer's hands seemed to come to a rest. I did not feel any pressure on the psoas muscle. I felt that a space was touched while I had a sensation of lift within this space.

In my notes I wrote down how I felt during the days after the session. Without overtly doing anything differently, I started to walk in a way that seemed to be slightly different from my usual pattern. My knees were swinging somewhat more easily forward, and my feet touched the ground much more softly. But aside from the sensations in the legs and feet, something else happened on a more global level of movement: I realized that my lower extremities became less important for walking. I thought about a tai chi master's statement: "Breathe from the feet and walk from the diaphragm."

Now, when doing psoas work so many years later, I frequently go back to my memories of this first Fifth Hour. What made this experience so profound at a time when we had so little conceptual and anatomical knowledge? Probably this was because much more was done in the session that was beyond activation of a muscle and also beyond the concept of "stretching fascia."

I remember being in class as a student in 1980. We were preparing for the Fifth Hour, busy trying to find the psoas on our classmates. And then the class assistant, Charles Siemers, told us something that helped us a lot: "Ida Rolf did not mean 'the psoas,' she meant the space that the psoas is running through." When Charles quoted Ida that day, he was probably not aware that he started a long-term investigation for some of us. We had become aware that psoas work is more than working on a single pair of muscles. And what is this "more"? Going back to my notes about receiving the first Rolfing series, I found another interesting detail. My girlfriend at the time, a young medical doctor, had watched the sessions. While the Rolfer was going after the psoas she asked nervously: "What is happening with the organs?" The Rolfer hesitated for a moment, and then answered: "They slide to the sides." Today we know that is only true up to a certain degree. Some parts of organs will go to the sides, but others – especially the peritoneum – will stay or react in a specific way that we should be aware of. If the practitioner's hands manage to go toward the psoas precisely between a part of the duodenum and another part of the colon, he will arrive pretty close to the muscle belly of the psoas. However, different layers of the peritoneum will always be between the hands and the psoas. Of course, we can try to work on the lower part of the muscle where it runs quite close to the body's surface to avoid the intense contact with the peritoneum. In this area - close to the groin - the muscle looks like a strong tendon and seems to need another mode of touch, dealing more with the nerves than with the fascia itself. (If we want to work more traditionally here, we can use the sidelying position. The client rests on her side while the practitioner contacts the groin area and moves the client's thigh several times through external and internal rotation. By doing this, different layers, situated anterior and posterior to the psoas, are encouraged to move in relationship to each other.)

Let's have another look at my notes from basic classes that took place so many years ago. They report that the outcome of our psoas work was not always what we expected. Sometimes a model in class would stand up after a session showing a smooth curve around the lumbar area, the pelvic bones serving very well as a container for the organs, and the abdominal wall seeming to have appropriate span. To our disappointment, this was not always the outcome. Quite often we found the opposite: the lumbars would suddenly shown a strong kink where the last lumbar vertebra and the sacrum meet, and the pelvic basin and its contents would seem to go different directions. And the more psoas work we did, the more the contents of the lower portion of the pelvis would fall forward and push the pubic symphysis inferiorly. We had no explanation for the fact that we produced opposite results while using the same techniques.

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And even today we have to be careful in offering simple explanations. Instead, we may ask some new questions:

- What are the important layers we travel through on the way to the psoas and what is their structural and functional role?
- How do these intraperitoneal components relate to each other in space and in active or passive motion?
- How do their retroperitoneal neighbors have an impact on the function of the psoas?

There is plenty to explore, looking at the small details. We may look in detail at adhesions between the posterior wall of the peritoneum and the anterior part of the fascia of the psoas. We may include the streaming direction of the serous fluid. And there is also plenty to explore within the more global context: how is the psoas acting as a "spacer" between the peritoneal, subperitoneal, and retroperitoneal cavities? This question might guide us down a trail to a different appreciation of the psoas,

seeing it not only to be functioning like a muscle, but also as a spacer. In this sense the psoas may be called a fluid bone that also works like a muscle. Anyway, the story of this fascinating area deep inside of our organism has yet to be written to its end.

Peter Schwind Certified Advanced Rolfer Advanced Rolfing Instructor

Rolf Movement Faculty Perspectives

The Role of Imagination in Structural Integration

By Kevin Frank, Certified Advanced Rolfer™, Rolf Movement[®] Instructor

S tructural integration (SI) is founded on the notion that posture can change, and that the shape of the body in gravity can make a lasting change. But what shapes our physical body? What shapes our perceptive body? These questions in turn lead us to ask, what is the relationship of imagination to perceptive shape and body shape? Imagination is an important part of SI and turns out to play a key role in our best explanation for why SI works.

Imagination is closely related to perception. Our brain assembles bits of sensation into an experience, which we call a perception. Putting bits of sensory material together into a meaningful experience in the brain is also imagination. At the sensory cortex level, perception of a sensation is the same as imagining the sensation.

Our experience of the world is, effectively, an assembled representation of the world. We build a perception of the world – the world we inhabit is the one we build. As we build the shape of our perceived world, our body shape develops correspondingly.¹ Depending on how we imagine our world, and what we imagine as our body, our body shape expresses the result of that internal process. The structure of our body and the structure of our perceptual processes are not normally plastic – they are not meant to change casually. Our welfare depends on reliability and consistency of perception, what Gibson calls invariant perception.² However, under some circumstances our perceptive possibilities can change. If our perceptive possibilities open to something new, and if something new is integrated into coordination, we have changed perceptive structure. Shifts in perceptive and coordinative structure in turn change body shape. SI is a means to do this.

Imagination is a skill.³ Skill with imagination develops through a learning process. An example of this learning process is embedded in SI. We learn to differentiate the map of body and peri-personal space⁴ – something we teach clients and students with fascia-oriented touch, and with movement, visual cues, and our own embodiment.

It should be acknowledged that imagination can be a confusing word. One might ask, "Isn't imagination just inventing anything in the mind?" Does "pretending" belong in the serious work of SI? Is talk about imagination a form of induction or, worse, an induction into a practitioner's pet cosmology or belief system? What specific kind of imagination is being referred to in the context of movement and SI?

To answer this question, it helps to talk about posture and coordination as a response of the body's movement system. "Movement brain" is a term that conveniently denotes the system processes of the body that guide our ability to move.5 This system process doesn't depend on thinking about it. (In neuroscience terms "movement brain" or "movement system" is roughly equivalent to "body schema.") When a body expresses ease of posture, effective response to demand, when we see examples of successful movement, it is because the body movement system, the movement brain, is functioning well, functioning congruently and aligned to the welfare of the person.

Some forms of imagination "speak to" the movement brain (body schema) more than others. "Speak to" here means facilitate useful information flow to liberate movement from whatever thoughts, habits or inhibitions might be getting in the way, as well as inspire the movement brain to find new answers to meeting demand.

What forms of imagination speak to the movement brain? Helpful forms of imagination build a sense of location, differentiation of body map, and differentiation of the space around the body. For example, imagining a sense of weight in the body speaks strongly to the movement brain because a sense of weight is an essential part of the calculus for motor control. Feeling the location of a bony articulation is a refreshing of the body map; the map becomes clearer and more differentiated.

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Imagining a direction, a vector in space, also refreshes the movement brain's map of the space around the body. When you imagine an arrow pointing up from the top of your head, or as an extension of one's tailbone pointing down and back toward the ground, you are imagining directions in space, you perceive imaginary vectors. These imagined arrows or vectors suggest to the movement brain a directionality, which in turn helps to organize movement. There are cells in the brain that are made to respond to directionality, place, and relational location.

What other examples of imagination help with movement? One can learn to imagine sensations in the skin of one's hands and feet, or arouse an accelerated sense of distance or an accelerated sense of weight. It becomes easier to do this with practice. At first, the conscious experience is vague and intermittent. With time, the experience becomes stable, clear, and easier to arouse.

Sensation can be aroused with touch or with movement. In addition to the sensory value of touch, another aspect of imagination is aroused within the central feature of SI – fascial manipulation. Fascial manipulation is a way to inform the body's map of itself through its most efficient portal of information – the fascial net. When fascial manipulation is accompanied by client movement, even more information is imparted. Slow movement is most effective, and if preceded by imagined sensory and directional perceptions makes the information package especially attractive to the movement brain.

Helpful forms of imagination can also be, and often are, aroused from remembered experience. We may remember how it felt to be heavy someplace in the body. We remember the feeling of being touched physically, or "touched" expansively by the spacious night sky. When we evoke a memory of a sensory experience, our brain can bring it alive in present time, as a sensory event. Once aroused, the sensory experience informs the body at the subcortical level in the same manner as sense perception. It is, in fact, sense perception.

What's not helpful for movement? Not all forms of imagination are helpful to the movement brain. Some forms of imagination remain mostly in the realm of thinking. For example, as you shop at the supermarket, if you imagine items missing in your refrigerator, that doesn't inform the movement brain. It helps you get needed food items. It may motivate you to start moving more quickly with your shopping cart, but your quality of movement probably won't improve. Your movement might even look more effortful, as you concentrate on mental images of groceries. Usually movement that looks effortful is movement that is inspired by thinking about a goal or an image. Goal-oriented images are not the province of the movement brain.⁶ They are they province of the thinking brain and they serve us in many important ways. We don't want to throw away goals and images, but we do wish to liberate coordination from their dominance.

At the same time, when we choose to pay attention to a sensation we are engaging in a cortical process. Choosing to direct one's perception is a cortical process. Cortical processes are not the enemy of movement.

When we use thought to arouse a remembered scenario, one that we feel positive about, or one that arouses a desired emotion, the theatre of our imagination can help change the meaning of a space or object. It is a multi-step process. We associate to a positive scenario and then feel the impression of that scenario. As we sense the effect of our imagined scene or object, our availability to movement changes. For example, if a client has trouble standing up from a chair, we might invite him/her to imagine a desirable object or person in the space. If the client takes the time to feel a sense of enticement in the path of movement, the coordination to stand up will benefit.

We also use cortical activity to recognize and record sensory experience in order to remember it, so we anchor a change in movement or posture. "What do you sense in your body?" is a request for the client to more fully inhabit a shift in coordination. Integrated memory (or explicit memory⁷) depends on cortical processes to put experience together and find a place for it within one's life narrative, so there is organization and coherence. Using our thinking mind to arouse imagination is an example of cortical activity that supports the subcortical activity in the movement brain. Usually the best use of the cortical brain in movement is when we choose what we pay attention to. We can choose how we

use our imagination, in what circumstances, and we can choose the forms of imagination that best complement a movement inquiry.

Imagination is a mind/body skill. It is a skill that is learned with trial and error, and with repetitions. Our skill grows through finding pleasure in the results because it motivates us to practice.

It's helpful to experience how different forms of imagination speak more or less effectively to our movement brain. As practitioners we have the opportunity to experience how language supports a client or student in arousal of his or her imagination, in forms of imagination that help movement. We have the opportunity to learn what kinds of language inspire creativity and ease, and which kinds of words and imagination make it all harder.

The more richly we develop facets of our perceptive imagination, the more adaptive capacity we gain for meeting challenges in all aspects of daily life. Most of the coordinative skills involved in motor control, which help with core stability and ease in posture, rely on skills of imagination.

For more discussion on the perceptual components of SI go to: www.resourcesinmovement.com and choose Article Archive.

Endnotes

1. Frank, K., "Posture and Perception in the Context of the Tonic Function Model of Structural Integration," *The 2007 Yearbook Of Structural Integration*. Missoula, MT: IASI, 2007.

2. Gibson, J., *The Senses Considered as a Perceptual System*. Westport, CT: Greenwood Press, 1983.

3. Mabel Todd, who wrote *The Thinking Body*, founded the study of Ideokinesis, which is the skill of body imagination. Todd was a major influence on Ida Rolf. [*The Thinking Body: A Study of the Balancing Forces of Dynamic Man* (reprint of 1937 original, with a preface by Lulu E. Sweigard). New York, NY: Dance Horizons, 1972.]

4. Our body map includes the peri-personal space around the body. The brain has many maps of the body at a sensory and motor level and they inform the movement brain about the potential for movement. The more differentiated the map, the more options for

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movement and the more opportunity for optimized and nuanced movement.

5. Frank, K., "Body as Movement System: A Premise for Structural Integration." *Structural Integration: The Journal of the Rolf Institute,* June 2008.

6. To be sure, all movement requires the function of our body schema / movement brain. When we construct a movement with a dominance of thought, however, we make

the distinction that we have interrupted some of the executive function of the schema with image.

7. Explicit memory is memory in which an event has been integrated at a conscious level. Implicit memory doesn't require that the experience has been integrated at the conscious level. Daniel Siegel is a good source for information about how this works in his books and audio about brain development. Trauma therapy is an example of helping to integrate implicit memories so they become explicit.

HOW WE DEVELOP AS ROLFERS[™] – AT OUR SCHOOLS Becoming a Rolfer:

An Instructor's Overview, a Student's Project, and Mentoring

Introduction

The following collection of articles offers insight into part of the current process of training Rolfers at the Rolf Institute[®] of Structural Integration (RISI). The starting point was a Phase II project by then-student Vivian Gettliffe. Her instructor, Thomas Walker, suggested that she write up her class project to submit to *Structural Integration: The Journal of the Rolf Institute*.

The timing coincided with our theme on professional development, and we encouraged Gettliffe, her instructor, and her mentor Darrell Sanchez to develop an article giving us not only Gettliffe's project but also a window into the broader context of the educational objectives of the Phase II projects and the optional mentoring chosen by some Rolfers-intraining during their studies at RISI.

Anne Hoff, Editor-in-Chief Robert McWilliams, Managing Editor

An Instructor's Overview of Phase II

By Thomas Walker, Certified Advanced Rolfer™, Rolfing[®] Instructor

Phase II of the Rolfing Structural Integration (SI) training is entitled "Embodiment of Rolfing and Rolf Movement[®] Integration." The purpose of the class is to learn at a beginning level about "the Recipe," theory, touch, therapeutic climate, movement, etc. that make up all that we do in Rolfing SI. As an instructor, one of my main purposes is to not only teach these technical aspects but also how to *be* a Rolfer. In what ways do practitioners need to transform within themselves to be able to be most authentic and efficient in our work? As many of you remember, the format of four days per week for eight weeks makes the class very intense, not only because of the amount of material, but also because of the intrapersonal and interpersonal "uncoverings" that can occur. Students are giving and receiving thirteen sessions in seven weeks, which is something few of us would do in our private practices.

In addition to the classroom learning, students are also given outside assignments

intended to enhance their understanding of the work. After the conclusion of Phase II, students must write a paper about the Ten Series and the three movement sessions learned in Phase II. This assignment helps deepen their understanding of what is occurring during the series and movement sessions, how the principles of Rolfing SI apply to each session, how the functional goals of each session reinforce the structural goals, and how the sessions build on each other and flow together.

Students are also asked to give an in-class presentation during Phase II relating to one of three topics - diaphragms, tonus, or the feet. At times, students may ask to research and present something of special interest relating to our work that is outside of these topics. The purpose of these presentations is to clarify the anatomical information learned during Phase II, develop critical thinking skills, and give students the experience of doing oral presentations to a group, a valuable skill for practice building. The presentations let instructors see how well students articulate their knowledge and experience of the class, embody the series, and express just what is it that we do in Rolfing SI sessions.

The following is a summary of such a presentation by Vivian Gettliffe, in which she researched what she calls the "trans-structural" aspects of the students' experiences of receiving the work. The inquiry that Vivian undertook and presented was very informative, and I encouraged her to publish it in *Structural Integration: The Journal of the Rolf Institute*. Much of what Vivian presents is understood by experienced practitioners, but she has added information from a quantitative survey to verify what each of us has experienced in our own beings and those of our clients.

A Student's Project: Survey of Trans-structural Experiences in Phase II

By Vivian Gettliffe, Certified Rolfer™

Editor's note: The following article is based on the author's class project conducted during Phase II of training in Rolfing[®] Structural Integration (SI).

Introduction

For the Phase II required presentation, I surveyed my classmates concerning nonstructural or "trans-structural" effects of Rolfing SI received from their classmatepractitioners during the eight weeks of Phase II training. By the time we were given the assignment, it was clear that the Rolfing process had impacted many students in ways that went far beyond their physical structure: bringing up significant life experiences, deeply moving their emotions, and transforming perceptions. Our instructor, Thomas Walker, and his assistant, Heidi Thrasher-McReynolds, helped many student-clients and their student-Rolfers to work through these experiences together. They also helped us to process and learn from the experiences as a class, placing them into a larger perspective and suggesting ways to support future clients who might undergo something similar. I am working concurrently toward a master's degree in counseling, and decided to learn more about my classmates' experiences and the implications for my future practice through questioning them via an anonymous survey.

Our class of sixteen responded to the survey after the seventh session of the Ten Series had been received. Although the percentage results cannot be extrapolated to Rolfing clients in general due to the small sample and the unusual context, they were informative nonetheless. I presented the results to our class in terms of implications for our future practices. Afterward the survey was discussed with Darrell Sanchez, a Certified Advanced Rolfer and licensed professional counselor who has served as my mentor, supervising my work with clients between Phases II and III (see "Through the Lens of Experience: Mentoring on TransTable 1: Trans-structural Experiences of Student-Clients

Experience Reported	Number of Students Reporting the Experience	% of Class Reporting the Experience
Sympathetic Activation	9	56
Emotional Release	8	50
Emotional Upset	6	38
Unsolicited Memories	6	38
Shifts in Meaning	4	25
Changes in Behavior	4	25
Unusual Thoughts	3	19

structural Experiences" on page 10). This further helped frame the results within the larger perspective of how Rolfing sessions may unleash transformative processes across many channels of human experience.

To see the survey, go to www.pedroprado. com.br. What follows is a summary of the key results and what I felt I learned from them, as summarized for my classmates.

Lessons Gleaned from the Survey of Sixteen Phase II Students Who Underwent Sessions One through Seven

Some of our clients are likely to experience effects from Rolfing sessions that go beyond the structural or physical (referred to here as "trans-structural experiences").

Table 1 shows what the students reported experiencing. Eleven of the sixteen student-clients, 69% of the class reported at least one trans-structural experience: either sympathetic activation, emotional responses, unsolicited memories, shifts in thought or understanding, or shifts in behavior. (Note: at least two more experienced some of the above in relation to Rolfing experiences outside the parameters of the survey, either with an outside practitioner or during a later session, pushing the percentage up to 81%.)

We can expect some of our clients to experience sympathetic nervous system reactions in response to Rolfing SI.

Of the respondents, 56% experienced sympathetic activation of the nervous system at some point during the first seven sessions as a response to the Rolfing work.

Sympathetic activation may manifest in a variety of ways, some of which are easier to recognize than others.

See Table 2 for a list of signs of sympathetic activation and the number of studentclients who experienced each

Watch the breath; be ready for the tears.

Over half of those experiencing sympathetic activation noticed that their breathing accelerated. Of those reporting indications of discharge (the dissipation of energy released during sympathetic activation), 80% experienced deep breaths. Of those

Table 2: Signs of Sympathetic Activation Experienced by Student-Clients

Sign of Activation*	Number of Students Experiencing Sign	% of Class Experiencing Sign
Dizziness	8	89
Faster Breathing	6	67
Increased Heart Rate	6	67
Nausea	5	56
Shaking	3	33
Sweating	3	33
Chills	2	22

*Additional signs reported by individual student-clients included cranial pressure, breathing difficulty, twitching, loss of balance, and drowsiness.

reporting sympathetic activation, 55% experienced crying as part of the discharge.

Some clients are likely to take transstructural experiences, including sympathetic activation, home with them.

All types of trans-structural experiences included in the survey occurred both during and outside of sessions. Of the forty-six total trans-structural experiences reported, 46% occurred during the session and 54% occurred outside of the session. Emotional release, emotional upset, and unusual thoughts occurred more often during sessions; unsolicited memories, shifts in meaning, and changes in behavior occurred more often outside of sessions. All types of sympathetic activation included in the survey occurred both during and outside of sessions. Of the thirty-six total experiences of sympathetic activation, 75% were experienced during a session, and 25% were experienced outside of a session. It is interesting to note that some studentclients never revealed their trans-structural experience to their practitioner.

When we touch our clients, we have our hands in their histories.

Of those experiencing sympathetic activation, two-thirds cited trauma or memories of past events triggered by touch as a factor in the activation. This is over onethird of the original class of sixteen! Almost 40% of the class experienced unsolicited memories as a response to the Rolfing work.

Safety matters.

Of those reporting a trans-structural experience, 36% checked that "the safe context led to an experience of change or healing," and 80% of those reporting a positive outcome checked this same statement.

The relationship matters.

Just under half of those experiencing sympathetic activation cited stress in the relationship with the practitioner as a factor in the trans-structural experience. In all cases where a negative or mixed outcome was experienced, stress in the relationship with the practitioner was identified as a factor. This was only true in 20% of the cases where a positive outcome was reported. How the practitioner responds to the transstructural experience makes a difference.

Highest satisfaction with the handling of the experience was associated with:

- allowing the experience to cycle through naturally versus attempting to end it;
- switching to a more grounding touch or removing hands entirely; drawing the client's attention to physical sensations, or engaging the client in conversation. Students' written comments also validated the above approaches as most helpful. Also reported as helpful were walking as a means of grounding, encouraging the client to keep his or her eyes open, and helping the client to remain aware of the present moment.

Lowest satisfaction was associated with student-Rolfers who continued work without regard to the client's experience. Suggestions for improvement included better awareness of the client's autonomic response, removing hands entirely, and improved practitioner self-awareness and communication.

Structural changes can lead to significant positive emotional change.

Of those who experienced a positive outcome of their trans-structural experience, 80% included structural changes as a causal factor, and 80% of those experiencing a positive outcome felt that the trans-structural experience led to significant emotional change.

Of those reporting a trans-structural experience, 45% reported a positive outcome, 27% reported a mixed or negative outcome, and 27% were neutral or did not report the outcome.

It is interesting to note that only 27% of those who experienced a trans-structural effect during the first seven sessions felt that it had been fully processed at the time of the survey. Might this percentage have been different if the respondents had received the final three integrative sessions before responding to the survey? Or perhaps this is in line with Darrell Sanchez's comments from the discussion that follows ("Through the Lens of Experience: Mentoring on Trans-structural Experiences," page 10) about an inner transformational necessity that is always present in a tensional balance with our stability. In other words, perhaps the process of self-organization, once engendered, is always in progress.

Conclusion

Engaging in this project while the Phase II Rolfing work was still in progress allowed me to tune in to non-structural layers of our group experience that might otherwise have gone under the radar. It also alarmed me somewhat, as I wondered to what extent my interactions with future clients might trigger some of the same surprising reactions. The project and discussion with Darrell Sanchez that followed confirmed for me that training in counseling or psychology is a good adjunct to SI training; if these other channels of human experience are so affected by changes in our structures, then I want to be as prepared as possible to support the client in those aspects as well. Even before the counseling training is completed, I believe what I have learned here will contribute to a greater awareness, sensitivity, and respect for what my clients may be experiencing on many levels, even if they choose not to reveal it. Hopefully this increased awareness will translate into a capacity to offer them the resources and referrals that will help them to obtain the best possible long-term outcomes from their investment in the Rolfing series.

The assignment and subsequent discussion increased my curiosity about the Rolfing principle of *holism*, vividly illustrating how our bodies, minds, and emotions are one. During Phase II, we learned to visit the "edge" zones of our clients' bodies, the junctures between dense and spacious, distressed and resourced, dysfunctional and organized, immobile and mobile structures. It seemed that by bringing clients' awareness to these contrasting elements through touch, their bodies responded with release and transformation. It's intriguing to think that this concept also applies at emotional or conceptual junctures of our lives. Perhaps such junctures are not only affected by Rolfing sessions, but are, in a way, different sides of the structural junctures - places where old patterns encounter new possibilities. I am learning that as our structures change, evidently these other edge zones of our lives also shift and evolve, offering changing yet fertile ground for transformation in the ongoing process of adaptive self-organization.

