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In Rolfing® Structural Integration (SI) sessions, our focus is on the unique features of the individual client – his or her structure, and what is required to bring it more into alignment with the field of gravity. Yet there are times when what we do and how we work interfaces with broader considerations, such as work for a specific demographic, or a domain of experience that is affecting the individual.

In the September 2017 issue of *Structural Integration: The Journal of the Rolf Institute®*, we looked at a particular demographic: infants and children. Articles in that issue explored how Rolfing SI is applied to infants and children, how the work is shaped by the fact that your client is not an adult, and what different considerations there may be for working with an infant, or a young child, or a teenager. In this issue, we look to another demographic – women – and also to specific female situations where special considerations again come into play – pregnancy and the postpartum period.

In our first theme, Rolfing SI for Pregnant and Postpartum Clients, we draw on the expertise of Rolfers™ who have worked extensively in this field. Jeffrey Burch opens the theme with an overview of the concerns and considerations merited during pregnancy. In two interviews, Pilar Martin, a nurse/midwife, and Monica Caspari, a doula, share from their perspectives and experience. Dorit Schatz, another nurse/midwife, informs us about the C-section procedure and how the Rolfing series can support recovery. Briah Anson and Christi Mueller Caspe each cover aspects of Rolfing SI from pre-pregnancy through pregnancy and postpartum. Our final article on this theme is a compilation piece that brings in Rolfers' stories from their practices: work with pregnant and postpartum clients, working as a pregnant Rolfer, the changes in one's Rolfing practice as motherhood enters the picture, and the impact of pregnancy and delivery on embodied experience.

In our second theme, Rolfing SI and the Female Body, we look at female embodied experience. We start with Carol Agneesens' evocative article on the female pelvis, where she covers a range from neurology through to transcendent experience. Then Sally Klemm speaks about femaleness in relation to being a Rolfing client, a Rolfing Instructor, and a Rolfer working with issues – physical or psychobiological – specific to women. In closing, Libby Eason threads between elements of experience that are female, yet still uniquely personal, rounding out our theme.

In the Perspectives section, we first remember Tim Law, who passed away this summer. Tim, as a child, received Rolfing sessions from Ida Rolf and was the model for the Little Boy Logo. Tim remained a lifelong believer in the power of Rolfing SI, attributing the longevity of his career as a carpenter to this early work he received. Wanting to encourage Rolfers to bring our work to carpenters' unions so that others could benefit as he did, Tim took time away from a final family reunion to speak with Jan Alarcon about his memories of Dr. Rolf and his adult life. John Barrett, Tim's older brother, helps flesh out the story. John also experienced Dr. Rolf's work during childhood, and being a couple of years older than Tim, he has more vivid memories of Dr. Rolf and the timing of events.

The Perspectives section also includes an interview with Luiz Fernando Bertolucci – following up on his work of Tensegrity Touch® – and an interview with Michael Maskornick on his iconoclastic view of Rolfing SI and craniosacral work.

Anne F. Hoff
Editor-in-Chief

Ask the Faculty

Pregnancy and Postpartum

Q: *Women can come to us with unique circumstances when pregnant or postpartum. Can you share something from your understanding or experience related to working at these times?*

A: To say that a pregnant woman is a body in motion (to borrow from Emily Conrad) is the least of it. Not only is she changing shape, but metabolically she is awash in different hormones associated with pregnancy. She feels herself differently. She is herself, and yet in a unique state. I do not work with pregnant women on their postural evolution. I aim to keep them as stable and organized as possible, and comfortable. I do not use the Ten Series for this work, but rather have developed some other systematic approaches that seem to serve them well.

If I do nothing else, I make sure the sacrum has a horizontal base and can be in easy neutral with the spine in a supine or seated position. As pregnancy develops, the prone position becomes less and less tenable. You can use sidelying for some women, but your understanding of structure and diagnostics have to be up to speed to keep track of the organization of the sacrum in this position. If you have not been exposed to craniosacral work, this is the time to at least crack the book, if not take an Upledger Institute class.