Through the Lens of Experience: Mentoring on Trans-structural Experiences

By Vivian Gettliffe, Certified Rolfer™ and Darrell Sanchez, Ph.D., Certified Advanced Rolfer

Editor's Note: Mentoring is available to Rolf Institute® of Structural Integration (RISI) students as an optional part of their training, usually between Phases II and III of the basic training. The following article/discussion is a product of the mentoring relationship between Vivian Gettliffe and Darrell Sanchez. Mentoring is also pursued by many Rolfers post-certification, as will be discussed in later articles in this issue. (Please let RISI know if you are interested in receiving or offering mentoring.) Below, Gettliffe and Sanchez share with us a discussion of Gettliffe's Phase II project, prefaced by their individual remarks on the mentoring process.

Preface: Remarks on Mentoring

A Mentee's Experience of Mentoring – Vivian Gettliffe

Mentoring between Phases II and III is recommended, but not required, by the Rolf Institute[®] of Structural Integration (RISI). Like many other students, I have turned for support in this educational experience to a local Rolfer who has worked with me and my family. Boulder Rolfer Darrell Sanchez (who discusses the survey in the interview "Through the Lens of Experience") supervised my Ten-Series work with practice clients between the two training phases. The format for the mentoring has been quite varied, ranging from extended assessments, to my observing his work, to his observing and instructing me as I work, and quite often, when appropriate, to "fourhands" work. This learning experience has been subsidized by the clients, who were happy to have the Ten Series and Darrell's expertise at a discounted rate. It has been great for me to know that even if I have a moment of bewilderment, or get bogged down, he will get the client out the door in optimal condition!

I chose to work with Darrell because of the double layer of expertise he brings to the Rolfing SI process. As is evident in "Through the Lens of Experience," even when he is not directly addressing the client's nonstructural "channels" of experience, he is acutely aware of and responding to them with sensitivity and support. It has been enriching to witness this aspect of his work during the mentoring sessions with clients.

In addition to these hands-on mentoring sessions, I have also called on Darrell at critical junctures of my training for other types of support. His encouragement helped me through the sense of panic I felt in Phase I when I couldn't feel what everyone else seemed to be feeling under the skin and my heart would start pounding the minute I touched someone. At the beginning of Phase II, I felt so devastated by another student's negative feedback that I didn't think I would be able to continue. Again, some supportive words from Darrell in an email made all the difference.

Darrell has received extensive lists of educational objectives related to the mentoring - not from RISI, but from me. After discussion concerning these objectives, we signed an agreement related to the mentoring and its format. Since then, he has been bombarded with revised and expanded objectives, as well as questions and comments related to this learning experience. Unfortunately, it has now become clear that it will take a lifetime to achieve my educational objectives. Some of what we have been working on between Phases II and III includes use of time, visual assessments, use of active and passive movement in conjunction with touch, ergonomics, and questions regarding direct or indirect work, including how to gauge which is appropriate in a given moment with a given client.

I don't know any classmates who have made as much use of the mentoring as I have. It has been a significant expense added to the cost of the Rolfing training. However, in my case, I don't see it as something optional. Without the support and encouragement my mentor has provided, it would have been much more difficult to make it past the stumbling blocks I ran into in the first two training phases. I've heard Dr. Ida Rolf's comments about tolerance for uncertainty repeated by many Rolfers, yet this is something that comes easier for some than for others. Thanks to the extra boost from the mentoring, I'm hopeful that by the end of Phase III my underlying base of confidence (one end of Darrell's "polarities") will be sufficient to allow me to begin practicing this wonderful art, even in the face of everything I haven't yet mastered and knowing I will be a novice for years to come.

A Mentor's Perspective on Mentoring – Darrell Sanchez

Over the years I have served as mentor for a number of Rolfing® Structural Integration (SI) SI students. The experience has ranged from supervising one or two sessions to providing much more extensive support. The students reported that these experiences were of value to them, and I believe that to be the case. Mentoring fills in gaps by addressing some of the myriad questions that arise from basic training but cannot be answered sufficiently due to time constraints. It also provides guided and focused practice of practical skills, and practical applications of concepts that are introduced in basic training but addressed to only a limited extent.

As students, practice on one's own or with fellow classmates certainly has value. That practice naturally leads students to deeper perceptions and stimulates a desire for insightful answers that practicing alone or with another student cannot provide. Mentoring fills this need in addition to honing seeing, touching, and listening abilities. The mentoring process accelerates the assimilation of both knowledge and skills, bringing students much farther in their ability to perform Rolfing SI than if they were to proceed without it.

At the same time, the mentor also benefits from this archetypal relationship. Experienced practitioners often feel a need or desire to teach or guide others who are motivated to acquire insights and abilities perceived to be valuable. Mentoring is one way to accomplish this. In the process, the one who is mentoring inevitably learns and gains from the relationship as both mentor and student point themselves in the direction of mastery. The mentor may truly have gained some knowledge and skills that could be nobly imparted to the one seeking learning, but the mentor also has a working edge. As mentors, not only must we develop further clarity in the conceptualization and expression of our approach to the work, but we are also challenged to examine the information conveyed within the wider context of the

professional domain, so that our teaching or modeling is clear, accurate, and measured against a larger field of Rolfing experience than our individual practices.

Balance is the key as the student's questioning calls us to continually weigh our approach and interpretations against those of the field at large. As our work is contemplated by the student, we cannot help but reflect on and refine it. In the archetypal sense, the mentor is always learning and always beginning anew as if a pupil. The student is always a source of unexpected insight.

A Discussion on the Trans-structural Survey

Editor's note: This discussion concerns Gettliffe's Phase II project, discussed in her article "A Student's Project: Survey of Transstructural Experiences in Phase II" (page 8).

Vivian Gettliffe: What is underlying all of these "trans-structural experiences?"

Darrell Sanchez: The so-called transstructural experiences your survey describes reflect a process of movement and transformation happening across the whole person, not just the structure. What attracts us to Rolfing[®] Structural Integration (SI) as students and keeps us interested and excited as Rolfers is this inherent and profound potency of transformation that exists in [the] Rolfing [process].

When you touch someone's structure you're tapping into all the channels of human experience that comprise [the person's] wholeness: the felt sense, movement, sensory perception, conscious thought and interpretation or meaning, emotional experience, imagination or imagery, social connection, personal and generational history . . . We artificially piece things out so we can talk about and understand them, but in reality there's a dynamic unity. One thing affects the others.

There's an essential drive toward transformation, a transformational necessity that is often unleashed across these channels as structural integration releases rigidity and creates room for movement. It's an inner force [that] involves the conscious and unconscious mind working together to produce change in the context of primal polarities.

VG: What do you mean by "primal polarities," and how does the Rolfing SI fit in?

DS: Creative transformation is the result of an interplay of polarities. Life is not a fixed state but a play between motion and stability. Embracing and living with a dynamic balance between motion and stability, opposites, is characteristic of health and one way of describing the creative life. The interplay of stability and motion helps us to feel secure while allowing us to satisfy our curiosity, to explore and interact with our environment.

The problem arises when there's too much of one or the other instead of a relative balance of both, so you get someone who's bogged down in rigidity and fixation, or else dispersing too much into chaos and instability. Physical compensations in tissue help stabilize a structure, but they can also prevent optimal movement or flow of energy. In releasing these and promoting organization of more chaotic structures to more stably support flow, Rolfing [SI] invites a dynamic tension between these two forces that brings about a new level of a more fluid whole being, one that can relate through many channels to the interplay of these polarities. Creative transformation begins to express itself across our whole being, including in the ways your survey describes, when structural changes allow us to hold the two [polarities], and they play, feed off of each other, inform each other. We don't get too dispersed in chaos or too bogged down in order.

VG: So you think the results of the survey are more about the effects of Rolfing SI in general than the context we were in as students?

DS: In a context like your [Phase II], there's an unspoken group agreement about going to a deeper level with the process. There's a single intent, which is learning about the Rolfing experience, so it's to be expected that the work would be very impactful. In a way, I'm surprised that the numbers from your survey were not higher. I assume this was not the first Ten Series for most of you. Maybe more movement and transformation occurred during the earlier Rolfing experiences, which is probably part of why you all decided to become Rolfers to begin with.

Transformation, meaning fundamental change, is inherent in Rolfing SI. We are agents of change for people's relationship to gravity, and that has profound effects. If I'm facilitating properly, proceeding through a basic series with respect to Rolfing SI, if I do my job, then everybody has some kind of new awareness or insight, change of meaning or perspective, self-reflection, unsolicited memories or emotional releases, sometimes even an existential crisis where the person explores or reconsiders his or her reasons for being or purpose in life. That's what I would hope for; it tells me that the series has brought the client to a new way of being embodied in the world. That happens, not 100% of the time, but a lot more than 50%, which is higher than your percentages.

VG: Can you describe more specifically what these changes would look like in a client's life?

DS: For example, a person might be inspired to re-evaluate his or her relationships . . .

VG: Some of our teachers mentioned clients getting divorced after a Ten Series. I hate the thought of clients getting divorced due to Rolfing sessions with me!

DS: I can't tell you how many times that has happened. Rolfing [work] is a catalytic process. It's uncanny how many people come to the process for whatever reason, and somewhere through the basic series they say, "I'm gonna get a divorce," or "I'm gonna finally . . ." do whatever, fill in the blank. Whatever they were waiting on, whatever was in a state of inertia, starts to move and change. Finding some new purpose in life, finally quitting a job that wasn't going where it needed to

Take any of the channels. You're thinking about life differently (the belief channel). You have insights into your grief, sadness, anger (your emotions), or you feel more alive in your body. Or suddenly you can imagine something is possible that you didn't think was close to being possible. Or you realize you need to change your diet...

VG: Or buy new shoes!

DS: . . . or buy new shoes, or take that trip to Argentina.

VG: You make it all sound so positive, but what about the activation? Isn't that typically trauma-related?

DS: If we look at the world we live in, everyone is overwhelmed at some level. Overwhelm is the definition of trauma, and yes, it often equates to more sympathetic activity.

VG: Our class sure seemed to experience a lot of activation, and two-thirds of it seemed to relate directly to people's pasts!

DS: The body is a kind of file cabinet for experiences. All experiences, our relationships, everything that feeds into our senses, what we see, hear, taste . . . those experiences, those memories register in the cells and tissues of our bodies. We adopt a certain posture or attitude toward the world based on the accumulation of those stored experiences combined with our present perceptions. We get used to walking, standing, being in a certain way, never opening those files. Then you go into the Rolfing training, and maybe for the first time, you're tapping into areas that haven't been tapped into before, opening files you didn't know or had forgotten were there.

VG: A research article from one of my counseling classes seemed to imply that when trauma-based sympathetic activation occurs, there is a six-hour window within which either reconditioning or reinforcement occurs. If a client gets activated and the activation isn't promptly processed in a way that helps to resolve it, then it seems like there is some retraumatization.

DS: Retraumatization and bringing something to the surface are two different things. I've had issues come up for me when receiving work that I may follow up with for days or weeks at a time. Was I retraumatized, or did it help facilitate the clearing of old, traumatic material that takes some time to resolve? Typically, in the creative process there's a feeling of discomfort, dissonance, confusion, or pressure that precedes the emergence of novelty, but this doesn't necessarily equate with trauma. If we are resourcing our clients, and if we ourselves are a resource for them in the process, then we are facilitating change to the traumatized material rather than retraumatizing them.

VG: I definitely don't want to retraumatize anyone!

DS: The chances of retraumatizing are much less than you think, not as scary or as likely as you think. Even so, it's good to keep that thought in our minds, that humbling idea that yeah, I have the potential to retraumatize this person. That's one side of it; the other is, if we don't go to where the change needs to happen, there will be no change. The definition of transformation is to change the nature, function or condition of something. That's why people come to

us, to Rolfing SI. If clients are coming in for the series, then ideally they're coming in to change the nature, function or condition of their being.

VG: Consciously they're coming in to change the nature, function or condition of their structure.

DS: Or maybe they just want to get their shoulder or back fixed! You tell them, "we can work on the shoulder and maybe it will get better, but we have to start working on other things if you really want it to change." You educate them about the series, and then it's up to them. If they let you, you begin to address their whole structure. You change their ankle and leg, and that changes how they use the leg, how they relate to the ground, how they're living on the earth. Before you know it they're into brand new territory, into new beliefs, affects, interpersonal relations, self-images.

VG: What if one of my clients does get into a traumatized space in the course of our work together? What can I offer, how can I help as a Rolfer who doesn't yet have the training in psychotherapeutic or traumaresolution processes?

DS: Offer references. Refer to people who do have the training. In the context of the session, slow things down, get [the client] back to the present moment. Don't push your agenda. Make sure [he or she is] ok and feels ok. Go back to the approaches you described that Thomas Walker suggested in your [Phase II] training: draw the client's awareness to [his or her] felt sense, engage conscious thought processes, offer a supportive, connected relationship. Offer resources and *be* a resource for the client.

VG: I was surprised that activation took the form of dizziness so often, and was also surprised by it taking the form of nausea. Have you experienced this in your practice?

DS: Yes. As people's bodies reorient, movement channels open up, there are new proprioceptive sensations, centers of gravity shifting . . . suddenly your head is sitting differently on your spine. Or you're able to have this wide peripheral vision that you've never had before. How many people go through life looking down, and suddenly they're looking to the horizon! Or people come out of a rigid holding pattern into a spine that's moving. This is physiologically disorienting, not to mention conceptually. Dizziness and nausea are motion sickness types of symptoms. Hopefully the Rolfer helps to get them balanced and grounded, and they reorient quickly. It's not necessarily a bad sign if it doesn't persist.

VG: Beyond the question of trauma or activation, how can I understand and support creative, transformational processes happening in my clients?

DS: If you experience these processes in your own life, clearing and understanding your own material, then it will be easier to recognize when someone else is changing.

VG: What might the signs of change be, for example?

DS: When [clients] come in and start sharing their experiences. They start to have memories. Or they may say, "I don't know what's happening. Is this common?" or "I feel like I'm standing differently." "I feel like I'm relating to people differently," or "I feel like people are relating to me differently."

VG: How often do you think people have experiences like the survey brought out, but don't report them to their Rolfer?

DS: Often. They may not be open about it. Outward changes are usually recognizable to an observer. Inward changes to our being aren't so easily identified. Others may not always see the alterations and evolutions of our perspectives, perceptions, cognitions, emotions; changes to the inner felt spaces of our lived experience, to how we experience ourselves and our relation to the world. If the Rolfing [work] is having an impact on the client's structure you can pretty much assume that these other channels are being affected at some level as well, even if the impact isn't fully comprehended.

VG: Going back to my question about how to understand and support these processes in a client

DS: Remember that the client is not the only one working with this creative, transformative edge. We as Rolfers are also working with that every time we have a session.

VG: How is the Rolfer working with a creative, transformative edge?

DS: The Rolfer must hold any number of polarities in the interaction with the client, all the while inviting and responding to the client's body's creative process. Some of these polarities might include direct/ indirect, asking/listening, suggestion/ response, weight/space, stability/mobility,

mind/body, structure/function, fascial/ fluidic, energetic/physical, support/ freedom, active/passive, stillness/flow

To understand the client's experience you have to undergo your own transformations. You have to experience the essential transformational necessity yourself . . . the play between chaos and order. You have to be creative, to practice the ability to hold two polarities at once, to be able to say it's not "either/or". What would it be like if I held both direct and indirect, yin and yang, chaos and order, stability and motion? We become the ground that resolves those polarities by having the ability and experience of holding them. And then you will recognize it in your clients; you'll see what they're struggling with. It's not always easy to be in the presence of ambiguity and dichotomy, holding onto one's strong beliefs while still being open to receiving new information.

VG: So how does one support people going through this?

DS: One of the biggest of these polarities in Rolfing SI is the old way versus the new way of being embodied in the world, letting go of the compensation and accepting and embodying the emerging order. The Rolfing process is about that very creative thing. How do we support and how fast do we take away the compensations while encouraging and supporting the emerging new organization.

VG: In our training we're learning how to do that from a structural standpoint.

DS: It's already a lot to learn. It's not in the scope of the basic Rolfing training to teach you how to do this from a psychological standpoint.

VG: Is it enough to get it right structurally for it to happen well in the other channels?

DS: It sure helps to have the structure more attuned to gravity. It goes back to us being in the world as physical beings. If we can experience confidence, harmony and joy in our bodies, you can imagine how that reflects on the other channels. But fixations in the other channels can also be obstacles. How well it translates to other channels within the individual depends on many factors and perhaps other processes: psychological, spiritual or philosophical, for example.

VG: In that case, how else can you support the client?

DS: Anything that supports and contributes to the health of the whole being. Again, offer and encourage resources. Within your scope of practice this could include functional movement and repatterning, talking with [clients] about the process, putting them at ease about changes (because we are going for changes; that's what it's about!). Finding practical ways to help them with the changes in their lives: ergonomics, referring them to other types of practitioners such as for counseling, nutrition advice, and so on.

A big part of Rolfing SI is educating, pointing out to people the nature of the process and where they are in it, to some degree normalizing, reassuring them about the creative healing process. Educate and resource the person at every stage and every step so that he or she begins to own the process.

VG: Is there anything else that this survey brings out that you feel would be useful?

DS: Understand that the very fact of being a student, and especially a Rolfing student, puts you in that space of creative, transformative movement that's reflected in your classmates' experiences. Look at the polarities you're dealing with: "I think I know something I don't know anything." "I just learned something, and now I have more questions than I had before." "One moment I feel confident, and the next moment I feel clueless, like I shouldn't even be touching anyone." "How am I supposed to decompensate these fixations at the same time as establishing this emerging order?" If you can live with these contradictions, creativity and artfulness will eventually emerge from them.

VG: What if you're always on one side of those polarities?

DS: Thinking you know something is a trap. Thinking you know nothing is a trap. Don't get too attached to either of those. That's where our own work comes in, the practice of sensing where we are with respect to the polarities. If you can hold both of those perspectives at once it can lead you into a potent state of awareness.

You're entering a field which requires tolerance of uncertainty. To be available to the creative surge one must do the work, tend to the details, and sit in the uncertainty of not knowing. The culmination of the creative process arises from uncertainty and the tension of polarities in a moment of wonder, and in that moment is a revelation of how to proceed. The moment of wonder is like a holographic grain of sand or multidimensional puzzle piece revealing the glory of the greater view.

I don't know when my clients will make the transforming breakthroughs or if they will link their realizations to grand insights. I don't know what the holographic grain of sand is or when and how it will arrive, but I'm willing to continue along an uncertain creative path to see, hoping for that divine emergence of meaning and understanding that is creativity, and that transforms both self and other.

VG: Are you talking about your Rolfing work or your counseling work?

DS: I'm talking about the creative transformational process that plays out in the wholeness of the person in response to the experience of Rolfing SI and in other modalities as well, and that is also playing out in the experience of the Rolfer. It involves an appreciation and surrender to a force immeasurably vast and incomprehensible to our conscious minds, a divine force that brings all things into being. We start to see beauty. We have this capacity to see and appreciate and feel this emerging beauty as someone's being is coming into physical expression in this [structurally integrated] way.

Rolfing SI forces us to really be in this world, or at least confronts us with the reality that we are here as physical beings in this world, the world we have right now. We're in a field of gravity; we must deal with it. Stop fighting against it. Get in tune with it. When our body gets in tune with the field of gravity, this opens us up to dimensions of energy we haven't imagined yet; we can stop using our energy to fight gravity. It opens the door to a way of being in our bodies that will probably completely astound us down the road. What these bodies could be . . . we haven't imagined yet what they could fully be. We're barely scratching the surface with a process like Rolfing SI. It's bigger than Ida Rolf. It's something so magnificent and beautiful. To be humbly in that, to have the honor of witnessing and even facilitating that inspires a childlike awe and appreciation for something beautiful that is bigger than us.

VG: What is it? Where does it come from?

DS: Unanswerable. I call it the Divine. It's the beauty of Creativity.

The Advanced Rolfing[®] Training

Completing the Arc of Study

By Michael Murphy and Robert McWilliams, Certified Advanced Rolfers™

Authors' note: This article stemmed from an informal phone conversation about the advanced training, which took on slightly more of a mantle of formality, if not perfect syntax, in an interview, later. McWilliams went on to attend the 2010 advanced training with Sally Klemm, Gael Ohlgren, and Lael Keen in Kona, Hawai'i.

Robert McWilliams: I wanted to ask you about the advanced trainings because of your long involvement as a Rolfer[™] and a teacher, having assisted, then co-taught the advanced training three times already for the Rolf Institute[®]. Could you tell me a little bit about why the course is structured the way it is?

Michael Murphy: Ida Rolf taught the class in a six-week outline; six weeks of four days each. For a long time, that was the way it was done. It was as if "because she did it that way, we're doing it that way." I think it was Jim Asher who initially came up with the idea of splitting the training into two parts. He certainly talked about the idea the most. Jan Sultan actually taught the first one in two segments. The idea was to reduce the time for the instructors to be away from family and their home life, and it also allowed the students to be away from their families and home life for a shorter period of time. I don't know to what extent they realized it, but certainly from what we saw, in the first iteration of the training, people learned so much in the first segment, that by the second segment, they had actually integrated a lot of it. And they're working at a much higher level. So, twenty-four continuous days of training did not lead to as advanced a level of practitioner as did two segments, in our judgment at the time. That means a little more airfare for the students going to . . .

RM: . . . Hawaii!

MM: But I think the learning is really expanded . . . the learning potential is much greater.

RM: I wanted to ask you: What types of questions do you think one should bring, and what kind of an attitude should one

bring to an advanced training? I will be attending one soon, and I really wanted to ask you about that.

MM: Frankly the most effective thing is a certain level of frustration. When your practice is big enough, and full enough, that you're starting to see a bunch of people with a wide range of problems, you come to class saying "what I do about this problem," or "I can't get the transmission to go through this joint," which really means "I need some new tools, new approaches, new ways of thinking." That experience, and that hunger for more learning, make a huge difference. So, we time it in terms of numbers of years of experience, and numbers of days of continuing education. We probably should tie it to numbers of sessions "in your hands" as well.

RM: When I think of the advanced training I think of learning about post-ten work, and a focus on the five structural elements. What are some of the standard curricular foci of the advanced training? Is it that you want to learn, for example, an axial session really well, or a radial decompression session really well?

MM: The focus is on two different levels: how do you design a strategic series for a post-ten client? [and] how would you do an advanced series? So, clients are recruited to come into the training [who] have already had ten Rolfing[®] Structural Integration [SI] sessions. You learn to think about strategy formation that doesn't rely so much on a recipe, but one that relies on a series of anatomical and structural goals. We're teaching a method of analysis that helps you get to those goals. Also embedded in the program are a series of practica. You might spend time on the ankle joint: what can you do to help get things moving better in the foot or ankle? How do you approach a knee, what do you do for a pelvis that's stuck? How do you work with specific structural elements, to develop the practitioner's skill? And then you're doing a series of work, talking about session strategizing, and session sequencing.

RM: So it's somewhat like a student going through the basic Rolfing training learning how to do [sessions] eight, nine, and ten?

MM: Exactly.

RM: I know that we talked about, and worked on, post-ten work in my [Phase III] with Russell Stolzoff. It seemed that the basic way to think about it was: Look at what you want to do structurally in eight, more functionally in nine, and try to integrate the whole in ten. Will there be some specific things taught in the training – not just "go address that ankle," but rather "here are some ways to address that ankle?"

MM: Some of what we teach is about "what can we do to free up that particular structure?" and some is about "what can we do at the other end of that structure to free it up?" – as in, "what can we do at the fibular head, to free up that ankle?" So, it's not so much that we're teaching techniques, but a way of thinking, and a way of approaching a joint in question.

RM: I see the connection with sessions eight, nine and ten, but could you explain the distinction between post-ten and advanced work? Also, does the advanced training prepare us to do advanced work on a client who hasn't had a Rolfing SI tensession series?

MM: Post-ten work is aimed at restoring the level of integration achieved in a previous series. Most of the time, advanced work is designed to take the client to an even higher level of organization. Also, an Advanced Rolfer can strategize a session or mini-series for clients who have not before received Rolfing sessions.

RM: I am also very much looking forward to seeing [in my training] how [instructors] Sally [Klemm] or Gael [Ohlgren] will approach some structural problems, such as how to unlock the ankle. I might not do it exactly the same way, but I look forward to learning how they do it, to better my skill and understanding.

MM: Also, in our current model you have two experienced instructors who are really

co-teaching the class, [so] you get that dialectic between the two of them, and then that broadens the intellectual/strategic horizons of the students.

RM: Nice. I know that the Rolf Institute's curriculum committee has been working to standardize elements of [Phases] I, II, and III, and that this has been implemented. Is there a similar process going on for the advanced training?

MM: The advanced faculty committee has a mission of collecting all the things that all of us do in an advanced training, and [determining] of those what are the things we insist are essential. There's some range for individuation: [one instructor will] do a little more of this, and [another] a little more of that. There's been some major progress in the last few years towards codifying that, so there's more consistency.¹

RM: What do you think about that? Is that a good thing?

MM: I think it's a good thing.

RM: Why?

MM: Because among the advanced faculty there's a level of cumulative experience – they as a group have been able to say "these ten things, or x number of things, are the most effective to help students move their skill to the next level." We can then make sure that in terms of this level of advancement, these skill sets and thought processes are in place. I think we've had a period of exploration and diversity and individuation, and now we are coming to our overall, community agreements about those things. So I think now is a pretty good time to take [the training], because of that.

RM: We talked, earlier, on the phone, about my preparation for attending the advanced training, and you said: "Think back on your practice, about the things you've done that have worked well, and the things that have not worked as well." That was really helpful. I then started thinking about "how am I working with certain clients' rib cases that are difficult for me to get to release, and what are some other methods I could try?" Then a thought would come, in session – Oh yeah! David Clark talked about work over at the rib angle, in my [Phase] II class, to affect the core and thorax more than just working right at the spine, and other similar ideas. It also really encouraged the process for me of thinking back on all these SOAP notes that I have. One of the main reasons that I've being doing SOAP notes is because

I really want to get better, having faith that, at some point, some things that didn't work will make sense later.

MM: Like I said earlier, some of what drives growth for a student is the frustration, and finding a way to try it differently. As in your example, try using a vector from the rib angle, and follow the line of the rib head, to affect the mediastinum.

RM: It seems like it [the advanced training] is the point in your work where you internalize this kind of thing, where you can feel like you are contacting the person's mediastinum from a point on the back. These are things that seem a bit abstract, when you start out. For me, this is similar to how doing the visceral work with Liz Gaggini was, at first. It is a way of "feeling into" stuff that may be hard to "put your hands on" at the beginning.

MM: Our basic training model was derived from the medieval guild structures, so that you learn a bit of something and then you go and put it into practice, first as an apprentice, then a journeyman, and slowly you build to a more experienced level. It was not all education; it was experience that drove you to that next level. People come and get the basic training, and then they go out and practice for a while. Then, they come back and take a six-day, or some other continuing education class, and they put that in their practice. Over time, they have enough years in the harness, and enough continuing education hours to come back and do the advanced training. If you look at the master agreement, that's the finished product: it is done only after the completion of the advanced training. So we see the entire arc of the student's studies, from the beginning to the end.

RM: Is that with the understanding that, even after the advanced training, you still do more courses?

MM: We have not required that.

RM: To me, that seems like a given, but maybe I am just so used to doing trainings, at this point in my Rolfing [SI] development. You're in there too, like when you took Liz's visceral manipulation class with me in Berkeley last year. It was wonderful to have you there! Isn't that one of the things that defines the term "profession," as opposed to a job – that you have a commitment to continued training?

MM: In my world, it is. It's not a requirement we hold each other to. It's a value I hold.

RM: It can be hard to explain to significant others why we spend all this time and money on trainings, but, to me, it's part of what makes us who we are. I'm inspired to do the advanced training to deepen my understanding of the work. It still sounds a bit mysterious, in terms of what actually goes on there. Is the advanced training designed to be another more holistic approach than, say, taking another continuing education class? Is it supposed to have a different overall scope that those classes don't have?

MM: It has a larger vision, in terms of transformative potential for the students. We're not just teaching techniques: we seek to alter their way of thinking about the work. There are also many more days of training involved. Ideally it brings a deepening of what the work of Rolfing [SI] is, both in your own and the client's structure. You receive a whole new series of work for your body, and learn to offer a whole new approach to a client, as well.

RM: What is your experience, from teaching, of how some people respond in these trainings? What, in your opinion, are some successful strategies?

MM: Well, the three classes that I assisted spanned seventeen years. One was in 1990, one was in 1996/1997, and one was in 2007. The quality of our instruction over that time, I think, has improved, along with the consolidation and codification of the curriculum that has occurred. Probably the best preparation, like I said, is a hunger for a new approach, and a readiness to be in a transformative relationship with the work. The requirements are intended to build to support that. This is designed to work through the combination, in the continuing education classes, of manipulation experience in an educational setting, together with the electives offered, and enough sessions worked outside of that framework.

RM: I'm going to an advanced training, and I want to make sure that I "get it," and at the same time I know that these things come in layers, and that I will probably absorb information that I won't know I have until I need to use it later. Do you have any advice about that?

MM: A good general response would be this: a big part of it is the camaraderie and collegial relationships formed over twenty-four days with your fellows, all of whom have come to this level, wanting

a transformative experience in the work. Couple that with high-level instruction and investigation of specific techniques and strategies for designing a mini-series in lecture, demos, and practica, and I think it's pretty easy to bump up to the next level.

RM: It has been my experience, too, in other trainings, that it is the listening and engagement between students that really helps us all learn.

MM: It makes it more of a seminar class, and less of a lecture class – a little more egalitarian. Each person comes in with [his/ her] own learning edge: one person may need a little more grounding in anatomical knowledge, another may need more inspiration about the "big picture."

RM: And I get that it is important to allow that feedback, as a student, to come in; to be modest and relaxed about it. Every bit of experience I have had in my life is helping me, but there are gaps in that, and I need to be ready to listen and learn, which will likely include being "wrong" sometimes. I guess it is important to just try to be patient with yourself and others, for any SI-related training that you do. It can be very humbling! And you don't necessarily know the areas that you're weak in until you get there.

MM: Right.

RM: There are a lot of Rolfers who have been certified in the last few years who don't know the history of the advanced Rolfing [SI] work. How did the idea of doing an advanced series first come up, for Dr. Rolf? It was a five-series, at first, right?

MM: I actually think her first draft of it was a four-series, and then it evolved into a five-series. All of that was before the time that I took the advanced training; I took it soon after her death, in 1979. [It] was before my time, but my belief is that going from four to five allowed the faculty to resolve some of the pedagogical issues that were brought up in the training, to help find resolution and closure.

It helped for the student's own experience, and for the client's experience of the work. In the training I co-taught with Tessy [Brungardt], there was a five-session series in the first phase, and a three-session series in the second.

RM: There's been a lot of water under the bridge since 1979, I would imagine, in terms of the evolution of the advanced training.

Is it equivalent to the evolution to a more "principles-based" approach to teaching the basic training that started, according to what I've heard, at some point in the 1980s?

MM: I think we freed ourselves to move in that direction after the split. [Editor's note: The "split" was the departure of some senior members of the Rolf Institute who then established the Guild for Structural Integration.]

RM: When did the split happen?

MM: The first "shots in the war" happened in about 1988. The sense was a desire for different ways of teaching the work. I might frame that, now, in terms of the principles, but not then. The terms we used [then] were "less formulaic" and more "client-structured."

RM: I always heard that [expression] during my basic training about a post-ten series: that it was "non-formulaic."

MM: So in that sense, this evolution of the basic training, and the evolution of the advanced work, and training, were parallel developments.

RM: In the advanced training, is there a sort of underlying structure to sessions, kind of like a basic structure in a dancer's improvisation?

MM: . . . or a blues player's sixteen-bar blues?

RM: Right. Do we learn some structure to use, referring to, say, certain things to try in an axial session, elements to explore while doing a radial decompression, and so on.

MM: It becomes part of the language that you learn, regarding the five structural elements: girdle, girdle, core, sleeve, axial. You learn to look at the person and ask which of these five would most be benefited by the intervention of Rolfing [SI], and what other structural element could you integrate through. That begins to form the core line of your strategic development. You learn to build a recipe, if you will, for that particular client.

RM: Back to talking about sessions eight, nine, and ten: Did Dr. Rolf truly always do a lower eight, at first, or, for that matter, always start a Ten Series at the feet? I keep hearing that.

MM: A lot of the lore about the development of this work includes stories that Dr. Rolf started her series of structural integration work with a foot session.² For a while, she

was doing feet, legs, feet, and legs as the initial intro. I don't know if those tales are apocryphal or grounded in fact. Again, according to the lore, she began to notice that, in general, structures were helped by beginning with the upper - with work in the chest. To me that looks like an argument in her own mind that might have sounded like "Do they need more adaptability, or do they need better support?" In a way, she was saying, perhaps, that it was hard for the client to utilize the added support without increased adaptability. So, in essence, how we teach sessions one and two uses that argument, and how we teach sessions eight and nine also uses that argument. The way to demystify the eight, nine strategizing has to do with that.

In a ten-session series, eight, nine, and ten are an integration of the whole series. In advanced work, however, it is the client who is hungry, the client that is wanting more. As if saying "I've come so far in this work, and I want to go a little bit father." The client, now, is looking for a sort of transformative possibility. The art of designing an advanced series is determining "what are the transformative potentials of the client?" in order to move to the next level. What is emerging from [the client] that will give access to that? That becomes the key to creating an advanced mini-series.

Endnotes

In the process of fact-checking this article, we contacted advanced faculty members Jan Sultan, Pedro Prado, and Tessy Brungardt.

1. Advanced Rolfing Instructor Tessy Brungardt commented: "First, the AF [Advanced Faculty] has written out and agreed to a curriculum for the AT [Advanced Training]. It does indeed have a certain amount of flexibility built into it, but we have agreed to certain things that are to be included in each training. Another thing that you did touch upon, but is a major goal of the AT, is that each student is to get specific work that s/he needs – [his/her] particular needs are to be addressed in the training – both learning and structurally. As a group, we hold this value strongly.

2. Jan Sultan reports: "Rolf did say that she originally started the Ten Series on the feet, but later it occurred to her that freeing the breathing was the first step. In those days a Second Hour was a challenging experience, and you needed to breathe to get through it."

Rolfing[®] SI in Japan

The Development of a Region Seen Through the Lens of Education

By Hiroyoshi Tahata, Certified Advanced Rolfer™, Rolf Movement[®] Instructor

Editor's note: Rolfers who trained in their own language in an established region – for example, at the Rolf Institute® of Structural Integration (RISI) in Boulder, Colorado – perhaps can't quite fathom the additional effort many of their colleagues went through to learn the profession, whether facing the challenges of a language barrier or having to organize their own trainings. Many Rolfers practice alone here and there around the globe, but to galvanize a region to the extent that the profession is established and grows takes a massive homegrown effort and great dedication, as illustrated in this account of the development of our profession in Japan.

The Early Years

Before local Rolfing Structural Integration (SI) trainings were held in Japan in the early 2000s, there were only a few Rolfers practicing in Japan. Yoshitaka Koda was the first Japanese national certified as a Rolfer, practicing since 1987. He and New Zealander Christine Faris, practicing since 1990, were the primary Rolfers inspiring the first wave of Japanese nationals to seek Rolfing training. Like Koda and Faris, this group had to go abroad for their training, sometimes paying for an interpreter to accompany them. With this hindrance, it was slow growth for the Rolfing profession in Japan, with the number of Japanese Rolfers increasing by one in 1996, one in 1997, one in 1998, and two in 2000.

The First Basic Training

During my Unit III class in Boulder in 1998, Jonathan Martine, the assistant instructor, talked to me about the possibility of a Rolfing training in Japan – the first ever in Asia. We imagined holding a Unit I within five years. The next year, Noboru Yasuda and Naomi Nakamura, inspired by their experience of Rolfing sessions, asked me to coordinate a training in Tokyo. Encouraged by their passion to become Rolfers, we joined forces to organize the class; I liaised with RISI as class coordinator and assistant instructor, while they were the information liaison for students and the bookkeepers. Finally, in 2001, a group of highly motivated people gathered for Unit I, with Martine and John Schewe delighted to come and teach in Tokyo. Ultimately, the cooperation of many people led to the achievement of this first step.

Next, Carol Agneessens, who was one of my Rolf Movement instructors, came to teach Unit II. I personally think her presence at this training planted the seeds for the first Rolf Movement training in Japan in 2005. Through Units II and III, the students themselves did the hard work of coordination and accounting.

This first training was completed in 2002, with twelve Rolfers being certified. Besides the central support that came from the steady practice of several Rolfers, I see a few key factors that helped to prepare the ground the first Rolfing training in Japan:

- An accumulation of potential students the people whose own Rolfing experience was meaningful to the extent that they wanted to change their lives and careers.
- Opportunities to learn and experience touch from Rolfers, which motivated individuals to become Rolfers. These opportunities included cranial workshops with Jim Asher, and workshops with Liz Gaggini in the 1990s.
- More opportunities to have Rolfing sessions using gentle interventions influenced by Somatic Experiencing[®] (and also Rolf Movement sessions, discussed next), as many Japanese prefer a non-invasive sensitive approach.
- The availability for Rolf Movement sessions as Japan had two resident Rolf Movement practitioners starting in 1999. Besides benefitting clients, this allowed potential students to fulfill the Rolfing training prerequisites.

Developing the Infrastructure for Ongoing Training

After this first endeavor, we had a process in place for our region to grow with local trainings. Again, a Rolfing client motivated to become a Rolfer stepped forward to provide the impetus for the next basic training: this was Takeo Ohnuki, who laid the groundwork for the training until 2004 when the newly approved Japan Rolfing Association (JRA)¹ took over the coordinating duties. A central role in organizing the next Unit I in 2005 was played by graduates of the first local training, including Kotaro Ogiya and Eiko Mizobe, collaborating with Kanji Hirose, who graduated from a training in Boulder. I greatly respect the energy and dedication of these new Rolfers whose motivation stemmed from having clients lined up for the class, who they wanted to have a good learning experience. After this second basic Rolfing training was completed in Tokyo in 2006. Hidenori Kato asked the JRA to organize a third training, this time in Kyoto, in 2008-2009.

So Japan has now had three rounds of basic training, these early ones all organized at the behest of potential students. With this base, a fourth basic training is in progress. As Rolfing [SI] develops as a profession in Japan with an increasing number of practitioners enjoying a steady private practice, enrollment seems to be getting easier. This has also been assisted by many descriptions about Rofling SI in books by Noboru Yasuda and by Mizuho Saito, and some magazine articles by Rolfers, helping to get our work better known in recent years. There has also been the contribution of introductory seminars by Rolfers.



Hiroyoshi Tahata teaching in the movement component of UnitI in Kyoto, 2008.

Movement Certification

As of June 2010, we have eighty-two Rolfers in Japan! Moreover, 55% of them have completed Rolf Movement training, more than double the worldwide average of 25%. Half of the movement certifications came from Carol Agneessens' two movement trainings in Tokyo, in 2005 and 2007, classes that graduated a total of twentythree Rolf Movement practitioners, and that most of the graduates of the first basic training attended. Agneessens' perspective and embodiment of the movement work particularly resonated with some local Rolfers who told me they may not have continued to work as Rolfers if they had not experienced Agneessens's training. After movement certification, some of them continued to attend small-sized workshops with Japanese Rolf Movement practitioners.

Rolfing Continuing Education

JRA is developing as an association, and thus far the focus has been on the groundwork of basic trainings and movement trainings. As of yet, we have no formal continuing education (CE) programs like mentoring or clinics, and no advanced Rolfing training has been held yet. Not many CE classes are held in Japan, so it is not easy for Japanese Rolfers to get enough CE credits and to participate in an advanced training within seven years of their basic training.

With the growing pool of Rolfers wanting to hone their skills, our region is now ripe for CE workshops and further trainings. One opportunity the JRA capitalized on was to hold some CE workshops with the instructors of each basic and each movement training while they were in Japan. Workshop topics were decided by arrangement between what the teachers wanted to teach and what the students requested.

Other Workshops

Other CE opportunities have come from Rolfers independently organizing various kinds of workshops and a few study groups. For example, Yoshitaka Koda, the first Japanese Rolfer: he has invited many instructors to give workshops – including Rolfers Asher and Gael Olghren and osteopath Tom Shaver – thus contributing significantly to the Japanese Rolfing community. Meanwhile, the first Somatic Experiencing training in Japan has started, organized by a Japanese psychotherapist. There are also some home-grown CE opportunities with resident Rolfers in the form of study groups regarding Rolf Movement or craniosacral therapy and one on joint issues with a Japanese osteopath.

Developing Local Instructors

I have trained as a Rolf Movement instructor, a process that involved being an assistant in various trainings as well as teaching a solo workshop under faculty supervision. Besides assisting in Agneessens' two movement certification trainings in Japan, I also assisted in a Principles of Rolfing segment for Unit II with Jane Harrington in Tokyo in 2006, a second with Rebecca Carli-Mills, Kevin McCoy, and Agneessens in Boulder in 2008, and a third with Lael Keen in Kyoto in 2009. I also taught movement in Marius Strydom's Unit I in Kyoto in 2008. The final stage as an instructor-in-training was my solo workshop in Tokyo in 2009, which was attended by fourteen Rolfers, including both Rolfers and Rolfers dualcertifed in movement. The JRA sponsored this workshop, which was the first Rolfing workshop to be taught in Japanese (with an interpreter for Pedro Prado, the faculty supervisor who came during a break from teaching Unit III in Kyoto). With this, I was approved as a Rolf Movement instructor in December 2009.



Hiroyoshi Tahata (seated, center) with the participants in his solo movement workshop, the first RISI-approved class taught in Japanese.

I could not have imagined these developments talking to Jon Martine twelve years ago. I appreciate all the instructors' support, especially Agneessens' continuous effort as my mentor. I am also grateful to all the Rolfers who participated in the various classes. I would like to support our local community now through Rolf Movement workshops to help each Rolfer in cultivating his/her skills and developing strong private practices. Hopefully the presence of a local teacher will spur further growth in our region, and I will be excited to see other Japanese Rolfers apply for instructor training.

I am also excited to have opportunities to share with the broader Rolfing community. Since my movement training with Agneessens and Carli-Mills, I have been developing a movement intervention that we call "yielding," which Agneessens and I will present as a workshop in the United States next year, and also introduce in a future issue of *Structural Integration*.

Conclusion and Acknowledgements

This article was written through the lens of my own experience in Japan and in becoming a Rolf Movement instructor. I want to give special thanks to Kotaro Ogiya, JRA's behind-the-scenes architect, who kindly provided information for this article. Many, many Rolfers have contributed to the development of Rolfing SI in Japan – as I hope is apparent from this article – and I apologize to those whose efforts I have not been able to single out here.

Endnotes

1. JRA was approved as a nonprofit organization in Japan in 2006, the result of the collective energy of many Japanese Rolfers.

HOW WE DEVELOP AS ROLFERS[™] – IN OUR COMMUNITIES The Kenai Peninsula Mentoring Program

By Mark I. Hutton, Certified Advanced Rolfer™

ur mentoring program here on Alaska's Kenai Peninsula has its roots in the mentoring I myself received from two wonderful Anchorage Rolfers, Barb Maier and Gwen Moerlein. From my earliest days as a Rolfer, their energy and generosity shortened my learning curve by years and inspired me to develop the program we now use. Every month for almost two years they came to my clinic to deepen my understanding of the work, help me out with my most difficult clients, or to teach me something new. Sometimes I would just bring out all my "before & after" Polaroids and they would patiently go through every photo of every client. Now, I offer the same service to every client of mine who becomes a Rolfer, and several of my colleagues do the same.

I turned sixty-one in 2010, and by the end of the year will have completed my thirteenth year as a Rolfer. In that time, I have delivered nearly 21,000 sessions. Of my own clients, twenty-four have become Rolfers, the twenty-fifth is in training now, and two more intend to enroll. Undoubtedly, the enormous demand for the work is one reason there are more Rolfers per capita in our area than in any other place in the world. I believe another reason is devotion to *growing the profession*.

It occurred to me early on that huge client rosters and long waiting lists (forty to fifty clients a week with a year waiting list) were no way to run a railroad. That approach was selfish and would never grow the profession. People needed ready access to the work and needed options among practitioners: old, young, male, female, weekends, evenings, etc. I was blessed when Andrew Mattson became the first of my clients to return with a B.S. degree and a Rolf Institute[®] certification. We spent a lot of time together as I tried to share with him everything I knew. Soon, as Andrew outgrew any need for technical assistance, the two of us were left with bigger questions and broader discussions about the nature and context of our work. Today, Andrew is one of the most powerful and competent Rolfers I know, and our conversations helped shape the mentoring program. He, Jeannie Sorenson, and others are now mentoring their own clients.

My own work, as well as the mentoring program I developed, is based on the business goals of mastering the work, creating recognition for the Rolfing® brand of structural integration, and weaving the work and the brand into the fabric of the community we serve. And, with the moral principle of Service Above Self (my Rotary Club motto) in mind, we try to grow the profession by attracting the best and brightest candidates to become Rolfers. But it takes more than that: when these candidates complete their training, they are not prepared to handle the size and complexity of the large practices awaiting them. To give you a sense of it, by my seventh week of practice, I had twenty clients a week; and by the end of my first year I had forty to fifty - a level I maintained for several years.

To address this need for further preparation, the mentoring program functions like an extended "Phase IV" of the Rolfing training in which whoever sponsored or recommended the graduate provides him or her with an "internship" through supervision. In the beginning, the main challenges were to make assessment more straightforward; to improve session strategizing; to manage expectations; and to nurture authenticity and confidence. The content includes any of several components, depending on the particular graduate's needs based on age, background, and focus:

- Teach how to conceptualize a basic series around a client's unique and often difficult structural or functional issues, and language this information for the client in order to turn an introductory session into a Ten Series.
- Teach how to use a dichotomous biomechanical model, which has proven itself to me to be the most useful taxonomy for the population in our corner of the world, as a primary assessment tool and session planning strategy. I use Liz Gaggini's "tilt-andshift" teaching model as my primary biomechanical model.
- Monitor, observe, and participate in one or more Ten Series while the new practitioner gets his or her feet on the floor. This always includes help with initial assessments, review of progress and willingness to be a safety net should a problem arise.
- Use the new Rolfer's most challenging clients as teaching and learning models during actual sessions.
- Be available for all questions from daily session questions, to weekly summary questions, to questions during sessions.
- Recommend continuing education classes to prepare for advanced Rolfing training, including introducing the new practitioner to various tools and adjunct modalities, e.g., craniosacral work, visceral work, osteopathic alignment and assessment, laser, and percussor.
- Provide guidance on the business aspects of our profession.

One of the biggest challenges has been meeting the needs of new Rolfers who are also young - 75%-85% of those I have sponsored. There was a time when one had to have attained a certain age and apparent maturity to be admitted to training. At that time, most Rolfers were like me: middleaged career changers, settled financially. Today, the Rolf Institute doesn't even require a four-year college degree and the minimum age is only eighteen, but these younger Rolfers tend to be bright, quick thinkers and quick learners, with seemingly endless energy. Though you can't judge the quality of a new practitioner by age, age does shift the focus of mentoring. With the younger practitioner, we pay a lot of attention to burnout, practitioner injury, confidence, and therapeutic relationship issues. In addition, we strongly encourage

each of them to get a four-year bachelor's degree in a related field, and all but one has.

Here on the Kenai Peninsula, Rolfing has gained such high visibility that we participate in high school career days and senior career counseling, school district in-service programs, business shadow programs, hospital grand rounds lectures, and surgery observation. Rolfing is so integrated into the culture that generally when one person here tells another about going to a Rolfer, the response is, "Who are you going to?" - not "What's that?" or "I heard it hurts!" Our work is covered by two insurance programs within the Kenai Peninsula Borough, through which ten visits per year are paid for without the need of a physician referral or prescription. We are also known for our services given free-ofcharge to children under ten and to military veterans. The children, some of whom come through physicians' referrals, are seen for conditions from torticollis to indigestion



Jeanne Sorenson and Mark Hutton working with a three-year-old.

to minor structural injuries. All veterans of World War II and the Korean War are scheduled free of charge, and Vietnam and Gulf War veterans are included as space is available. Most Rolfers offer these services during the regular course of a working day. As all Rolfers know, this is some of our most rewarding work. Along with the name-brand recognition we enjoy comes the responsibility to maintain a high standard of competence and professionalism among entrepreneurial practitioners without licensing or proactive institutional oversight. This makes our mentoring program all the more important. It is difficult for me to assess how good a job we are doing, but our intent to help is clear and we work very hard. The need is real.

In closing, I feel confident that our program is not unique and that ones like it exist in many communities. I do, however, want to encourage each Rolfer to make a more concerted effort to *grow our profession*. Our work has the potential to help humankind profoundly, yet its potential will not be realized until we have more Rolfers. We are a profession of service, and placing *service above self* includes seeking opportunities to mentor others.

The NAPER Clinic

A Vehicle for Continuing Education and Professional Development in Brazil

> By Pedro Prado, Certified Advanced Rolfer™, Advanced Rolfing[®] Instructor, Faculty Chair_

n 1998 a group of Brazilian Rolfers got together with the goal of creating a clinic for Rolfing Structural Integration that would function like the professional school clinics at universities and teaching hospitals. The clinic was set up to serve clients who might lack the resources to receive private sessions. Through this grass-roots project, we have served over 1000 clients.

What's more, as it turned out, this project met several needs of the group, the school, and even the ABR (Brazilian Rolfing Association). It is a social activity at an institutional level, a way to promote the work, and a vehicle for participation in community projects. It has also promoted contact among colleagues, and become a space for discussion, supervision, and exchange of visions about the work.

Ongoing Education

The project, named NAPER (Nucleo de Atendimento, Pesquisa e Estudo em Rolfing,



Rolfers Madalena Alveskog and Lucila Brandão in a Rolf Movement[®] session in the children's clinic, one of NAPER's projects.

or Center for Practice, Research and Study of Rolfing), also offers several exceptional educational opportunities. First, it is a study group that really works: practitioners at all experience levels – from recent graduates to senior clinicians and faculty – meet weekly

to study various subjects and discuss cases. Second, practitioners do their clients' body readings together and deliver their sessions simultaneously within the shared space. This format, much like a class context, allows practitioners to share among themselves the ideas and areas of emphasis of their various Rolf Institute® instructors. As much as the faculty strives for consistency and uniformity in the basic curriculum, it is true and perhaps inevitable that not all potentially important material is even presented – much less taught at the same depth - in every class. While access to ideas not presented in one's own basic training normally comes only from shared written materials, the live cross-fertilization through NAPER offers a far richer alternative.

NAPER also allows new Rolfers, who often have more energy than clients to serve, to practice immediately and gain the handson experience essential for professional growth. While new practitioners are investing the time required to build their own practices, they can put their skills and energy to work in the ambulatory clinic, where they continue to learn from their peers, as well as from the supervision of instructors and more senior colleagues.

NAPER supervision benefits not only the NAPER practitioners, but also the supervising faculty and the school itself. At NAPER, faculty have the opportunity to assess how well students have comprehended and are applying the lessons of their basic training. This is especially valuable here in Brazil, where graduates of basic trainings are certified in both structural and movement work, having been taught to combine movement and manipulation techniques. Besides bringing observations at NAPER to bear on future basic classes, we have the chance to correct or supplement individual practitioners' trainings: keeping them on track, correcting mistakes, giving reminders, and nipping bad practices in the bud while cultivating good ones.

The rich educational opportunities NAPER offers have led the ABR and its faculty to consider making NAPER participation a part of the basic training. Through NAPER, students between Units II and III could use their existing skills in a professional, supervised setting. This would solidify the students' learning, as well as allow the faculty to improve the Unit II curriculum. Following Unit III, the NAPER setting facilitates formal "for credit" continuing education, leading to preparation for the advanced Rolfer training.

Inspiring and Supporting Research

The group context has encouraged and supported research. Ongoing discussion, shared observation and the existence of a database have enabled us to develop a series of questionnaires for consistent tracking of client and practitioner processes.¹ As the questions were selected and revised, and the answers analyzed and tabulated, participants undertook research projects and prepared articles to share their findings. In this context, practitioners with aptitude for research and writing may discover and hone their strengths.

Promoting the Work to Other Professionals

Networking as an institution with other groups offering services in similar settings facilitates conversation between Rolfers and members of other professions. This gives our practitioners experience in explaining structural integration to others and promoting their work in an effective and positive manner, and allows us to correct misimpressions about the work that members of other professions might have. We are currently cross-referring clients with the Bioenergetics Association and the Homeopathic Clinic, as well as conducting multidisciplinary research in cooperation with these groups.

Endnotes

1. NAPER's ongoing research led to the development of these questionnaires, which, in turn, facilitated my own 2006 doctoral thesis, "Explorations on the Psychobiological Dimension of Rolfing: creation, development, and evaluation of questionnaires," which is available at the Ida P. Rolf Library of Structural Integration (www.pedroprado.com.br). The questionnaires themselves are in Appendix B, pp. 482-509.

Resources on NAPER

Other articles concerning NAPER and the research conducted there include:

"Including the Stomatognathic System in Rolfing[®] SI – A Collaborative Experiment in Broadening Our Scope," which includes case reports regarding NAPER clients by Yahra Silveira Perdomo, Rosangela Baia, Beatriz Pacheco and Maria Beatriz Whitaker. *Structural Integration*, 2010, Vol. 38, No. 1.

"Reflections on the São Paulo Ambulatory Project," by Paula Mattoli, and "The São Paulo Ambulatory Project," by Pedro Prado, both in *Rolf Lines*, 2001, Vol. 29, No. 1.

"Profiles and Evaluations of Rolfing Clients in the Núcleo de Atendimento, Pesquisa e Educação em Rolfing (NAPER) Brazil," by Yeda Bocaletto, *Structural Integration*, 2007, Vol. 35, No. 4.

A Forum for Cross-Disciplinary Education An Interview with Peter Schwind about the Munich Group

By Anise Smith, Certified Rolfer™

Editor's Note: Rolfing[®] instructor Peter Schwind, Ph.D. has been offering classes in the visceral and cranial fields in Munich since 1990. The Munich Group was formally established in 2001 by Rolfer Schwind and Christoph Sommer with the intention of being a forum for interdisciplinary manual approaches, bringing osteopathy (visceral manipulation by Jean Pierre Barral, D.O.) and fascial and membrane techniques (Schwind's approach) to manual practitioners of different backgrounds. The Munich Group is not officially associated with the European Rolfing[®] Association, but classes can be used for credit toward advanced Rolfing training in either the elective or manipulation categories. At least one-third of the participants are European Rolfers, and the mix of Rolfers, osteopaths, and physical therapists has become a very fertile ground for further cooperation and understanding of the different concepts.

Anise Smith: Peter, how long ago did you and Christoph Sommer found the Munich Group?

Peter Schwind: Actually, I do not remember our official start, but I do remember that our starting point was a course on visceral manipulation we took with Jean-Pierre Barral somewhere in the north of Germany. At the end of the course, Dr. Barral stated that he did not plan to continue teaching. The students, however, were enthusiastic and asked for a continuation of the course work. Dr. Barral said that he would continue to teach if we would organize the courses in Munich. **AS:** So you organized courses exclusively about visceral manipulation?

PS: Yes, at the beginning – that was 1989. For a number of years Dr. Barral came to Munich several times a year to teach the basic visceral classes. After a while Didier Prat took over the basic classes and Dr. Barral continued with the advanced courses.

AS: How come your program was only dedicated to visceral work?

PS: For many of us – Christoph, some other Rolfers from Munich, and certainly myself – the visceral approach was the missing piece for structural integration. In practice we had found that the fascia of the muscles

is important, but it is not everything. We all felt that we sometimes did visceral work when following Ida [Rolf]'s concepts during the Fifth Hour without knowing what we were doing. Barral's work opened a big avenue for us to look at the organism from a different perspective.

AS: But nowadays you also offer other courses?

PS: For us the visceral theme is still the main interest. The visceral courses are the basis for all our teaching activities. Aside from that we have been following Barral's work in new directions. We now offer courses about nerve manipulation applied to the extremities and to the cranium, as well as courses about treatment of the arteries. We also offer a whole sequence of courses focusing on Barral's new techniques for an efficient treatment of joints. And last but not least, we offer a whole sequence about fascial and membrane techniques.

AS: How does this relate to traditional Rolfing Structural Integration (SI)?

PS: What I teach in these courses is problem-solving therapy. It can add to structural integration, but in no way can it replace what we do in traditional Rolfing SI.

AS: What kind of practitioners come to the courses offered by the Munich Group?

PS: We have osteopaths, Rolfers, physical therapists, doctors of manual medicine, and practitioners of other manual disciplines. Sometimes surgeons and gynecologists participate. Most people come from Europe, but some travel to Munich from the U.S., from Canada, and even from Australia.

AS: Do you have a "philosophy?"

PS: Most of our teachers have published innovative books about their work. Barral and Croibier are the best examples for that. The philosophy we share is our strong belief in the value of dialogue between different manual disciplines. We also have a great dialogue with doctors of allopathic medicine. When we started, we wanted to get out of that isolation of [being categorized as] alternative medicine. That's why we have a consulting team of orthopedic doctors, internists, and dentists. This is not merely a formality. Christoph and I are constantly exchanging ideas with these people within the context of our daily practices.

AS: Do you have any new projects for your program?

PS: I have been working with a doctor of internal medicine - Dr. Martin Güthlin - for seven years now, who is also well qualified in nuclear medicine. We have been exploring the value of ultrasound to document what we are doing in visceral manipulation. This year we shared our experiences in a course that we co-taught. Participants could literally see on the screen the individual fibers of the psoas and learn to observe the whole context of this muscle as it relates with the organs – for example, the kidneys. Also, they were able to watch precisely what their hands were really doing. Actually, we may all learn that what we think we are doing with our hands is sometimes quite different from what happens in reality.

AS: Why do you still organize these courses after more than twenty years? What is your personal interest?

PS: At the Munich Group I meet people I can learn from. For me the most inspiring moment is when I realize that somebody is able to do the work in a more precise and efficient way. After a class we usually meet at one of our beautiful beer gardens in Munich to talk and kick around ideas, get inspired again and again, and sometimes get desperate about the limitations of our practical skills.

AS: Thank you for this interview.

Anise Smith was certified as a Rolfer in 2008. She also continues her career as a dancer at the opera house in Munich. Peter Schwind, Ph.D., has been working as a Rolfer in Munich since 1980, and has been teaching basic Rolfing trainings since 1985 and advanced trainings since 1999.

HOW WE DEVELOP AS ROLFERS[™] – INDIVIDUAL PERSPECTIVES Learning About Pain Management

Post-Certification Training and Integration in a Rolfing[®] SI Practice

By Clay Cox, Ph.D., Certified Advanced Rolfer™

Introduction

Over the years, many estimates have been made as to what percentage of clients seeks out Rolfing[®] Structural Integration (SI) because of issues related directly to pain, and the answers range from 80% to 95%. I believe that there are very few, if any, Rolfers who have not intentionally worked to reduce a client's pain. My problem is that Rolfers are trained in Rolfing SI, and are not specifically trained to address the pain-management cases that will show up in their practices.

Obviously, it is impossible to complete an authentic Rolfing series without proper training. It is also impossible to render effective and reproducible painmanagement treatment without proper training as well. If you have not been well trained in this particular domain, there is a significant possibility that you will make mistakes. The Rolf Institute[®] of Structural Integration (RISI) currently has over thirty teachers of Rolfing SI, yet no one teaches pain management specifically. This is something I have worked to redress, both in my own professional development, and in the work I do mentoring other Rolfers.

In Section I of this article, I will discuss how I came to where I am in my career, and how I have structured my trainings to assist other Rolfers in learning painmanagement skills. I hope readers will see the possibility of determining their own paths through the maze of what is

available in post-certification trainings. In Section II, I discuss elements to consider in having an integrated practice in Rolfing SI and pain management, and ways to best use these together. I attempt to present the case for how it is possible to help reduce the suffering in the world – a noble cause - from a well-educated, well-trained, and experienced platform. I also attempt to show how it is possible to integrate a traditional Rolfing practice, basic or advanced, with a practice in pain management as well. Your clients then will have a choice of the two: of you addressing their pain issues directly, or of getting Rolfing work. In my practice, it is often the case that after the pain issue is under control, the client may be interested in Rolfing sessions. S/he has experienced your touch, is familiar with you and your process, and is comfortable with both. You are in charge of your post-certification training and where it takes you and your client base.

Section I: Learning and Teaching

My Own Journey of Professional Development

Thirty years ago the Rolfing training was simple: you did your basic training, completed three six-day workshops, and then went on for your advanced training, because that was all that was available. The original five teachers that Dr. Rolf, trained passed on her edict that new Rolfers should do nothing but Rolfing SI for the first five years of their practice. Then it was time for your advanced training, and then you were done. Well, some of us were done.

After my advanced training the great "split" at the RISI occurred and I was disenchanted with both sides and took my studies elsewhere. I did some of Peter Levine's early trainings. John Upledger gave a class in 1981 to the RISI teaching staff and a few others, me included. Off and on during the mid 1980s I studied with Robert Fulford, D.O., training in the use of the percussive hammer/massager. In 1987, I trained with Jean-Pierre Barral at his first U.S. visceral manipulation class. I was certified by Mary Burmeister in Jin Shin Jyutsu[®] in 1983.

At the RISI annual meetings of 1985, 1988, and 1989, I presented papers and gave talks on a number of pain-managementrelated topics including: arthrogryposis in children, soft-tissue management of acute pain, and chronic-pain management as it relates to Rolfing SI. I presented papers and lectured on sacroiliac dysfunction, treating musculoskeletal disorders, Rolfing SI and structural realignment and functional anatomy. All of these papers were based on work I did in my clinical setting. Over the course of my career I have shared office space with medical physicians, chiropractors, Rolfers, and massage therapists. All have taught me on many levels of being and learning.

I was elected chairman of the Southwest Regional Rolfers Association and traveled between Tucson, Phoenix, and Los Angeles for meetings from 1986 through 1991. These meetings allowed me to meet with other Rolfers, diversify my perspective, have the opportunity to learn new techniques, and enhance what I already had learned.

In the 1990s I studied pain management with a number doctors of medicine, osteopathy, chiropractic, psychology, and psychiatry. I joined and have maintained clinical membership in the American Back Society and the American Academy of Pain Management. I also have maintained membership in the American Board of Forensic Examiners since 1994. I did Gil Hedley's class on human dissection and assisted him teaching the same class at St. Regis College in Denver.

During this decade there were a number of SI practitioners in the Tucson area. Half a dozen of us took advantage of this opportunity and began meeting weekly, once again allowing me to meet with other SI workers, diversify my perspective, have the opportunity to learn new techniques, and improve what I already had.

In the 2000s I trained with the American Academy of Craniofacial Pain for motor vehicle collision-related injury diagnosis and testimony preparation. I took five ten-hour classes in the University of Arizona (UA) Mini-Medical School program covering a variety of health- and pain-related topics that included hands-on clinic work. I completed three eight-hour dissection classes of fresh cadaver knees and shoulders at the Department of Orthopedic Surgery at the UA Medical School.

My Approach to Teaching Pain Management

A full client load in my private practice has allowed me over the years to implement and practice what I learned in my diversified training and study program in pain management. In the 1990s I started mentoring newer Rolfers in pain management, usually for a week at a time. Some had more time and different commitments and would do an internship for a month to six weeks. Others would rent office space for longer periods of time and we would do case reviews, four-handed work, and assisted assessments when appropriate. Below I will discuss these approaches to professional development and what I seek to impart to mentees.

Preparation

Before starting any study of painmanagement, there are some essential selfstudy components the practitioner should familiarize him/herself with:

- 1. Language of medical, osteopathic, and chiropractic physicians.
- 2. Images and their reports.
- 3. Common syndromes such as neurological entrapments, gait alterations, and postural deficits and anomalies.
- 4. "Red flags" in patient examinations.
- 5. Range-of-motion limits.

Formats

One approach I have used is workshop training for a class of practitioners, a "handson approach" laid out in either a four- or six-day format. These are formulated to the needs and wishes of the individuals, but some things are common – elements that are aspects of any practice regardless of the practitioner's intended emphasis or practice focus:

- 1. Review of case history form with each new client.
- 2. Review charts of existing clients returning for further treatment prior to appointment.
- 3. Review changes in status with each existing client.
- 4. Review of images, image reports, and referral information.
- 5. Perform basic physical exam.
- 6. Assess the state of the client and his/her issues.
- Application of appropriate treatment modalities utilizing algorithms and a self-teaching cycle.

For those doing longer mentoring or interning, I use a four- or six-week format that entails learning how to utilize and

benefit from direct client treatment utilizing the following:

- 1. Diagnostic/treatment algorithms and protocols for common conditions.
- 2. Techniques specific to pain-management patient care with specific circumstances.
- 3. Thermal scanning.
- 4. General pain-management practice tools and techniques.
- 5. Practice enhancements, including: aspects and benefits of a computerized practice, establishing supply vendor accounts, appropriate exercise protocols, ergonomics and treatment-room equipment.

In this format an individual practitioner (who already has the foundational knowledge taught in workshops) works with me in my daily practice to take clients from initial interview to problem resolution in an onsite pain-management clinic setting. I also give these practitioners direct phone and email access for twelve months for case consultations and pain-management practice support.

Section II: An Integrated Practice in Rolfing SI and Pain Management

Once a Rolfer has learned effective painmanagement skills, there is the work of integrating this into an existing practice of Ten-Series work, Post-Ten work, and advanced work.

Identifying the Pain-Management Client

The majority of pain-management cases will reveal themselves through the basic intake procedure: case history, physical examination, and assessment. In the same way as our postural evaluations prior to a Ten Series guide us, pain-management work requires specific training in history taking and assessment to enable the practitioner to determine first whether treatment is appropriate, and then the appropriate course of treatment. A number of questions should come to mind early in the relationship with a new or prospective client: Is s/he in the right office given the complaint(s). What are your objective findings? What differences between the objective and subjective come up and how are these differences rectified? All of these questions and considerations are part of the history and exam.

As the practitioner becomes more proficient s/he will ascertain that there are particular findings that lead to asking the client more detailed questions. Perhaps the client initially did not report pain, but upon examination and running through the protocols the practitioner determines that there are probably pain generators that the client has adapted to. Maybe in running a low-back pain protocol you determine that the client has a pelvic torsion, which leads you to look at the sacroiliac joints, the pubic symphysis, and the lower lumbar vertebral units. Then, upon palpation, the client reports that "yes, in fact, there is pain where you are touching."

In order for folks to live their lives, they have to adapt to low-back pain, headaches, and large assortment of other maladies. Living in pain is very draining. Living in pain without awareness can be very confusing. "I'm tired but don't know why" is often a complaint in these cases; so is weight gain, sexual dysfunction, and irritability. It builds trust in the process when as a practitioner you can proactively educate clients as to why they are not feeling as good as they could, when you can help them understand their pain, perhaps even before they are fully aware of it. Hope is built and the client is encouraged for, in some cases, the first time in a long time. The underlying belief is that if there is trust and hope then relief might follow. (Somebody say "Hallelujah!")

Complementary Care

Some pain-management clients will be referred by other practitioners - allopathic or complementary - specifically for pain management. The focus of a painmanagement approach is complementary by design. "Complementary" is a process where there is more of a "team" approach to client care. (In contrast, an "alternative" approach to care infers the idea "instead of.") Most pain-management clients seek complementary treatment because traditional allopathic approaches generally addressed the symptoms and not the problems. An important service that the allopaths are able to provide is to rule out pathology. Once pathology has been ruled out, there is a greater probability that the pain generators in questions are biomechanical. These clients may have given up on allopathic care, or they may be seeking your work in addition to allopathic and/or other complementary care. In some cases, interaction with an attending physician (whether medical doctor or chiropractor) may be necessary to work with the client, particularly in third-party insurance cases that may require referral and diagnosis codes from an attending physician (medical doctor or chiropractor), as well as appropriately formatted SOAP notes. (Third-party payments will be the topic of a future article.)

A working understanding of appropriate health-care vernacular will help in these situations, and in reviewing the client's history and records to make treatment decisions. Given that the focus is on the care of the client, it is important to utilize all relevant information in assessing the client's needs, including allopathic diagnostic findings. We stand on the shoulders of those who have been trained to know different things than we know for the betterment of those in pain, who seek our services.

If before the client presents at your office s/he has had an image taken – say a CAT scan or MRI – you can use that report and the client's case history to determine with a greater margin of safety whether it is or isn't appropriate to treat. For example, if the client's image report indicates an abdominal aortic aneurism, obviously the practitioner will decide not to relieve the client's abdominal discomfort with a traditional fifth-hour psoas approach, but with consideration still treat the client.

Treatment Considerations

One of the important aspects of addressing pain management in a Rolfing practice is *not to forget about Rolfing SI*. However, without specific training, a considerable amount of case and pain management is rendered through "incidental consequences" of doing something else. I call this "shot gunning," where the practitioner attempts lots of things that s/he hopes might help, such as a random Fourth Hour of the Ten Series, without a specific plan; often these attempts include a collection of things that have worked in the past with other clients but may not be appropriate for the current clinical presentation.

In learning to work with pain management in a Rolfing SI context, consider these factors: The absence of pain will often lead to reduced postural aberrations. The absence of pain will often lead to a higher level of cognitive function. Higher cognitive function can lead to increased self-awareness, which can lead to better posture. Antalgic posture or gait is a function of seeking to reduce pain. Many clients have

adapted their conscious awareness of their pain issues and unconsciously altered their posture and consequently their gait. Some of the pain is historical and adapted to somehow. Sometimes pain is very current and present but simply placed out of conscious awareness for a variety of reasons.

Given all of this, it is easy to understand the *importance of addressing both pain and posture* in working with these clients.

As for how to work, while the client is in the acute phase of suffering, sessions two to three times a week for the first two weeks with no specific Ten-Series work will often serve best. When s/he reports that suffering is noticeably reduced, and your objective findings corroborate, introducing early Ten-Series work seems to be in order. Interjecting Ten-Series sessions in sequence during a course of pain-management work is always prudent (see discussion below, and also "Four Chronic Pain Syndromes and the Basic Rolfing Series"¹).

There is the potential for an ethical issue here commonly referred to as "bait and switch." It is imperative that the practitioner not use pain treatment to lure the client in any way – into perhaps a more expensive treatment regime involving ten sessions of Rolfing [SI] – when all s/he came for was a nagging headache. The practitioner is the responsible party in the treatment room to make sure that there is no possibility whatsoever that this ruse could happen. Be careful to make it very, very clear that these two components of your practice are separate and independent. You are in charge of how the aspects of your practice integrate and benefit your client base.

There are a number of treatment strategies that are appropriate for various stages of the reduction of suffering. Here are some examples of factors that affect the setting of a particular treatment strategy: the level of suffering that the client is experiencing, the objective projection of the progression of the client's given condition, finances, upcoming holidays and vacation schedules, etc.

The nature of the issue or issues addressed in pain management will determine the duration of your work with any given client. In some cases only a session or two of additional work may be needed to successfully achieve the goals of Rolfing SI and address the pain issue/s. Sometimes with chronic and intractable pain conditions, the ten-session series provides a framework on which to organize and format your painmanagement work. I have clients whom I have treated for years and continue to treat to this day for intractable pain. They can't be fixed. I assist them through reducing their need for medication. I assist them by keeping them functional by helping them reformat gait and stance weekly as they deteriorate in their pathology. My hands-on work with active AIDS clients helped them when everyone else was afraid to touch them in their suffering.

The client and the practitioner will always be in dialogue as to the efficacy of the treatment strategy. You will adjust and adapt minute by minute, session by session, and week by week. It is a living working process. It is a relationship.

Ten-Series Work

I discuss different strategies for integrating pain-management work and the Ten Series in my publication "Four Chronic Pain Syndromes and the Basic Rolfing Series."¹ Above I discussed how I interject Rolfing Ten-Series sessions into a pain-management series. Here I will discuss how I interject pain-management sessions into a Ten Series. Knowing when each strategy is appropriate depends on a multiplicity of factors, some of which I have already mentioned. It is a subject beyond the scope of this paper, best covered in a training setting.

It might be commonly assumed that good places to bring in pain-management work in the Ten Series are after the third and after the seventh sessions, because these are points where the designed intention changes. However, I more commonly break to interject pain-management work after the second and sixth sessions of the series because of a different take on the same reasoning, as follows. We are changing intention and the course of focus after sessions three and seven of the series: after the third session, the focus becomes more one of the intrinsic musculature and the muscles of balance and organ support; after session seven, the focus becomes more integrative. Accordingly, before closing down one aspect of the work, I want to have completed what is necessary at that stage.

Thus, I would want to complete more superficial issues *before* closing that first phase with session three of the series. If the pain-management work needed is going to take more than the time allowed in a given session, I find it often works well to interject additional sessions between the traditional second and third sessions of the Ten Series. Likewise I will add pain-management sessions after the traditional sixth session, so that the seventh session closes that phase of work. With sessions three and seven having some integrative aspects/findings, the Rolfing series work and the aspects of the pain-management work fit together with more ease.

Post-Ten and Advanced Work

Work in pain management after the Ten Series needs to have two primary characteristics other than pain reduction:

- The work needs to be able to stand by itself. That is, the clock should not have to be taken apart to find out the time. (I remember one of the early Rolfing instructors had the reputation of taking Rolfers apart in their sessions with him to the point that it would take days if not weeks before they could function well again.)
- The work must not take away from the integrity that has been established in the Ten Series.

In an Advanced Series, specifically tailored sequences of sessions for individual issues such whiplash, post-surgical recovery and complications, and post-partum issues set up for the most efficacious treatment plan.

Rolfers trained in pain management can treat patients outside the Ten Series with the specific intention of reducing patients' pain and/or need for pain medications. When following the basic protocol training that I teach, you will have formats for evaluation, screening for appropriateness to treatment, and for appropriate treatment itself. In those cases where pain management is the primary issue, you may work solely in pain management until pain management is no longer the primary issue and structural integrity moves to the forefront. There is often a period or periods where you will have to go back and forth between these two approaches to achieve your case goals. Sometimes the case falls into a special category such as third-party payments, which will be discussed in a future article.

Conclusion

It is my wish that those addressing pain issues in their clients do so from a very educated and, eventually, a very experienced position. You have been well trained to bring your clients and their structures up to a higher level of functioning. You have helped them get out of the way of their own evolution. I want

Rolfers who so choose to be equally well trained in pain management, to give clients hope that something significant can be done to reduce their pain and suffering and to enhance the quality of their daily lives.

Toward this end, I would like the RISI to offer two types of advanced training: one in SI, like it offers currently, and another a certification in pain management. I believe that Dr. Rolf's dictum is appropriate - Rolfers should first learn how to practice Rolfing SI. Her idea, I understand, was for newly certified practitioner to do nothing but Rolfing SI for five years. (Jan Sultan told me this many times.) After that, practitioners would have a better idea of what Rolfing SI was and the potential for change that was inherent in the process. And after five years, enough questions have come up in your practice to make you very curious. In satisfying that curiosity, some practitioners may lean toward finding a higher level of order in structure and learning how to establish that in their clients, while others may lean toward focusing on intentionally reducing pain in suffering in a way that no other discipline can possibly approach, for what sets us apart from the rest is our understanding of order and function and singularly - our ability to establish that order out of chaos as only Rolfers can do.

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Mentoring for RolfersTM

By Shonnie Carson, R.N., B.S., A.N.P., B.C.S.I, Certified Advanced Rolfer

entoring, in professions like Rolfing® Structural Integration (SI), can play a significant role. What we Rolfers do is very much an art – a creative process. Yes, there are aspects that are very logical and linear, such as knowledge of anatomy; but there are other aspects that are nonlinear, very "right brained" and intuitive. These are skills that, for most people, are developed over time. These aspects are difficult to teach in depth during the initial training because there is so much basic information to be covered. In my view, this is an area where more senior Rolfers can contribute by sharing their skills and insights developed over years of doing this work.

For about ten years, I have been mentoring Rolfers and graduates of other SI schools. I first began in Washington state when a student going through training at the Rolf Institute® (RISI) asked me to mentor her doing the ten-session series on a client. There were a multitude of discoveries that both of us made during this process. Contrary to what I had heard (and much to my relief and delight), the classes at the RISI still teach the essential basic Ten Series! I also discovered an exciting new way to contribute to my profession and thoroughly enjoyed the mentoring/teaching process. I continued mentoring sessions with newer graduates of the RISI, the Guild for Structural Integration, and Hellerwork schools. In general, these mentoring sessions were with two practitioners, and they were in a series of sessions with the practitioners trading work on each other.

After moving my practice to Phoenix, I initially did mentoring sessions with two Rolfers here at their request. These Rolfers were established and were out of training at least ten years. They had met me at workshops I sponsored in Phoenix and felt I could offer them new insights and assistance with some problems they were experiencing. We met once a month over an eight-month period and the Rolfers would trade session work on each other. These Rolfers were so pleased with the experience that they encouraged me to offer mentoring to smaller groups of Rolfers and other SI practitioners here. These have happened about every two to three months and have provided a wonderful way of sharing skills and encouraging a sense of community.

My style of mentoring is very involved with the less linear aspects of what we do. To become a "master Rolfer," it is necessary to:

1. See what needs to be changed.

2. Know what you have to do to change it.

3. Use skilled touch to carry out the change.

To provide the opportunity for Rolfers to grow into mastery, these are some of the areas I address in mentoring:



Phoenix mentoring workshop participants: (back row L to R) Donna Jo Cross, Shonnie Carson (mentor), Bill Kamer; (front row L to R) Deanna Melnychuk, Patti Selleck.

Seeing

In general, when we begin a session I spend time listening to how the practitioner "sees" the structure we are evaluating. I feel that developing your ability to "see" is essential to becoming a master Rolfer. Most commonly, the practitioners I have observed in workshops and those I have mentored tend to discuss structures in terms of muscular anatomy. Viewing structures in terms of muscular anatomy is fine, but there are other ways of perceiving structures that can often add depth to the practitioner's sense of the client's structure. I encourage and facilitate perceiving the structure in terms of shapes: shapes of inside spaces; how the organs relate to these shapes or imbalances; how these shapes relate to each other; and how they may assist or hinder the structure in gravity. Then we discuss strategies for effecting change. I also encourage more conscious awareness of things like perceptions of the client's general energy and emotional tone, coloring (especially of tissues), what parts of the structure seem not to match the general structure, tissue texture, etc.

I encourage practitioners to learn to relax their eyes, scan the whole person, and allow information to come to them. This is very different from the narrowed-eye "looking intently for something" behavior I usually see when practitioners are trying to figure out the part of the muscular structure on which to work. There are qualities of movement in tissues that are subtle but "seeing" them is invaluable in evaluation. I continually encourage "seeing" in nonanatomical terms during all the sessions and share techniques for keeping "seeing" ability fresh and sharp during the session.

Receiving and Giving Sensory Information

Having watched and mentored a fair number of practitioners in my thirty-year career, it is my observation that most have developed habits of sacrificing their own structures in the process of doing the work. I share more effective ways of using positioning, and of using their bodies, hands, and arms in an efficient, effective way that accomplishes the work with less effort on the practitioner's part and more comfort for the client. I show how to perceive the appropriate layer to work on by "seeing" and by touch. I do a great deal of demonstrating and require the "client" to give feedback so that the practitioners get a sense of when they discover the "sweet spot" in whatever we are doing. This is a very important process for both parties as it raises awareness of how it feels on both the working and receiving ends. Here is a communication I received from one of the Phoenix Rolfers involved in mentoring sessions with me that I feel makes this point clearly:

You asked about my comment that I felt I was able to learn for the first time while being worked on. There are several parts to it. I noticed in your class that it was very helpful to experience watching then doing then receiving from you, and then receiving from another person. Each aspect gave a different perspective and together they form a more 3D view. Also the way you work giving feedback regarding what you are feeling helped me to understand better what was happening as I received it. I have received feedback from other Rolfers, of course, but since I had not just been on the giving or watching side of things, it did not seem to be meaningful to my learning process. Also I think it is possible to give feedback in many different ways and the way you do it does allow the client to participate completely in the whole process.

Miscellaneous Topics

1. How to design a session and identify goals for that session specific to the client. This applies to basic Ten-Series, post-ten, and advanced work.

2. How to keep focus on that design and goals during the session so you do not end up just "wandering around in the tissue."

3. The importance of awareness of energy curves within each session. Ending the session at or near the top of that curve rather than at the bottom allows both the practitioner and client to end the session feeling revitalized rather than depleted.

4. How to do "mini-reassessments" during the session to check in with your progress towards your initial design and goals.

5. Combining aspects of several basic Ten-Series sessions in one session for more effective results.

6. Assorted techniques for organizing the client at the end of the session.

7. Tailoring techniques for individual practitioners. (Offering options for working within their individual structural issues or problems so they do not keep "disintegrating" their own structures.)

Summary

In summary, there are two points I specifically wish to state. First, it is probably not possible or even practical for much of this to be covered in the basic or even advanced trainings. Second, our senior Rolfers (a strategic RISI resource) and their expertise are not being utilized effectively. Therefore, I offer that a more formal post-graduate mentoring program for continuing education credits would be an invaluable addition to the RISI's current curriculum.

Shonnie Carson's earliest dream was to be a doctor, which eventually became a career in nursing. In 1968 in Los Angeles she became social friends with Dick Stenstadvold and Emmett Hutchins. In 1971 during a visit to their new home in Boulder, she began her Rolfing process with Emmett and knew she wanted to become a Rolfer. Because she was under the minimum weight requirement of 140 lbs., she was not able to enter training at that time. After the weight requirement was dropped, she entered training in 1981 with Tom Wing and Betsy Sise for the first (auditing) portion, then deliberately chose to do the final part of training (practitioning) with Stacey Mills (known for her subtle work), Rosemary Feitis, and Louis Schultz. For eighteen years Shonnie's nursing and Rolfing work overlapped. She had a full-time practice for twenty-four years in Seattle, Washington and has had a practice in Phoenix, Arizona since 2004. She continually supports the profession of structural integration as a past member of IASI Board of Directors and in her present roles as vicechair of the Certification Board for Structural Integration (CBSI) and member of the RISI Law and Legislation Committee.



Shonnie Carson demonstrates shoulder technique to Bill Kamer with Donna Jo Cross as model.

The Psoas Musings of a Rolf Institute[®] Anatomy Instructor

By John Schewe, Certified Advanced Rolfer™

da Rolf recognized the importance of the psoas early in her career. One of the "cornerstone" muscles, the psoas is covered in depth in the basic Rolfing® Structural Integration training as well as in workshops, the advanced training, and the Rolf Movement® certification training. Having been a petroleum geologist in my previous career, I had never heard of said muscle when it was first mentioned by my RolferTM, Ed Hackerson, as he delved deeply into my abdomen. It turned out that the psoas was particularly important to my structure - more so than it is for many people - and Ed made sure to contact it numerous times in my basic series. I had been plagued with shooting pains in my lower back since injuring it while working as a grocery store clerk in high school. The situation with my low back was bad enough that I could not sleep supine with my legs out straight. This was especially so when I slept on the ground during numerous forays to study rocks while a geology student at Louisiana State University in the late 1970s. I often ended up sleeping with my knees up while still in my sleeping bag, my posture providing no end of amusement to my fellow students.

I thus feel I have a particular relationship with this most important of muscles and have always emphasized this fact during my anatomy lectures to both beginning students in Phase I classes as well as in the anatomy lead-in class for Phase III. As an anatomy instructor, I understand that unless one uses this anatomical information on a regular basis, it can be easy for the particulars of the anatomy of the psoas and surrounding structures to become a little fuzzy. Hence, when asked to write an article on the psoas for Structural Integration: The Journal of the Rolf Institute, I immediately agreed and set to work. If you feel you have a good grasp on the particulars of this muscle, please don't feel offended when I review some of the basic anatomical facts. I will also share some of the insights I have gleaned over twenty-two years as a full-time Rolfer and fifteen years as a Rolf Institute anatomy instructor.

The Basics

As all Rolfers will agree, one cannot discuss the psoas without discussing the equally important iliacus muscle and the often-overlooked psoas minor (when present). This complex is central to the anatomical structure of the abdominal region, and its importance has been stressed in the bodywork community for many years now. With the advent of Pilates and "core training" regimens in the gym, your average client will probably have heard of the psoas, if not actually have a good grasp of its importance. We will also look at the importance of other nearby anatomical structures – namely the quadratus lumborum and respiratory diaphragm (see Figure 1).

The right and left psoas muscles are classified as fusiform (tubular-shaped) muscles and are located deep in the lower

Figure 1: Anterior views of the abdominal region showing the relationships of the iliopsoas, quadratus lumborum, and respiratory diaphragm (from Gorman's *The Body Moveable*).



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abdominal region of the human body. (Interesting tidbit for your next cocktail party: the psoas in the cow is the tenderloin, hence the round, tubular shape of filet mignon steaks.) The superior attachments of the psoas are the transverse processes and bodies of the five lumbar vertebrae, with its most superior fibers reaching up to T12; its distal end is a cord-like attachment to the lesser trochanter of the femur.

The iliacus is classified as a triangularshaped muscle. It has a broad, flat origin that completely fills the iliac fossa of the coxal bone; as it passes inferiorly, its fibers merge with those of the psoas at the pelvic brim to form the common tendon that attaches to the lesser trochanter. There is an underlying bursa at the pelvic brim where this common tendon passes over that minimizes wear and tear.

Since these two muscles work in tandem, I like to use the common term for this complex: the iliopsoas. The iliopsoas is considered to be the major flexor of the hip joint. When the two iliopsoas contract bilaterally, they work to flex the trunk, as when lifting the trunk from a supine position while doing a sit-up.

The third member of this complex is the psoas minor, a muscle said to be found in about 40% of the population, and, therefore,

commonly overlooked. It can be more tendon than muscle, though not everyone agrees with this. It runs from the bodies of the twelfth thoracic and first lumbar vertebrae down the anterior surface of the psoas major and inserts on the iliopectineal line of the pubic bone (and thus, does not cross the hip joint). It is believed to add strength and a certain amount of rigidity to the underlying psoas major. I believe its importance lies in the fact that when the psoas major muscle becomes hypertoned, the psoas minor can add to this tightness due to its tendon-like nature. This will usually show up as a "ropiness" when palpating and/or working on the psoas major.

Along with the importance of the iliopsoas itself is the crucial relationship this muscle has with its neighbors - primarily the quadratus lumborum and the respiratory diaphragm. For me, one of the hallmarks of my advanced training in 1991 with Jan Sultan and Jeff Maitland was the emphasis they placed on working the lumbar triangle to access this vital area of the body -the so-called "sweet spot" in Jan's lexicon (see Figure 2).

Figure 3, from Carmine Clemente's Anatomy: A Regional Atlas of the Human Body, is one of my most cherished images of human anatomy showing the relationship between the psoas, quadratus lumborum, and the



anterior thoracolumbar fascia (as opposed to the posterior thoracolumbar fascia, or the aponuerosis of the latissimus dorsi). This anterior section of the thoracolumbar fascia is composed of three layers of connective tissue, one from each of the three abdominal muscles wrapping around from the front of the body. This fascial layer forms a "wall" between the psoas/ quadratus lumborum complex and the sacrospinalis group of muscles (the erector spinae and transversospinalis muscles) of the spinal column. In accessing this anterior thoracolumbar fascia, we have a profound effect on the psoas and quadratus lumborum as well as the respiratory diaphragm (and of course, the deep abdominal fascia covering these structures).

In referring back to Figure 1, we can see the important anatomical relationship between the psoas major, the quadratus lumborum, and the respiratory diaphragm. The posterior inferior edge of the diaphragm forms two small arches - the medial and lateral arcuate lines. The upper end of the quadratus lumborum slips beneath the lateral arcuate line on its way to its superior attachment on the twelfth rib, while the psoas major slides under the medial arcuate line. The entire complex is covered in a layer of fascia and is intimately related to the anterior thoracolumbar fascia previously mentioned. The importance of the quadratus lumborum cannot be stressed too highly. It not only works as the "hip hiker" in raising one of the coxal bones, but it can also be viewed as a muscle of respiration. When the respiratory diaphragm contracts during inhalation, the quadratus lumborum contracts isometrically to stabilize the twelfth rib - one of the attachment sites of the posterior edge of the diaphragm. Again, working the area of the lumbar triangle in a sidelying position will allow a small amount of work (especially when done with hip-hiking movements and/ or deep breaths by the client) to have farreaching and profound effects on this core area of the human structure. Additionally, contacting the deep fascial layers via the lumbar triangle will also feed the work down into the pelvic bowl. So, even doing "superficial" work in the lumbar triangle early in the Ten Series, we will be preparing the area of the deep pelvic bowl for later work in sessions four, five, and six.

Another important anatomical consideration of the iliopsoas complex is the presence of the lumbosacral plexus of autonomic nerves. These nerves control the sympathetic

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Figure 3: Transverse section through the lower abdominal region showing the relationship of the various myofascial components of this area (modified from Clemente).



response of the organs of the abdominal region and are embedded in the fascia lying over the psoas/quadratus lumborum muscles. Overwork in this area can cause a sympathetic ("fight or flight") response. This was shown to me in a most dramatic fashion on two separate occasions early in my Rolfing career. On both occasions, it was the instructor who triggered this response; and in both cases, it involved hyperventilating and uncontrolled shaking by the model/ client. Breathing into paper bags and some craniosacral work relieved the response, and in the "post mortem" (ahem – I know, a bad choice of words) both instructors admitted that they had gotten a little carried away and overworked the psoas. It was a great learning experience for us students, and I vowed that I would always err on the side of doing too little, as opposed to doing too much, when it came to the psoas.

In looking back on my teaching career, it is interesting to note that there have been changes in how we Rolfers approach working on the psoas. I was taught to carefully sink down through the abdomen, gently pushing the intestines out of the way until I came to the psoas. I had seen the psoas worked with the client supine, knees either up or flat on the table, and have used both approaches in my practice. A number of years ago while teaching a Phase III lead-in class, I went to palpate the psoas in this fashion and there was an audible gasp from the class: "We were told in Phase II to never work the psoas like that you could puncture the intestines if you are not extremely careful." Acquiescing to the

students' concerns, I showed them how to access the distal end of the iliopsoas muscle just lateral to the femoral artery, as well as the edge of the iliacus muscle just behind the anterior superior iliac spine (ASIS). The following year, teaching another Phase III lead-in class, I asked the students how they were taught to access the psoas in their respective Phase II classes, and to a person, they said they were shown to carefully sink down through the abdomen. So, I'm not sure where that little "blip" in approaching the psoas had come from, but it seemed to fade within a year of surfacing.

Internal vs. External Considerations

Being an acolyte of Sultan's internal/ external typology, I have two distinctly different ideas with regards to addressing the iliopsoas. Any undue bilateral psoas tension will cause the lumbar vertebrae to be compressed, thereby exacerbating any ill effects of lumbar compression. Unilateral hypertonicity will cause compression as well as rotation. In externals, with their typically flat or posterior-tilting pelvises, I believe that the psoas major lies centered in the mid-coronal plane with a decidedly erect orientation slightly posterior to the bodies of the lumbar vertebrae. In internals, with their typical anterior-tilting pelvises, the psoas major will lie forward of the mid-coronal plane and more anterior to the lumbar bodies. Any undue bilateral tension in the internal configuration can accentuate the anterior tilt while unilateral tension will cause rotation as well. In general (and I do mean in general), I have found that

externals tend toward hypertoned psoas major muscles more so than internals. This makes sense if you believe that externals tend to be more "core bound" than internals – and what could be more "core," muscularly, than the psoas muscles? One final observation: if I do encounter hypertonicity in the two iliaci muscles, almost invariably the tighter of the two muscles is the one on the left. Now this is not some scientific study I have done, just something I have noticed over the years and food for thought.

Working with the Iliopsoas

My "standard" approach to accessing the iliacus and psoas muscles is the one I learned in basic training – the client lying supine, knees up, feet flat on the table. I usually start with both iliaci just behind the ASIS and have the client rock his pelvis very slightly. While still contacting both iliaci, I then have him slide one leg down onto the table, then the other. I pick one side and have him slightly raise his knee while still working that iliacus behind the ASIS. The work can be done with hands, or gently with an elbow. After doing the same on the other side, I move to the psoas with the client's legs still down. Once I have contacted the psoas on that particular side, I have the client slightly raise that knee. A couple of these movements will finish the work here. If I feel that the psoas needs more work, I will work something else to give both psoas muscles a chance to integrate and settle down. Then I may go back and briefly touch in on them again later that session, or make a note to do some more work here later on in the series. With both internal and external types, I have found that the hallmark of a well-toned and integrated psoas is that it is hard to find and contact, even with the client's leg laid out flat.

Obviously, I have tried different approaches to the psoas including standing and seated work, but I find that this basic approach will suffice for almost all of my clients. While this may seem a bit conservative, I have found that I have never "overcooked" a client and have had nothing even approaching a sympathetic response. (The two instances of instructors overworking the psoas, mentioned earlier, involved seated work in one case and standing work in the other.) I also believe that I have not *under*worked the psoas in this approach. While not eliciting a sympathetic response, I have encountered numerous emotional releases from clients while working this area. (One time, at the beginning of my career, I merely touched the two iliaci and my client had a dramatic emotional release – naturally, that was enough work in that area for that session).

The Iliopsoas and Rolf Movement Integration

During my training in Rolf Movement Integration, I was impressed with the amount of time and energy devoted to the iliopsoas and its effect on the free and easy movement one looks for in walking. In my basic training, I was shown Dr. Rolf's "bell clapper" exercise and have used it repeatedly throughout my career. For those of you who may never have heard of this technique, it is performed as follows:

Place a small footstool (a large phone book will work as well) near a wall, leaving a space between the stool and the wall. Have the client stand perpendicular to a wall, with the foot further from the wall on the stool and the closer side of her body supported against the wall; in this position, the leg closest to the wall will hang freely, ready to swing. Ask the client to gently swing her leg forward and backward, as if it were a bell clapper - the psoas/leg is the clapper and the respiratory diaphragm is the bell. I place my fingers in the lumbar region and gently coax this area to lengthen when the leg swings forward. For most clients, in doing this action the lumbar region either contracts slightly or stays neutral. By using my fingers to promote lengthening here, I believe that I can alleviate any unnecessary contraction of the lumbar region while the psoas is doing its job. This intervention promotes the functional integration of the legs, pelvis, and lower back while walking.

Also part of my movement training with the iliopsoas was a discussion of the difference between the swaggering gait of John Wayne and his severely restricted psoas/pelvis and the smooth gait of Mikhail Baryshnikov whose legs seem to float and reach out from his pelvis. I like to say that John Wayne walked "around" his pelvis while Baryshnikov walks "through" his pelvis. In the John Wayne style of walking you do not see the torsional movement across the two sacroiliac joints that you do see in the

Baryshnikov-style of walking. We can look at these styles of walking as two ends of a continuum, with the goal for our clients being to have the John Wayne style more closely approximate the Baryshnikov style. In order to accomplish this goal, I employ a lot of iliopsoas integration, especially in sessions eight through ten of the ten-session series. This integration includes, but is not limited to, the "bell clapper," classic Rolf Movement "heel drags" with the client supine, and the visualization of the connection from the lower limbs up into the lower trunk and beyond while doing bench work. Needless to say, when the iliopsoas is healthy and working properly, it shows up immediately in the client's gait.

Conclusions

Every Rolfer will have his or her own style of working with the iliopsoas. That, to me, is one of the beauties of the ten-session series and all subsequent advanced and movement work – there is plenty of room for variation and creativity depending on the client's needs. Dr. Rolf realized the importance of the psoas at a time when very few people even knew it existed. It is a "cornerstone" muscle in the integration of the human structure, and the more educated and comfortable one is in working with this crucial complex, the better the work of Dr. Rolf will be integrated by our clients and subsequently move out into the world.

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John Schewe was certified as a Rolfer in 1987 and completed his Advanced Training in 1991. He began teaching anatomy and physiology, and structural kinesiology, for the Rolf Institute® in 1996. He is a Phase I class coordinator and is currently the Chair of the Life Sciences Group at the RISI.

The Connective-Tissue Matrix and the Psoas Muscle

By Kevin McCoy, Certified Advanced Rolfer™, Rolfing[®] Instructor

Embryologically, connective tissue is one of four "tissue types" which together make up the entire body. The other tissue types are muscle, nerve, and epithelial tissues. Connective tissue is classified as either general or specialized. General connective tissue differentiates into fascia, ligaments, tendons, and joint capsules. Specialized connective tissues differentiate into cartilage, bone, and blood cells. This article will discuss the fascia related to the psoas muscle. After this review, some suggestions regarding how to work with the psoas muscle using this understanding will be discussed.

The study of the human body has a long history. Much of that history has focused on everything but the fascia. As a result, anatomy is taught, even in many schools of structural integration, from a perspective of musculoskeletal anatomy. My basic training as a practitioner was taught according to this method – attention to the musculoskeletal model and little attention to the connective-tissue matrix model.

Review of Named Fascial Layers Related to the Psoas

We will discuss the following fascial layers and their relationship to the psoas muscle:

- Iliac fascia
- Anterior, middle and posterior lamina of the thoracolumbar fascia
- Transversus fascia
- Rectus sheath

Iliac Fascia

The iliac fascia covers the iliacus and psoas muscles.

Relationships in the connective-tissue matrix: Iliacus fascia is derived from connective tissue. As mentioned above, other forms of connective tissue include bone and ligament. Here we will describe where in the connective-tissue matrix the iliacus fascia "ends" in bone or ligament.

The iliac fascia transforms into bone or ligament at the following places:

- Lumbar spine
- bodies of first and second lumbar vertebrae
- transverse process of first lumbar vertebrae
- Pelvis (inominate bone)
- inner lip of iliac crest
- pelvic brim
- iliopubic eminence
- pecten of the pubis
- Ligamentous
- arcuate ligament of lumbar spine
- posterior margin of the inguinal ligament

There are other places in the connectivetissue matrix where the iliac fascia continues on as fascia, however it is no longer covering the muscles named above – iliacus or psoas – and thus changes its name. At these places the fascial layer is known as:

- Anterior lamina of thoracolumbar fascia (see below)
- Transversus fascia (see below)
- Obturator fascia (not discussed in this article)

Anterior, Middle, and Posterior Lamina of Thoracolumbar Fascia

The thoracolumbar fascia (aka lumbodorsal fascia or LDF) has three layers or lamina: the anterior, the middle, and the posterior lamina of LDF. All three lamina have an anchor in the connective-tissue matrix at the crest of the ilium as follows:

• Posterior lamina attaches to the outer lip of the iliac crest.

- Middle lamina attaches to the very top of the iliac crest.
- Anterior lamina attaches to the inner lip of the iliac crest (it is continuous here inferiorly with the aforementioned iliacus fascia).

The posterior lamina of the LDF covers the erector spinae. This article will not cover in detail anything further regarding the posterior lamina of the LDF.

The middle and anterior lamina of the LDF envelop the quadratus lumborum muscle. The middle lamina provides the fascial layer covering the posterior aspect of the muscle while the anterior lamina provides the fascial layer covering the anterior aspect of the muscle.

Relationships in the connective-tissue matrix: Both layers of fascia (anterior and middle lamina of LDF) transform into bone or ligament at the following places:

- Transverse processes of L1 L5
- Twelth rib (inferior border)
- Iliac crest (see above for specific site of attachment to the crest for each lamina)

As these two lamina of the LDF meet at the lateral boarder of the quadratus lumborum, the fascia changes its name and becomes the transversus fascia (see below).

Transversus Fascia

The transversus fascia lies deep to the transversus abdominis muscle.

Osseous, ligamentous, and fascial continuities are as follows:

- Ilium: at the crest between the muscular attachments of transversus and iliacus
- Inguinal ligament at the posterior margin
- Iliac fascia
- Anterior lamina of the LDF
- Rectus sheath (see below)

At the lateral border of the quadratus lumborum, the transversus fascia divides into two layers and changes its name. The anterior layer, which covers the anterior surface of the quadratus lumborum, is known as the anterior lamina of the LDF (see above), and the posterior layer, which covers the posterior surface of the quadratus lumborum, is known as the posterior lamina of the LDF (see above).

Rectus Sheath

The rectus sheath is the connective tissue covering of the rectus abdominis muscle. It is formed by the aponeurosis of the internal oblique, external oblique, and transversus abdominis muscles. The sheath extends superiorly to the costal margin and inferiorly to the midpoint between the umbilicus and interpubic disc - the acus tendineus. The posterior wall of the rectus sheath is formed by the internal oblique and transversus abdominis muscles (and their respective associated fascial layers). Given that these muscles are very thin, palpating the lateral border of the rectus sheath to the underneath side is in an effective way of contacting the transversus fascia.

Working with the Psoas Via the Connective-Tissue Matrix

Psoas work is a very important aspect of Rolfing Structural Integration. However, it is not always necessary to touch the psoas to be effective. Having an appreciation of the connective-tissue matrix and its relationship to the psoas muscle allows practitioners subtle and powerful means to "work with the psoas." Furthermore, practitioners are becoming more and more sophisticated in the utilization of movement principals, specifically coordination and perception, to enhance their work with clients.

In closing, we will discuss a few aspects that practitioners may utilize to effectively work with the psoas, incorporating an understanding of fascial layers and movement principles.

Positional Strategies and Movement Concepts

Here we will discuss two different positional strategies and the movement concepts related to each position.

Position 1: Hook Lying. This is a position where the client is supine with the knees up, feet flat on the table. Movement concepts related to this positional strategy for psoas work include calling for movement (coordination) and inviting body awareness (perception). Begin by inviting the client to feel his feet on the table (perceptual awareness) and to gently press into the table with the whole foot (coordinative pattern). This may help the client and practitioner to begin to feel the activation of transversus abdominis. As the client engages the transversus the practitioner may now invite

a slow gentle movement through the axial complex by asking the client to curl his tail toward the ceiling. This needs to be a slow and easy "call to movement." The practitioner is now assisting the client to discover new possibilities of coordination involving psoas in balance with rectus femoris, rectus abdominis, and piriformis. These types of explorations of micromovement can be seen as assisting the client to develop a new anticipatory postural activity (APA) to support further motor programming. As the practitioner and client are able to perceive a degree of success with this movement pattern, more complex movements may be added such as slowly raising one foot off from the table or sliding the foot down the table, movements involving contraction of the psoas. Practitioners can look for pelvic stability during these more complex movement patterns. If the practitioner notices a lack of stability through the pelvis - for example, tilt, shift, rotation, or torsion of the pelvis - during this movement invitation, it may be best to go back to the prior step to establish better activation of transversus.

Position 2: 1/2 Hook Lying. This is a position where the client is supine with one knee up, foot flat on the table, and the other leg stretched out. The movement pattern would be the same as above - however, now the activation of transversus will come primarily from the foot in contact with the table, and the activation of the psoas will come from the leg that is lying straight on the table. The call for movement will consist of a small invitation for knee flexion of the straight leg. Again, if there is a lack of pelvic stability the practitioner may wish to return to the activity described above in Position 1, and assist the client in his ability to perceive pelvic stability prior to proceeding with Position 2.

Incorporating Fascial Layers into Psoas Work

Practitioners may further enhance the effectiveness of their work with clients through their hands-on skills. While attending to the positional strategies and movement concepts described above, a practitioner may also work with his client from a fascial-layers perspective. Potent areas to contact include:

Rectus Sheath. Contacting the rectus sheath with the intent of gently finding the underside surface gives the practitioner direct contact with the transversus fascia (see rectus sheath above). By contacting the transversus fascia the practitioner can feel through the fascial layers – actually one continuous layer that changes its name – from transversus fascia to anterior lamina of LDF to iliac fascia (covering the psoas muscle). By contacting the rectus sheath in this way and asking for movement as described above, the practitioner is effectively working with the psoas and the client is enhancing his coordinative and perceptive reality.

Crest of Ilium. Contacting the crest of the ilium (client in hook lying position, see above) at the point superior to the anterior superior iliac spine, the practitioner is able to fairly easily and gently explore the contour of this aspect of the client's ilium. Explore in particular the inside aspect of this point on the ilium just above the inguinal ligament. As you come into the bowl of the pelvis from this point, know that you are now on the iliac fascia, the fascia that covers the iliacus and psoas muscles. Therefore, the intention of the

practitioner can be to affect the psoas with a clear line of contact. If the practitioner stays on this inner surface of the ilium and brings his touch to just above the crest, his direct touch is now where the iliac fascia has transitioned into the transversus fascia. Once again the practitioner can follow the connective-tissue matrix from transversus fascia to the anterior lamina of the LDF to the iliac fascia (covering the psoas muscle). Again, by contacting the tissues in this way and asking for movement, the practitioner is effectively working with the psoas and the client is enhancing his coordinative and perceptive reality.

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SI Psoas Intervention Considered in Terms of Normal Stability Response for Hip and Trunk Flexion A Perceptive/Coordinative View

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Abstract

The psoas muscle topic highlights important differences between structural integration (SI) practice and allopathic approaches to musculoskeletal symptoms and dysfunction. Ida Rolf's SI approach restores system coordination integrity rather than claiming to cure disease or organ, nerve, or muscle pathology. Out-ofbalance psoas function is part of a motor control pattern. Psoas issues are part of confused patterns of stabilization: the psoas is frequently recruited as the primary or secondary rather than tertiary stabilizer. SI is about restoring primary (normal) stability tendencies so that muscles such as the psoas are available for appropriate function. Rolf made fascial touch with the psoas part of her protocol, and it is integral to restoration of normal stability and coordination in the Rolfing[®] SI series. SI work benefits when it is described as part of a package of coordinative system interventions for primary stability and security. It is enhanced by a comprehensive approach to stability that includes perceptive-based self-care programs that mirror the work of the series.

The Myth of "Psoas Work"

"Psoas" is a word you hear a lot in body therapy circles. It's an icon that stands for successful or pathological movement and posture. Rolf steered body therapists to think about the psoas and incorporate psoas "manipulation" into touch therapy. She described healthy function in terms of correct "uses" of the psoas muscle. SI training involves learning to administer the classic manipulations developed by or inspired from Rolf's sessions. Psoas work - direct touch to the psoas muscle accompanied by active engagement of the muscle by hip flexion/extension and spinal movement - continues to be an important tool.

But are image and reality congruent? Is the psoas the appropriate protagonist of this story? How do mythologies about the psoas serve or hamper the message of SI?

Do We Know What Is Going On?

What are we doing when we do what is called in SI "psoas work?" What is the logical role of the psoas in the story of body posture and movement? What is the logic behind our model of psoas function?

The psoas muscle is the primary hip flexor. It is also a flexor, rotator, and side-bender of the trunk. When the psoas contracts, as with any muscle, attachments are pulled toward each other: the lesser trochanter of the femur and the front of the transverse processes, as well as the sides of the bodies, of the lumbar spine are pulled toward each other. Depending on movement choreography, the fixed point may be distal or proximal or both. The body's movement control system, the "movement brain,"1 recruits synergists and antagonists to establish stable fixed points as necessary for the intended action. Absent good choreography, the psoas is just another tool for putting the body into a concentric ball.

The psoas, like all muscles, is a collection of motor units; only some of those motor units will fire as signaled to do so by the body's movement brain. Motor unit selection within what we call the psoas muscle, along with motor unit selection in synergist muscles and antagonist muscles, are the movement brain's way of shaping movement. Motor units do just that – they contract and relax. They respond to innervation by motor nerves. They obey the choreography of the movement brain.

"With Your Knees Bent, Raise One Foot Slightly Off the Table"

When we ask a client (bent-knee, supine) to raise one leg while we apply manual pressure through the abdomen to encounter a bulge of active psoas tissue, what's the net effect of this technique? What do we say we are doing? How does the psoas narrative fit the overall SI narrative?

Are we rehabilitating fascial tissue associated with the psoas? Are we teaching people to "use" their psoas in a different manner? Such results may occur, but these descriptions are suspect. They imply that one or both muscles are somehow sources of dysfunction. Is psoas function (or dysfunction) the culprit in back pain, temporary scoliosis, compression of the lumbar spine, or walking with legs in front of the body? Or is there corruption at the level of system-wide motor-control patterning? If the latter, what is the relationship of fascial manipulation to poor motor control? Fascial touch, combined with strategically initiated movement, in fact demonstrates an efficient means to change motor control.

Does the Movement Brain Know What It's Doing?

What activity do we restore in SI? Are psoas muscles the issue? Is the fascia of the psoas the thing we are trying to change? It is convenient to say that it is. It adds mystique to the practitioner's role. It is convenient for marketing the work (and now many body therapies and workshops market the psoas feature to attract interest), but do we seduce ourselves and our clients into an unfortunate model?

The movement brain is smart. Human beings can do extraordinary things. Acrobats, dancers, jugglers, athletes, and *parcour* masters, to name a few, fill YouTube clips with astonishing feats of coordination.

If the movement brain is so smart, why do our clients' psoas tissues feel so tight? Why do iliacus and abdominal tissue feel tight? Why does the diaphragm feel fixed? Are these tissue issues? Are these neurological issues, or organ issues? There may be organic issues, but within the SI scope of practice what is our fundamental point of view?

SI is Body Integrity through Gravity

The prime directive of the human body, of the movement brain, is, "Don't fall down!" To obey this directive we develop what is called in the world of adult physical fitness "core stability." Core stability isn't a technique – it's developmental health. "Core" isn't a thing, although it is marketed as such. "Core" is normal adaptive response to demand. It is a system event.

Core stability begins in childhood with the stable feeling of being held by the ground, and by competent caregivers who offer their own postural stability as a feeling tone for our little selves to absorb. From a place of stability we explore the world, and we encounter "demand." Demand denotes the stuff we need or want to do: the desire to nurse, or reach for a toy, the impulse to push something or someone away, the impulse to stand and to stand and walk. We encounter many demands from the world, a world that flies in our face with unexpected challenges to our physical or psychological well-being. How we meet demand is a measure of core stability. The movement brain's primary goal is to help us meet demand without falling down.

From the beginning of human life, falling down physically and falling down psychologically are not separate matters. Posture, sense of identity, and physical competence are inextricably linked through biology that senses verticality. The biology of verticality is fundamental to Rolf's view and offers a metric for integrity of function: how well are we negotiating verticality? Rolf understood that biology is at the root of psychology, and she saw that our biology forms in response to, and with integral sensitivity to, gravity. Biology doing well with verticality is body security. SI addresses body security and, conveniently, it underlies psychological security.2

We can talk about biology and gravity when we talk about the movement brain. The movement brain orchestrates messages of support from our contact with the ground and our orientation to the space around us. These messages, in turn, guide our postural system to stabilize our axis.

It is the job of our movement-brain system to provide a dynamic adaptive response to, among other things, the need of the hip to flex. We do this every moment we walk: our hip joint flexes so one foot catches our fall. To effect hip flexion, psoas motor units briefly fire to assist the hip in swinging forward. Why would the psoas need our touch? Interruptions to movement-brain response occur. This is a form of motorcontrol confusion.

What "Confusion" Is Our Work the Answer To?

Our question regards motor-control confusion – confused coordination – and SI addresses this. We support the body so it can sort out confusion and restore integrity. Our work informs the movement brain to clarify postural preparation for actions that necessitate recruitment of psoas motor units. SI refreshes and differentiates the body's proprioceptive and action maps so optimal choices in preparation are once again possible. What is an example of a postural confusion we find in bodies that have wandered off the path of optimum coordination?

Phasic Muscles Substitute for Tonic Ones

Frequently, we see phasic muscles used as tonic ones. We find that action muscles are recruited for sustained stabilization. This covers a broad range of situations and includes not only the psoas, but also superficial abdominal muscles, the respiratory diaphragm, pelvic floor, lateral rotators, quadriceps, trapezius, pectoral, and rhomboid muscles (to name a few) enrolled as chronic (as opposed to episodic) postural stabilizers. Put simply, the "lastline-of-defense" (tertiary) stabilizers are used as "set it and forget it" (primary) stabilizers.

Why does this condition arise? What leads to such a dubious choice? The answer, simply put, is that in moments of overwhelm we compel the body to make temporarily expedient choices.

Movement Brain Overridden

Expedient considerations override the movement brain. We preempt automatic movement intelligence in moments of overwhelm or to serve image-based posture choices. We replace movement-brain choices with effort-based choices, because they feel better, look better, or because it feels like we just have to (lest we fall down). Some effort-based movement patterns stick right away; others take repetition. In either case, we face one problem: there is no reliable body function to undo this, no reset button to restore movement-brain primacy to everyday events, ones in which lastline-of-defense recruitment is reserved for last-line-of-defense moments. Special-case override becomes a permanent solution to everyday situations. This is a source of what Rolf called, "random bodies." Randomized bodies express confused stability function.

Enter the structural integrator. The offer: assist clients in their path back to appropriate motor control. SI helps people recover automatic responses to demand – body responses that use economical motor unit choices and synergies.

What Happens When We Touch Psoas Fascia?

We touch the fascia of the psoas to inform the body about preparation and stabilization. We teach the body that with sufficient stabilization - from feet, hands, differentiated and bidirectional orientation of the spine, and support from the spatial dimensions of the environment - we may flex the hip without subverting psoas function into a stabilizing function. We touch the fascia of the psoas while insisting that movement be slow and wellprepared. We touch the fascia of the psoas while insisting on presence to the sensory landscape of the event. We touch the fascia of the psoas as part of a system-wide restoration of stability.

Fascia is an efficient communication network for differentiating the body's map of itself.³ At the same time, it helps to know what we are trying to say when we touch fascia. We touch fascia to help the brain sort out what body parts need support and fixation and which ones need to act. Our touch wants to be informed about stabilizers.

What Are Stabilizers?

The human body is an example, to quote Gracovetsky, of controlled instability,⁴ for which there are evolutionary advantages.⁵ A body designed for instability can move quickly and efficiently by letting go. This evolutionary improvement – instability – requires parallel improvements in the mechanisms that assure stability. Rolf thought humanity was still working on this part of the equation.

Our upright body is upright only so long as a set of automatic reflexes keeps us upright: for standing, walking, and all the things we do. In his tonic function model, Godard points out the distinction between muscles that are designed to hold us upright, the tonic muscles, and the ones that are for action, the phasic muscles, and how important the tonic system (including tonic muscles) is to understanding the role of gravity and gravity response to the work of SI.⁶ The take-home message for structural integrators: it's the client's gravity response system with which we work.

"Tonic muscle" denotes a muscle that is physiologically endowed to function for stability in gravity. "Stabilizer muscle" (rather than tonic muscle) is a more userfriendly idea for many clients. Stabilizers are muscles (along with fascia) that fixate the body so that other muscles have a fixed point from which to move a body part that is not fixed. In the spine, stabilizers play the role of erecting the spine, holding it erect, and stiffening the spine as necessary to resist bending stresses from muscles or loads applied to the body as a whole.

Different Types of Stabilizers

In the service of stability the body has different structures for different predicaments. The movement brain, in the absence of subversion, will employ primary stabilizers first. Primary stabilizers are less corruptible; that is, we are much less able to manipulate them at our whim. They are economical: optimum geometry; optimum stretch receptor density (lending nuance to amplitude and timing); optimum blood supply; and optimum linking with fascia to help them carry the load better. Optimum economy gives primary stabilizers a "set it and forget it" function that is handy for us (bipeds) in meeting the challenges of life.

Primary stabilizers are designed for small amounts of action and large amounts of nuanced and economical stabilization of the spine. But not all stability is provided by primary stabilizers. There is a line of reasoning, articulated by Chaitow and others, that we improve our muscle model by positing three classes of stabilizers.⁷ Thus, stabilizers are broken down into primary, secondary, and tertiary stabilizers. Secondary stabilizers trade off some stability economy for a greater chance at effecting action.

Secondary stabilizers are very important because sometimes we briefly need greater resistance to falling down. Tertiary stabilizers trade off still more economy and efficiency of stability than secondary stabilizers do. They, in turn, achieve greater

potential for action-oriented movement. However, when the body needs the absolute highest resistance to failure, they can provide robust and dramatic stability.

No particular muscle is bad or good – each has importance for survival and well-being; otherwise, we wouldn't have it. However, orchestration of stability can become confused, as mentioned earlier. Muscle classification can itself be a trap. Focus on muscles won't revive system stability. Focus on trying to activate a muscle usually makes movement worse; and, ironically, we increase stability confusion. With regard to the psoas, knowing more about function and tissue type may, in this case, help ease our muscle-focused thinking.

The Evidence for Psoas as Primarily an Action Muscle for Dynamic Movement while also a Tertiary Stabilizer for "Last-Line-of-Defense" Stability

Considered through Function

The psoas is a muscle that can move the femur, or move the trunk in a large range of motion. Psoas function can exhibit a whip-like, rapid force. We see this in limb movement and also with spinal movement. Jim Asher, a Rolf Institute® of Structural Integration (RISI) instructor and close friend of Ida Rolf, pointed to popular athletes to illustrate integrative function: in 1987, he spoke about the amazing ability of O.J. Simpson to jerk his body sideways to escape being tackled, what Asher referred to as his ability to "juke." Asher mentioned Simpson to demonstrate an unusually skillful move involving the psoas. In this case, the distal attachment of the psoas is momentarily fixed so as to effect the movement of the spine to evade capture. (One observes that Simpson later developed other capacities to evade capture as well.)

With proximal psoas fixed points, the distal motion of the femur can be similarly dramatic, as with a skillful kick of a ball in the midst of a sprint down a field. Psoas action can also be part of efficient gait, as with aboriginal hunters who run twenty or more miles to catch their prey.

The psoas is part of rapid and dynamic trunk or lower-limb movement; however, it doesn't function on its own. Our message weakens if we imply that it does so, if for no other reason than it steers people to think about the psoas muscle when they move

The Simpson example makes the point that the psoas is an action muscle – a phasic or mobilizer muscle. However, it can also act as a powerful stabilizer. Gibbons describes psoas stabilization in terms of axial compression.⁸ Stiffening the spine by compressing it is a form of stabilization, but an expensive form. One can also imagine the evolutionary advantage for early hominids in being able to wrestle another hominid or wrestle a large angry antelope, aided by brief recruitment of the psoas muscle to resist the twisting of the other mammal.

We can think of psoas stabilization as a part of our coordinative repertoire: it enables us to overwhelm or resist overwhelm by an opponent or prey or predator. The psoas can powerfully lock the spine, or contribute to snake-like power. (Holding a house cat still, to treat an injury, it's surprising how it can wiggle out of one's grasp.) We need this function and, at the same time, we need to reserve it for special occasions – for moments rather than hours of sustained contraction. Functionally, the psoas fits the picture of what Chaitow terms a tertiary stabilizer. It can supply high levels of force and stability but is a very expensive choice when other choices are available. (The iliacus belongs logically in the category of secondary stabilizer not ideal for sustained control, but also less of a mover than psoas. When iliacus functions as primary stabilizer, it is a similar confusion to psoas. Differentiation of the iliacus and psoas through fascial touch and coordinative demand is typically part of the Rolfing protocol.)

Considered through Physiology

Functional assessment of the psoas as an action muscle is bolstered by psoas physiology. Muscle fibers are classified as slow-twitch (type I) and fast-twitch (type II), where slow-twitch muscles are set up to provide long-lasting stability and fast-twitch fibers are best suited for action. It turns out that the psoas fibers are fast-twitch (type II) at both superficial and deep levels of tissue. Contrast this with multifidus, a primary stabilizer muscle – the fibers of which are slow-twitch (type I).⁹

Functionally and physiologically it is logical to think of the psoas as an action muscle that can function as a stabilizer, but function expensively.

Psoas Converted to a Primary Stabilizer – Gravity Organization and Psoas Use

The question remains, why and how does the psoas end up committed to stabilization rather than action? What leads to psoas function tied to dysfunction? What leads to the palpatory impression that the muscle has been holding on for dear life, and is painful to be touched?

How do People Find (Or Not Find) Adequate Support?

A person sits on a chair or bench: where is the support? Do the feet register pressure and weight? If the upper body center of gravity (G') is posterior to the hip-joint axis, what keeps the head and trunk from falling backwards? A chair back offers some support, but does the movement brain register the intended support? Is the lumbar curve kyphotic and therefore evading support? Even with a chair back, and especially in the absence of one, we see the psoas, with a distal fixed point, used as a back sling. The issue of a posterior gravity center is amplified in cross-legged posture. Is there weight on the knees and rami, or are these points unloaded? When people sit on the floor, upper center of gravity behind the hips, the body learns to use the psoas as a primary stabilizer. The psoas is recruited to prevent a backward fall. With time, this posture reinforces itself and spinal compression amplifies.

Driving a car is an interesting case: as with other seated postures, the psoas spends time passively shortened in hip flexion. There is a seat back, but is the body relaxed against the seat? A G' posterior posture while operating a car is a perceptive conflict. When one drives in traffic, an activity that draws the attention forward, it involves a sustained "sit up and lean forward" response, consciously or subconsciously. The messages to the body are not congruent. One message says "Lean forward to avoid hitting something," while seat architecture says, "Lean back." For some there will be no apparent conflict: many people feel a car is a secure womb from which to calmly weave through the bustle of life. For some, however, a car provokes an extension of body vigilance - to gain advantage; to avoid being struck - for which the perceptive system puts the extended sense of body out in front of the car itself. The movement brain tries to help. The psoas activates

(futilely) to put the physical body closer to its target of interest. A long car ride can produce many debilitating results; a tight psoas is one of them.

When we observe a person walking or running energetically, but with the upper center of gravity behind the hip joint, the trunk is necessarily "towed" forward by the psoas, while the same muscle is being used to lift the leg out in front of the body to take a step. The psoas has no secure upper fixed point, and at the same time is being used to hold the spine from falling backward.

In contrast, if we observe a person walking or running with the upper center of gravity ahead of the hip joint and the lower center of gravity (G) in front of the Chopart¹⁰ joint of the foot - in other words a person with both gravity centers forward of their respective points of reference – we observe another psoas conflict: the need for both upper and lower psoas fixed points. The strategy requires concentricity of contraction. The respiratory diaphragm and psoas are keeping the feet "suspended" off the ground and at the same time, paradoxically, keeping the body from falling forward. The psoas is part of a defense against the lack of lower support and acts in a sustained role of stabilization.

Observe a plumber, carpenter, electrician, auto mechanic, logger, or weekend warrior doing backyard chores. The person stands bent forward over his or her task, holding a tool or heavy machine. These situations extend over time, periods in which there is lack of support from hands and feet and directionality in spine. Slowly, surely, the secondary and tertiary stabilizers kick in, but not for brief periods of time - they stay engaged. The psoas is recruited to stabilize the spine to produce work. Unfortunately, forward lean of the trunk combined with axial compression from psoas anterior to the gravity line compounds gravity load on the tonic extensor muscles in back. The struggle between flexors and extensors of the trunk becomes background to the struggle with the saw or wrench. This struggle goes unnoticed for long periods of people's lives.

We observe a person lifting a heavy box. He or she anticipates the load with some mix of willpower and angst. The upper body doesn't relax forward – it gets pulled forward to grasp the load. Psoas is evoked unnecessarily for trunk flexion. What is the chance that the psoas may remain tensed as the body stands upright and asks for hip extension? The psoas is recruited as a flexor and stiffener that holds the body forward, while the body is being asked to erect itself under load.

In competitive rowing, what happens as the crew is urged to row faster by the coxswain? Does the brief trunk-flexing action of psoas release fully in the pull phase of the stroke? Or does urgency tell the rowers to keep the spine stiff to exert earnest effort? The psoas slowly converts to spinal stabilizer to master the event of competitive rowing, a conflicted pattern.

We watch a client demonstrate the leg-lift portion of the Five Tibetans exercise, or any manner of crunch exercises such as the Hundred in Pilates training. What gets practiced? Is hip flexion preceded by an appropriately stabilized (stiffened) spine prior to engaging hip flexion, or is it more likely that hip flexors (as well as other secondary and tertiary stabilizers) are being asked to stiffen the spine and then simultaneously flex the hip? Again, we see a conflicted use of the psoas and, at the same time, a conspicuous absence of attention to stability. In the author's experience, no client has the level of stability to seriously engage in supine bilateral leg-lifts without exacerbating confused motor control.

The psoas moves from tertiary to primary stabilizer in any number of ways. The common thread is episodic to habitual subversion of the psoas from actionoriented (or tertiary stability) role, to primary stabilizer role. The reader is encouraged to consider his or her own list of examples.

Psoas Free to Respond to Demand

Human gait shows optimum stability and harmony of hip flexion when we don't see localized points of tension and effort. What we read as tightness, effort, or tension usually involves agonist and antagonist co-contraction, and secondary or tertiary stabilizer muscles recruited to hedge against failure.

A healthy human body walks in a manner that suggests a flow of highly differentiated events, brief and nuanced, so as to give the observer a sense of fluidity. A healthy walk looks both effortless and, at the same time, secure. Falling down appears unlikely, even if a surprise occurs on the way. The psoas muscle stops being a source of concern as star or villain of movement.

What Coordinative Exercises Expand the SI Tool Box?

Rolf's "psoas work" was, as previously mentioned, an advance in teaching clients to find improved posture and function. This article affirms the value and efficacy of what we already do. Fascial work typically combines with movements such as: bent knee raise supine; knee extension and flexion supine; segmental flexion and extension of lumbar spine accompanied by guided touch anterior and posterior to spine; and lateral flexion of spine supine. In addition, seated work can include lumbar flexion and extension, lateral flexion and rotation of the spine, and hip extension. This list is not exhaustive but suggests the breadth of dynamic movement/ coordinative challenge that accompanies attention to the psoas in SI.

We reframe and clarify the action of our work by understanding the role of the psoas in relationship to the role of primary stability, biomechanically and experientially. We clarify our message when we support clients discovering what stability feels like. Clients are happy to find that perceptionbased exercises arouse the sense of having received a session. In this way, Rolf's claim that change improves over time becomes more plausible. Clients are less likely to think of their practitioner as someone who cures them of "psoas problems," which is a false idea. Additionally, we update the SI message so it reflects contemporary models of motor control and stability.

What Are the Goals for Exercises?

Exercises for core stability will be done differently in an SI context than when done in most other exercise or therapy contexts. As SI practitioners, we know that if we wish to make a deep change, a lasting change, we will want to contact gravity orientation.

Our goals for exercise are specific: stabilize at the level of orientation; stabilize at the level of perception; invite recognition of the feeling (and pleasure) of stability; sustain the perception and recognition of perception; execute a sufficiently feasible challenge to amplify stability from demand. This approach supports movement-brain priority: establish position in gravity; establish the sensory landscape of body and

action space; receive the experience of body security; respond to demand.

An additional goal: experience how the spine can lengthen as demand load increases. As load increases and the spine lengthens, the sense of personal "doing" reduces, or disappears. For most people, this is a relief and an unusual experience. It's counterintuitive but also a welcome contradiction to our belief that life is effort. Lengthening response to load is part of our human birthright, one that we may never have known. Rolf's message points to this phenomenon with passion, and is communicated by bodies in which it has come alive. The mission of SI is to transmit this message. A body that lengthens with increased load is a body in which the psoas functions well. Psoas function is a reflection of how well the body has prepared for psoas recruitment. The ground of the psoas movement, the background activity that precedes the psoas action, is the basis for exercises and the basis for living life.

Stability exercise is mostly impeded when we think about specific muscles. The exception is when we interrupt muscles that don't belong in primary stability, such as rectus abdominis.

Strategic Considerations for Exercise

The 20% rule: The figure 20% describes the level of effort desirable for improving stability. Richardson mentions the figure 10%-15%.¹¹ In any case, the point is to reframe exercise as something more perceptual than physical, but physical enough to arouse the body's interest. If an exercise provokes too much effort we risk perpetuating stabilizer error, which we also call strain patterns.

Low reps: Exercises are designed to challenge the body, but more important is to challenge and capture the imagination. The mind is bored with many repetitions. The work needs to stay fun and be interesting. Three repetitions per action prevent boredom; if the exercise involves both sides of the body, then three repetitions per side. The goal is presence. We need the full attention and engagement of the whole person. We want to continually challenge the notion that we are building "stuff" (such as bigger, harder muscles). We are reviving system intelligence. We treat the movement brain with respect and recognition of its sensitivity. **Stop:** If an exercise starts to feel wrong, stop. Stop completely, then rebuild the perceptive basis and start again, slowly. Pre-movement is just that – it has to happen before we move. After we are moving it's too late to fix. The quicker we stop a mistake, the better the brain learns.

Small demand/larger demand: In this style of work, a small demand precedes a larger demand. Often stability happens twice. Stability is provoked as we use perception or use perception and add a small demand. Stability adjusts and amplifies as a stronger demand is introduced.

Walk: After a short cycle of exercise, walk. Notice what you experience, what has happened. Perceptive work needs confirmation. Our experience needs to know that a system event, a change in coordination, has occurred. Typically such a change is instantaneous. When, after perceptual preparation, we do a brief exercise and feel a change in coordination, we receive an important message about how body systems work. This experience reinforces the value of what we are doing. Taking time to notice right away makes a habit out of tracking sensory experience which, in turn, makes a habit out of anchoring change.

Don't wait (I): Start early in the Rolfing Ten Series - don't wait. Introduce stabilitybased movement to the process on day one. Make it logical to test client stability, so the issue is framed. As you progress, stability work has precedence. Simple exercises usually take many episodes of repetition so an early start makes it possible to review, modify, and add new material multiple times. Stability work creates a context for further work. Rolf's advice was this: only do ongoing work (past the Ten Series) if you can take the work to a deeper level of integration. Improved coordination, better integrated into life, constitutes deeper integration.

Don't wait (II): Consider exercise instruction as a way to start the session rather than (only) to finish it. You may be surprised to find that it makes the session more efficient. Practitioner and client define session relevance in the terms of a simple stability challenge before and after.

Movement brain: Teach the client about the movement brain concept and the "where and what" model of movement brain versus cortical brain. Work with peripheral gaze and the various perceptive skills involved in SI, the activities that assist in reviving movement brain primacy.^{12,13} Practice these skills in the course of most fascial interventions in the Rolfing series.

Select Exercises to Support Normalized Stabilization in the Context of SI

Brief descriptions of exercises to support normalized stabilization in the context of SI follow. A manual for teaching/ learning the exercises is beyond the scope of this article. Some are described in How Life Moves: Explorations in Meaning and Body Awareness¹⁴ and in articles in the Resources in Movement article archive (www.resourcesinmovement.com/Archive. htm). Others, not currently documented, will appear in future articles or video at the Resources in Movement web site. Typically, perceptive core stability catches the interest of practitioners in rehabilitative and somatic movement therapy fields more than fitness trainers. This is slowly changing. Motivation comes from the experienced failure of conventional approaches. Once motivated, it helps to have in-depth instruction for clarity.

The exercises are part of the repertoire that is currently taught in RISI Principles classes and Rolf Movement Certification classes, as well as continuing education classes by the author and other Rolf Movement instructors.

Exercises for Perceptive Core Stability

Leg Raise Supine

Leg Raise Supine is central to our discussion of psoas function. Base line: the client is asked to raise one leg, with extended knee, and invited to feel what happens. How does the body respond to this demand? The client is asked to do whatever he/she can to keep the pelvis from rotating in the transverse plane while doing the leg raise. This is a good opportunity to speak about primary, secondary, and tertiary stabilizers, and to review the anatomy of the psoas, transversus abdominis, and multifidi.

Intervention: The client is instructed to induce a small demand by pressing the contralateral heel into the table or the entire calf against the table, perceiving the directionality of the press, and maintaining perceptions of directionality in the space and weight on the table. The client is asked to sustain the downward press of

the contralateral foot, then to feel upward directionality of the foot to be raised, a directionality toward the ceiling, and then to follow that direction in movement. Client raises foot and straight leg (see Figure 1).

Figure 1: In the Straight Leg Raise Supine, the heel of the stability leg pressed into table; action leg raises; hand checks for soft abdomen and no rotation of pelvis or spine.



Evaluate the degree of stabilization in the lumbar spine and pelvis – how much rotation occurs during the leg raise? Are the abdominal wall and costal arch relaxed and soft? A soft abdomen is essential. If stabilization is secure, recommend a few repetitions per day. If stability is poor, shorten the lever arm of the movement with a bench under the calves, knees bent at 90° (see Figure 2), then repeat the pre-movement and the leg raise. Other interventions to help stability include exploring missing places of orientation and evoking upper-girdle stability as a pre-demand for lower-limb stabilizing movement.

Emphasize that the psoas can only produce competent action when the axis of the body is sufficiently stabilized. With spinal stability assured, the psoas is relieved of a potential dual function – it doesn't have to be stabilizer and mobilizer at the same time. (Leg Raise Prone is very similar but works

Figure 2: In this modification, the calf presses the bench, the opposite leg raises; watch for soft belly and no rotation of pelvis or spine.



with hip extension rather than flexion. As with Leg Raise Supine, a small demand with the contralateral foot evokes stabilization that amplifies as leg extension starts.)

Lordosis: Range of Motion Revival

As addressed in *How Life Moves*, a discussion of lordosis – the investigation into mythology around lumbar lordosis – is fertile territory for client education. It's helpful to interview clients to find out about the stories they live with on this topic. It's useful to know what the client's beliefs are. Since the mid-twentieth century, lordosis has been a convenient, if simplistic, target of blame. Ironically, lordosis is the evolutionary leap that permits human beings to be upright.¹⁵

SI's point of view is that lordosis is part of adaptive capacity to demand. Lordosis of the spine, as with other aspects of spinal movement, is an adaptive resource that SI helps revive.

To revive latent capacity to whatever degree of lordosis a client is physiologically able to move into is already a profound step toward improving the stability equation. A spine that is held "out of lordosis" is a spine stabilized through confusion. Yet many of our clients are in this condition. To revive lordosis through perceptive work gives the movement brain vital information.

SI practitioners have the opportunity to revive lordosis with support from the hands and feet with the client seated or with the client "on all fours" (on floor supported by hands and knees). In either instance, the process is part reassurance and education and part strong touch to the spinous processes of the lumbar vertebra.

"On Floor" Version

The client is educated about the "front of spine" concept. Ideally the client is shown what we mean by front of spine when we pass a finger up and down the anterior line of the bodies of the vertebrae on a model skeleton. The client is invited to imagine the front of his or her spine as a living sensory experience.

With an imagined sense of the front of the spine, combined with directionality out of the top of head and the end of the tail, peripheral gaze, and sense impression in the hands and knees and toes, the client is prepared for supported spinal movement (see Figures 3 and 4).

Figure 3: The client finds support from hands and knees, allows the front of the spine to lengthen and the pressed segment to move the anterior end point.



Figure 4: The client links support of hands and knees to the pressed segment and presses that segment posterior. The belly and chest should feel soft, and the breath at ease.



The hands are supported by the floor. The practitioner applies anterior pressure on one lumbar spinous process. Mindful of support, the client lets that spinal segment move anteriorly, allowing the whole spine to move in concert with the segment being pressed anteriorly. At the end point of range of motion, the practitioner maintains some pressure for a moment. This gives the movement brain information about what coordinative pattern may prevent further anterior movement. The client then refreshes perceptions of support and directionality, and then presses the segment posteriorly against resistive pressure from the practitioner. One or two repetitions typically lead to improved anterior/posterior (A/P) range of motion. A/P range of motion can be practiced in several segments. This sequence is at the heart of perceptive core stability: hands and feet, directionality of the spine, and orientation to gravity lead to segmental competence and stability. Stay within the client's capacity to stay present and to feel supported in the process.

Seated Version

The seated version of the preceding lordosis work fits naturally into the seated back work typical to Rolf's classic series. The emphasis shifts slightly from tissue work to articulated segmental stability supported by perception of the hands and feet. The client's feet are on the floor and hands rest on the edge of the bodywork table or on handles fixed to wall or floor (see Figures 5 and 6). Other planes of motion of spinal segments can be adapted to the stability issues of the client.

Although it is not unusual for facet fixations to release in the course of this work, it is not the primary goal. The goal is restoration of coordinative integrity, linked

Figure 5: The client is supported by hands and feet; the front of the spine is allowed to lengthen and the pressed segment moves anteriorly.



Figure 6: The client supports posterior movement of the segment from her hands and feet.



to a comprehensive program to empower the client in stability understanding and maintenance.

Have the client walk after doing a small amount of work. A walk reveals changes of coordination as stability is provoked. Practitioner and client want to see and feel the consequences of each piece of the process.

Arabesque – Eccentric Contraction and Other Variations

The "arabesque" is a figure from ballet. Godard adapted Arabesque for stability exercise in SI (see Figure 7).

Figure 7: Arabesque expresses the bidirectionality of the spine and epitomizes stability from perception. The arabesque is a snapshot of Rolf's Fourth Hour of the ten-session series.



Preparation for Arabesque is similar to other exercises. One foot stabilizes and the other extends. The stabilizing foot is aroused to receive contact with the floor. Space above and around the head is evoked as a field of interest and attraction. It takes practice to make these perceptions simultaneous and easy. A practitioner can

Figures 8a-8f: The Flight of the Eagle movement sequence involves coordinative challenges that express the goals of the Rolfing series. Stability derives from orientation with the hands, feet, and directionality originating at the hands and feet, ends of spine, and ischial tuberosities. The spine learns segmental stabilization as a perceptual event.



shorten the client's learning time with his or her own embodiment of the exercises. Clients see the practitioner's perceptive preparation if the practitioner demonstrates the contrast between a strong perceptive field and absence of the same.

The up and down sense between space overhead and ground below the foot is amplified until the trunk lengthens easily and the opposite hip abducts slightly so that the hip can extend with the foot clear of the floor. The arm/hand swings forward slightly on the side of hip extension. The moment of hip extension should be brief, especially at first. Range of motion can be small. Preparation contains most of the benefit, but actual execution of the movement keeps the movement brain convinced stability must mobilize.

We do the exercise to arouse the coordination of the trunk and sacroiliac stability. Arabesque also offers a snapshot of the landing phase of gait. It is a snapshot of Rolf's Fourth Hour in the ten-session series in which the standing leg lengthens in the adductor line, while the extended leg abducts and releases in the front of the hip.

The embodied Arabesque is an icon of SI, in that so much of the ease and power of gravity orientation and movement-brain stability is concisely expressed.

Arabesque is illustrated and discussed in an article about contralateral gait and coordinative structure^{16,} as well as in *How Life Moves*.

Flight of the Eagle

The Flight of the Eagle is a multi-part series of movements that recapitulates Rolf's entire Ten Series in perception and coordination (see Figures 8a-8f). Upper and lower girdle stabilization reinforce each other. Segmental movement of the spine is supported by hands and feet and vectors of directionality. The learning process for Flight of the Eagle can be challenging because the skills are often totally new. The form of the movement is deceptively simple; that is, it looks simple but our bodies are often confused as we try to imitate it. The work has many tangible benefits, however, including the kind of stability for hip and trunk flexion that "psoas work" is meant to achieve.

The basic instructions for doing Flight of the Eagle are lengthy and aren't reproduced here since they are already well documented. For a detailed description, refer to *How Life Moves*, or "Flight of the Eagle – Self Care for Structural Integration Clients"¹⁷ There is also a YouTube video showing Caryn McHose doing the exercise (www.youtube. com/watch?v=lbRxgIOQ2wE).

Shot Put and Pulling Rope

Shot Put (see Figures 9a and 9b) and Pulling Rope (see Figures 10a and 10b) are both examples of rotary torso exercises that arouse the body's urgency to stabilize from the hands and feet. The elastic band (or cable attached by pulley to a weight) is used to provide resistance. Both exercises begin with establishing sensory aliveness in the hands and feet and by registering floor contact along the inner and outer arches of the feet. Floor contact along both arches is critical while doing the exercise. In Shot Put the front foot is most likely to lose contact during trunk rotation. In Pulling Rope the abductor line to the cuboid bone and floor. and the adductor line to the navicular bone and floor, need to lengthen alternately with rotation from one side to the other.

Figures 9a and 9b: Shot Put combines orientation to directionality and to ground. Trunk rotation arouses natural stability responses. The delivery of the throw arouses shoulder stability.



Figures 10a and 10b: Pulling Rope, like Shot Put, arouses the trunkrotation stability response as well as shoulder stability responses.



Shot Put is similar to throwing a heavy metal ball called a shot put. It is also analogous to other ancient human activities: throwing a spear, scything grass, throwing a ball or a punch. The band or cable comes from the side and one stands facing it. The front foot attempts to maintain contact and the back foot pivots onto the toes as the hand accelerates the band with a twist of the trunk.

Pulling Rope is similar, but the band or cable is in front. The feet stay planted and the twist alternates to one side and the other. This can be done standing or sitting down.

Segmental Roll of Spine

Seated or standing, this exercise is a selfcare version of SI seated back work. A handle attached to a band or cable is held with both hands. The client is instructed to start folded over and then slowly roll up the spine one segment at a time with

continuous and sustained foot contact on the floor along with a soft abdomen (see Figures 11a-11g).

Figures 11a-11g: Seated version (a-c) and standing version (d-g) of the Segmental Roll of Spine recapitulates aspects of Rolf's classic seated back work in which hands and feet support sequential movement of the spine.















Spinal Wave Movement

Beginning with segmental "rolling" up and down the spine in the bent-knee supine position, one explores segmental undulation in the sagittal and then coronal and transverse planes. Wave motion in three dimensions is a signature of Continuum movement and shows up in many other somatic movement disciplines. Wave motion belongs in the psoas discussion because it is a metric of stability to gain differentiated sequential movement of spinal segments. Wave motion alone does not insure stability upright in gravity and meeting life demands, but combined with other exercises it plays a helpful role.

SI Model and the Background to Healthy Psoas Function

Rolf provoked discussion of psoas function through development of the Rolfing series and through demonstrations, lectures, and writings passed down as her legacy. The work has stood the test of time. Posture changes. Bodies integrate. As of this writing, eighteen schools of SI are recognized by the International Association of Structural Integrators (IASI) as legitimate places to train in the work sourced from Ida Rolf.

Theory has held up less well. Fascia has become an established concept in modern culture, partly due to Rolf. Fascial research has, in part, been propelled by the field of SI. The research is brilliant and exciting. There are important questions to answer about the mechanical and biomechanical nature of fascia in the human body. As of 2010, however, fascial research falls short of corroborating Rolf's gel to sol model, fascial plasticity, or the idea of fascia as the arbiter of postural habit. Fascia, nonetheless, plays an important role in posture and is an important part of the motor control system. The neuroscience community has ushered in an era in which the brain's sensory and motor maps show provable plasticity. Fascia functions, most probably, as an excellent communication channel through which practitioners can revive or modify brain maps.18

Psoas work benefits from this change in thinking. SI's contribution to people's everyday lives benefits as well. Models of coordinative change give SI a better shot at its rightful niche amidst the plethora of somatic therapies. Fascial differentiation, combined with perceptual and coordinative challenges, is, and always has been, an effective and impressive package. When we spell this out as a system event, to clients and students, the process is less mysterious and more believable.

The psoas muscle will continue to have special status for body therapists. Why? We like to have something to point to, something dramatic that is good or bad, something to compare. It's harder to point to "system coordination." It's not a "thing." "Show me the movement brain" you might say, and we can't do so. That's the point – it's safely out of our hands.

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Our confusion in body coordination mirrors our confusion in ontology. We want to look at the body mechanically and in terms of fixing identified parts, but the body is more complex than a collection of parts. Parts are inventions of our mind. Parts belong to models that fail to answer the question about why stability fails. Normal stability means that, mysteriously, primary stabilizers initiate first, most of the time, without having to think about it. Failed stability is less mysterious, but not well solved when we look for a failed part.

We can point to timing failure in muscles such as the multifidi or the transversus abdominis. That's worth learning, but we don't revive primary stability unless we listen to, and speak with, the movement brain to find out which messages it has heard and which messages it is starved for. The movement brain listens through channels of sense perception and speaks in the language of sensation and movement. A client's movement brain senses practitioner presence and resonance. A practitioner's movement brain senses the client's perceptive field. Familiarity with movement-brain messaging helps structural integrators find success in reviving integrated function.

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Does Rolfing[®] SI Enhance Quality of Life?

A Pilot Study

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nherent in the practice of Rolfing[®] Structural Integration (SI) and inseparable from it is the desire of the practitioner to help others improve the quality of their lives. As a holistic enterprise, SI affects all dimensions of the person. To support an integrative, process-oriented, third-paradigm practice – and, above all, to show that Rolfing SI epitomizes a newly emergent paradigm to address the multiple dimensions of the whole human being – we need some standard by which to evaluate the results of our work. The experimental method of isolating and controlling for particular variables within the human experience seems ill suited to the evaluation of integrative practices.

We would prefer a standard that takes into account all dimensions of the human

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experience our work affects. One possible standard is the World Health Organization Quality of Life index (WHOQOL), as its taxonomies are similar to the ones Rolfing practitioners use to conceptualize and perform their work. Thus, it made sense to explore the possibility of measuring, through the WHOQOL questionnaires, the benefits that clients gain from Rolfing SI.

In the past twenty years, tools to evaluate quality of life (QOL) have evolved and undergone considerable elaboration, departing from the simplistic metric of presence versus absence of illness, or that of objective assessment of material conditions, and moving toward actually considering and integrating the various aspects of human experience (physical, emotional, social, environmental and spiritual, among others). This has spurred the creation of metrics validated internationally, in the context of many languages and cultures.

Aiming first to encourage in Rolf Institute[®] students' scientific investigation of the outcomes, and also to start a formal investigation of the effects of Rolfing SI on the clients' QOL, I designed a study that came to include 160 clients, all of whom were treated as teaching models in Rolf Institute classes in either Boulder, Colorado or Sao Paulo, Brazil.

Empirical Evidence

How many structural integrators – freshly minted graduates and old hands alike, favoring manipulation or movement techniques, working in North or South America, East or West – are delighted to see in their clinical practices that their work seems to improve the clients' QOL?

Whatever the clients' remaining or ongoing issues or objectives might be, when they perceive improvement in their QOL, it is both satisfying and reassuring. It suggests that we're on the right track and that the work is going in the right direction. Whatever the techniques or strategies, what we see is the actualization of the ultimate and transformative purpose of the work.

Sometimes this happens because clients have fewer or diminished aches and pains, or because they feel more agile, healthy, or emotionally stable. Sometimes they have greater awareness of their bodies and themselves, or even perceive that the work is helping them to move forward in personal life projects. Sometimes this happens for no more reason than the client's general and nonspecific experience of feeling better. Many reasons factor into this equation.

From a scientific viewpoint, the practitioners' observations are empirical evidence of a possible relationship between SI and QOL, which relationship has been, in our collective experience over the past fifty years, so abundantly revealed in most of our practices.

Defining Quality of Life

How do we define "quality" in a person's life? Do we account for internal factors as well as external ones? Do we measure current circumstances, or more abiding conditions? Should the criteria be objective or subjective, the measures individual or societal? Although all aspects of the human experience - ranging from the physical (general state of health, organic function, physiological condition), to the emotional, spiritual, and social – are part of the matrix of variables that coalesce to establish a person's QOL, many visions of QOL emphasize one or more isolated aspects (e.g., health, personal liberty, material prosperity) of human existence.

Regardless of how a person's circumstances might appear to an outside observer, it is the perception of one's own QOL that allows one either to enjoy – or to take charge of things and take steps necessary for improvement. This perception is both subjective (as only the person himself can evaluate his own life), and unique for each person (each person having a particular viewpoint as a function of his objectives, preferences and needs.)

Interest in the formal evaluation of QOL began in 1940, with the development of indices focused primarily on physical wellbeing, measured according to the presence or absence of illness. Scales to measure functional capacity first appeared around 1950, assessing aptitude for everyday activities such as eating and dressing. These scales, which connected the effects of illness to limitation of function, still came from a medical perspective. The 1970s brought the first studies of the patient's perception of his own health and related aspects of experience. These were followed, in the 1980s, with the SIP (Sickness Impact Profile) or NHP (Nottingham Health Profile), as well as the SF-36 (Medical Outcomes Study 36) – all generic questionnaires about the quality of life relative to health (QLRH), developed with the goal of heightening perception of the impact of health problems. Thereafter, many QLRH surveys were developed to measure specific effects especially important to particular patient groups.¹

It was a departure from this thinking when, in 1991, the Mental Health Division of the World Health Organization established a multidimensional vision of heath as "the state of complete well-being, physically, mentally and socially." This took the mission far beyond simply the absence of infections or physical diseases, and opened the doors to more comprehensive and wide-ranging research and study. Today, there are more than 800 questionnaires and inventories concerning QOL. In today's world, we see that the definition of QOL needs to be broad, complex, and dynamic, capable of accommodating the diversity of social and individual circumstances.

The WHOQOL Index

Finding a way to assess QOL through the perceptions of the subjects themselves was the task the Mental Health Division of WHO proposed in 1991 when it began the process of constructing a generic tool to measure and quantify QOL. A working group of researchers from fifteen countries defined QOL based not on the presence or absence of disease, but as the subjects' own perceptions of their circumstances, "as perceptions of their position in life in the context, the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns." The researchers gathered questions relevant to a person's QOL, and an instrument was developed using cross-cultural standards. Eventually, the instrument included 100 questions, which covered twenty-four aspects of experience, which aspects were grouped into six domains: physical health, psychological state, level of independence, social relations, environment, and spirituality/religion/ personal beliefs. The self-administrable instrument was validated in twenty languages.²

A subsequently developed short-form instrument, the WHOQOL-BREF, shows a high degree of correlation with the WHOQOL-100, and is now under evaluation as an independent measurement. It has twenty-six questions divided among four domains (physical, psychological, social, and environmental), along with two general questions.

Rolfing SI: Its Idea, Principles, and Paradigms

Rolfing SI began with one principle: that the integration of the human structure in gravity furthered the evolution of the human being.³ What's more, a person is seen as a single phenomenon with multiple dimensions, which suggests that the integration of somatic structures has repercussions for all other dimensions of individual human experience. It is a holistic proposition, with its point of departure being the somatic view. Therefore, research about how Rolfing [SI] affects the human being requires instruments capable of measuring simultaneously multiple aspects of human phenomena and their relationship.

Because our work of SI takes place in the contexts of many countries, cultures, and languages, we selected the WHOQOL-BREF as the instrument to measure its results. In addition, this instrument is quick and easy to use, and allows us to attend to the various aspects of human experience that might arise in the clients' processes. It also lets this research dovetail with related research focused on specific dimensions; e.g., Prado (2006), in "Exploratory Studies on the Psychobiological Dimension of Rolfing,"4 brought up the existence of psychobiological data, collected on questionnaires developed as part of a NAPER research project,⁵ and observed that clients often reported major transformation in this dimension throughout the process of SI.

The Project's Objectives

One can exercise the faculties of the "scientist" and the "clinician" simultaneously, and observation and investigation can take place in a clinical setting. I also believe it is important to instill and nurture in students the scientific attitude, to plant in their minds a scientific curiosity about the results of the work even as we train them to do it. My hope is that as research techniques are applied across the profession over the long run, we will better understand the practice and outcomes of Rolfing SI. Beyond that, the number of QOL research studies in human sciences and the general interest in the subject brought us to believe that studying the influence of Rolfing SI in QOL had the potential to correlate our work with other areas of understanding and make our work more widely known.

Sample

Between May 2004 and December 2005, a total of 160 clients each participated in one of six Rolf Institute Unit III (professional phase) classes – 105 in the United States and fifty-five in Brazil. Their processes were variously investigated by eighty-four students (sixty in the United States and twenty-four in Brazil), who were instructed by five different teachers.

The sample was distributed as follows:

- 50 cases, 16 students, Boulder, CO, U.S., May 2004
- 27 cases, 12 students, São Paulo, Brazil, December 2004
- 11 cases, 12 students, Boulder, CO, U.S., August 2004
- 19 cases, 16 students, Boulder, CO, U.S., October 2005
- 28 cases, 12 students, São Paulo, Brazil, December 2005

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 25 cases, 16 students, Boulder, CO, US, December 2005

The totals are: N = 160 105 US 55 Brazil

Procedure

The study began in May 2004, in a class I taught, assisted by Duffy Allen. To explore the relationship between the effects of Rolfing SI and the clients' QOL, students were asked to evaluate their class clients' QOL before and after the Rolfing process by means of the WHOQOL-BREF. The questionnaires were distributed by the students to the clients, who completed them both before the first session and immediately following the end of the series of between ten and thirteen sessions. Other instructors who participated in the project by having their students use the WHOQOL-BREF included Sally Klemm, Monica Caspari, Patrick Ellinwood, and Paula Mattoli. Later, I tabulated and analyzed the information supplied by the clients. This project had no control group.

Results and Analysis

We calculated the means, standard deviations and the Fisher "t test", which compares the means for dependent samples. We used a margin of error of 5%. The tables below present the results for each school (Brazil and U.S.) and for the combined sample.

Discussion and Conclusions

A significant correlation was shown among the clients' perception of improvement in their QOL following Rolfing SI, both for the study group as a whole (N=160) and for the American (N=105) and Brazilian (N=55) subgroups.

	Mean	N	Standard Deviation	Mean Standard Deviation
Physical-before	69.64286	40	14.124549	2.233287
Physical-after	76.96429	40	14.375860	2.273023
Psychological - before	67.75794	42	11.787252	1.818812
Psychological - after	74.50397	42	11.501531	1.774725
Social Relations - before	70.08547	39	15.848094	2.537726
Social Relations - after	76.28205	39	14.627247	2.342234
Environment - before	63.22674	43	12.022835	1.833465
Environment - after	67.87791	43	16.069938	2.450643

Table 1: Brazil – statistics for paired samples

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Table 2: Brazil – tests for paired samples

	Mean	Standard Deviation	Mean Standard Deviation	t	df	Sig. (2-tailed)
Physical-before Physical-after	-7.32143	10.728013	1.696248	-4.316	39	.000
Psychological - before Psychological - after	-6.74603	9.54296	1.412539	-4.776	41	.000
Social Relations - before Social Relations - after	-6.19658	15.019231	2.405002	-2.577	38	.014
Environment - before Environment - after	-4.65116	12.262856	1.870068	-2.487	42	.017

Table 3: United States – statistics for paired samples

	Mean	N	Standard Deviation	Mean Standard Deviation
Physical-before	72.40705	73	14.860227	1.739258
Physical-after	79.50098	73	14.495330	1.696550
Psychological - before	68.96368	78	13.999965	1.585184
Psychological - after	75.42735	78	11.910519	1.348601
Social Relations - before	65.33333	75	17.003356	1.963378
Social Relations - after	74.00000	75	15.191471	1.754160
Environment - before	72.44318	77	13.824998	1.575505
Environment - after	74.83766	77	14.328587	1.632894

Table 4: United States - tests for paired samples

	Mean	Standard Deviation	Mean Standard Deviation	t	df	Sig. (2-tailed)
Physical-before Physical-after	-7.09393	15.028944	1.759005	-4.003	72	.000
Psychological - before Psychological - after	-6.46368	10.019989	1.134540	-5.697	77	.000
Social Relations - before Social Relations - after	-8.66667	13.313612	1.537323	-5.638	74	.000
Environment - before Environment - after	-2.39448	10.644527	1.213056	-1.974	76	.052

Table 5: Combined samples – statistics for paired samples

	Mean	N	Standard Deviation	Mean Standard Deviation
Physical-before	71.42857	113	14.601110	1.373557
Physical-after	78.60303	113	14.440295	1.358429
Psychological - before	68.54167	120	13.229749	1.207705
Psychological - after	75.10417	120	11.728807	1.070689
Social Relations - before	66.95906	114	16.700917	1.564184
Social Relations - after	74.78070	114	14.975419	1.402577
Environment - before	69.14063	120	13.884480	1.267474
Environment - after	72.34375	120	15.280606	1.394922

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Table 6: Combined samples - tests for paired samples

	Mean	Standard Deviation	Mean Standard Deviation	t	df	Sig. (2-tailed)
Physical-before Physical-after	-7.17446	13.612113	1.280520	-5.603	112	.000
Psychological - before Psychological - after	-6.56250	9.87919	.84382	-7.420	119	.000
Social Relations - before Social Relations - after	-7.82164	13.903953	1.302225	-6.606	113	.000
Environment - before Environment - after	-3.20313	11.252498	1.027208	-3.118	119	.002

The only domain for which the difference in the "before" and "after" Rolfing SI QOL perceptions was not shown to be significantly correlated was the "environmental" subgroup in the U.S. sample. The result for the U.S. sample (p=0.52) was diluted when the data was put into the context of the total sample of 160 (p=0.002). The data suggest that probably, given the fact that the environmental conditions did not change with Rolfing SI, the subjects' perception of those conditions did not change significantly (p=052).

This high correlation invites the following important reflections:

1. It corroborates what we perceive in our clinical practices and with our class clients – that undergoing Rolfing SI changes the person's perception of his own QOL for the better.

2. It also corroborates my own research concerning the connection of Rolfing SI with the psychobiological dimension. My analysis of data from the NAPER questionnaires and protocols⁶ suggest that Rolfing SI does indeed affect the psychobiological dimension of the person. Therefore, the results of the WHOQOL-BREF, which includes the "psychological" domain, are especially significant to me, as they seem to converge with my findings.

By describing this study, I hope to stimulate the same curiosity in others so that we may begin a discussion of our collective observations. Themes for further study and exploration include:

- Making comparisons with more detailed studies using control groups.
- Testing whether these results are consistent over time in a significant way.

- Expanding the investigation to cultures beyond Brazil and the United States.
- Taking this type of investigation to contexts outside the classroom.
- Verifying the correlation among results obtained in the classroom with studies in the clinical context.
- Making studies to correlate Rolfing SI and QOL in more specific samples.
- Investigating the degree to which the condition of being structurally and functionally integrated, independent of the Rolfing process, correlates with perception of QOL.

Comments

The school samples having used the WHOQOL-BREF before and after Rolfing SI, we observe that the results are consistent with preexisting empirical evidence, and corroborate the hypothesis that the changes induced by Rolfing SI enhance QOL as a whole and in the various domains of human experience that Rolfing SI considers. The data is meaningful and important because, just as we need to find standards to show the effects of Rolfing SI and its value to society, the WHOQOL questionnaire, a respected instrument with a substantial track record, presents itself as an easy-to-use inventory, validated in twenty languages, which is congruent with the philosophical premises of Rolfing SI. Use of this questionnaire makes possible a collective exploration of how Rolfing SI can help human beings to lead better lives. In that sense, it supports Dr. Rolf's vision of her work as a means to advance our evolution as upright beings.

Endnotes

1. For more information on tools to measure QOL, please see:

Sullivan, Marianne, "Quality of life assessment in medicine." *Nordic Journal of Psychiatry*, 1992, Vol. 46, No. 2, 1992, pp. 79-83.

Also: http://informahealthcare.com/doi/ abs/10.3109/08039489209103305

2. The World Health Organization Quality of Life Instruments: Field Trial Manual from WHO, Geneva and U.S. versions. Seattle, WA: University of Washington, 2004. Available at www.who.int/mental_health/ media/en/76.pdf.

3. Rolf, I.P., "Gravity: An Unexplored Factor in a More Human Use of Human Beings." *J. Inst. Comparative Study, History, Philosophy Sci.*, v.1, n.1, 1963, pp. 1-19; also Rolf, I.P., *Rolfing: The Integration of Human Structures.* New York: Harper & Row, 1978.

4. Prado, Pedro O.B., "Estudo Exploratorio da Dimensão Psicobiologica do Metodo Rolfing de Integração Estrutural: Criação, Desenvolvimento e Avaliação de Questionarios." São Paulo, Brazil: Pontifícia Universidade Católica de São Paulo, 2006. Available at www.pedroprado.com.br (Ida P. Rolf Library for Structural Integration).

5. Mattoli, P., "A Brief History of the São Paulo Ambulatory Project." *Rolf Lines*, Vol. 29, no. 1, Jan 2001, pp. 5-7.

6. Prado, op. cit.

Congratulations to the New Graduates

USA – April 2010

Faculty: Jim Asher (Instructor), Ray McCall (Instructor), Meg Maurer (Assistant)

Students: Angelo Bigontina, Carol Joy Campbell, Sasha Cardenas, Brett Holland, Laura Machen, Paul Matthews, Kaytlyn O'Connor, Theodore Sadowski, David Satarino, Roel Seeber, Robert Tacchino, Hee Kiah Tan, Asako Uemoto, Kimberly Hinton Ureta, Theresa Zordan

Europe – June 2010

Faculty: Giovanni Felicioni (Instructor), Maria Rosaria, Cristina Crivellari (Assistant Phase II), Angela Biancalani (Assistant Phase III) **Students:** Davide Angeli, Rita Balestri, Enrico Cammilletti, Alberto Campagnol, Consuelo Cataldi, Fabrizio Cesaretti, Daniela Cirillo, Catherine Figueccia, Rosita Munusco, Denise Panighi, Giovanella Pattavina, Carla Ranalli, Daniela Risser, Fiorenza Sala, Giancarlo Tenuta, Mario Trivisonne, Lucia Vecchi

USA - July 2010

Faculty: Kevin McCoy (Instructor), Jeremiah Evers (Assistant) Students: Misty Crawford, Jazmine Fox-Stern, Tim Hanson, Sharalee Hoelscher, Victoria Huss, Scott Linde, Philippa Mackinlay, Aaron Meiggs, Patricia Mueller, Adam Oostema, Moylan Ryan, Tam Tran

USA – September 2010

Faculty: Ray McCall (Instructor), Adam Mentzell (Assistant) **Students:** Chad Corradini, Joseph Culhane, Vivian Gettliffe, Nori Harada, Carol Huntsbarger, Amy Iadarola, Sarah Marie Jones, Mio Katori, Keisuke Matsuura, Karen Mayabb, Misako Nakano, Diana Newby, Kelly Skinner, Rebecca Sorenson, Jennifer Wissman

2011 Class Schedule

BOULDER, COLORADO

Phase I: Foundations of Rolfing[®] Structural Integration

January 24 – March 7, 2011 Coordinator: John Martine

June 13 – July 25, 2011 Coordinator: TBD

September 5 – October 17, 2011 Coordinator: Michael Polon

Phase I: Accelerated Foundations of Rolfing Structural Integration

March 13 – March 26, 2011 Instructor: John Schewe

August 14 – August 27, 2011 Instructor: Michael Polon

October 30 – November 12, 2011 Instructor: Suzanne Picard

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

January 10 – March 3, 2011 Instructor: Ray McCall Principles Instructor: Mary Bond

April 4 – May 26, 2011 Instructor: Bethany Ward Principles Instructor: Kevin Frank

August 15 – October 6, 2011 Instructor: Ray McCall / Jon Martine Principles Instructor: Carol Agneessens Phase III: Clinical Application of Rolfing Theory

March 21 – May 13, 2011 Instructor: Kevin McCoy Anatomy Instructor: Juan David Velez

June 6 – July 29, 2011 Instructor: Larry Koliha Anatomy Instructor: John Schewe

October 17 – December 16, 2011 Instructor: Valerie Berg Anatomy Instructor: John Martine

LOS ANGELES, CALIFORNIA

Advanced Training

Phase I: June 13 - 30, 2011 Monday - Thursday / Friday - Sunday off (Jun 13 - 16 / Jun 20 - 23 / Jun 27 - 30)

Phase II: October 24 - November 10, 2011 Monday - Thursday / Friday - Sunday off (Oct 24 - 27 / Oct 31 - Nov 3 / Nov 7 - 10)

Instructor: Jan Sultan

GERMANY

Basic Rolfing Training: Intensive

Phase 3: January 31 – March 23, 2011 Instructor: Pierpaola Volpones Phase 1: August 1 – 20, 2011 Phase 2: October 3 – November 23, 2011 Phase 3: January 30 – March 21, 2012

JAPAN

Unit II

February 7 – April 1, 2011

Unit III

September 26 - November 18, 2011

SOUTH AFRICA

Unit II

April 4 – May 26, 2011

Unit III

September 5 - October 27, 2011

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