The next big focus is how the pelvis is organized on the legs, or how the legs are supporting the weight of the body across the pelvis to the thorax. At this juncture it is useful to remember that the ilia are part of the legs, and part of the pelvic basin as well. As legs, they participate in the stride of walking with a nod anterior as the leg pushes off, and a corresponding nod posterior as the leg swings through to the heel strike. With a pregnant woman, it is not the time to do any major leg work; instead it is time to relieve the legs as much as possible. Staying below the knee, work along the anterior and posterior borders of the fibula, and along the medial border of the tibia. Add the plantar fascia, and some clearing of the medial and lateral arches, and you will have opened the interosseous membrane and the neurovascular channels. What is both mysterious and delightful is that this lower-leg intervention will often normalize the motion restrictions of the ilium and contribute to the easy neutral of the sacrum.

The reason we start the intervention with bringing the sacrum to 'easy neutral' is to facilitate this subtle counter-rotation of the ilia around the sacrum in walking. It should be obvious that if the sacrum is motion-restricted, then the ilia can't complete their normal gait movements. And further, that if the sacrum is motion-restricted between the ilia, then the normal mechanics of the sacrum on the fifth lumbar also become stressed. The organization of this delicate complex of the lumbars, sacrum, and ilia is essential to the felt sense of well-being in a pregnant woman. Motion restriction here is usually at the root of low-back pain at the level of the iliac crest, and/or felt as a deep ache in the buttock.

The next major areas of stress for pregnant women are the costo-transverse junctions. A simple rib motion restriction will give no end of discomfort. The presenting symptom for this is a persistent unilateral ache/pain adjacent to the spinal 'groove'. This is best addressed in sidelying, with systematic exploration of each rib near the discomfort until the most tender rib is located. This rib is then gently tractioned lateral and inferior. Don't slide. After establishing depth and direction, just wait for a motile response. Your quality of touch here is everything, and your quantity of time may be ten seconds or more than a minute. This technique can be adapted from ribs three to twelve. The upper two ribs require a different approach, as they are functionally related to the neck through the scalenes and bracket the upper lobes of the lungs.

It is hard to speak of the neck without including the arms. As the arms grow out of the neck embryologically, all neck discomfort is suspect to having genesis in the way the arms are used or held. This can obviously be a two-directional situation, in which neck strains can cause real arm discomfort. For the purposes of this discussion, I'll first talk about the neck. The primary issue in working with pregnant women is that the neck takes a lot of strain as the pregnancy develops. As the abdomen gets bigger, the woman's instinct is to lean back to counterbalance the weight. The strain for this can be alleviated somewhat by assuring that the atlanto-occipital junction has the possibility of easy neutral (same principle as the sacrum). Remember that the head on atlas is not the primary place where rotation happens, but that this easy neutral allows adaptation to more system-wide movement patterns. The primary locus of rotation for the head on neck is between C1 and C2. It is around the odontoid process of C2 and the facets of the C1-C2 interface where most of the motion and potential neck pain come from. To establish an easy neutral here will go a long way to making the woman more comfortable.

Finally a word about arms as a factor in well-being in pregnant women. As the legs are the primary support in the biped, the arms are a primary source of balance and, of course, how we move the world. In pregnancy the arms will come under much use for changing equilibrium. As such they are liable to be a source of discomfort. Oddly they will not necessarily register pain and discomfort, but rather be a silent accessory to neck pain. It is a simple matter to relieve the general stress of the arm by working into the interosseous membrane both ventrally and dorsally along the radius and ulna, and the palmar fascia. Note that dorsal forearm work will ease trapezius and dorsal occiput pain, while ventral forearm work goes to the front of the neck and jaw. There is a lot of theory that backs this up, but for now it is fun to play with empirically and observe your results.

Taken in sum then, a coherent approach to keeping pregnant women on their feet and functional is a matter of working with the occipital region, the sacrum, and the extremities below the knees and elbows. What you have here is the pattern of 'radial decompression', adapted to a system in more movement than usual. (Editor's note: see Valerie Berg's interview with Jan Sultan on this topic, "Radial Decompression: Its Origin and Use," in the September 2009 issue of this journal.)The only significant divergence is the attention to the costo-transverse junctions. Remember that the object is to relieve the adaptive stress of the changing body and not to perform a postural/structural overhaul as we might do in a normal Rolfing® Structural Integration (SI) intervention. Slow and easy, and if you get to see the client once a month, this working pattern will give you plenty to do,

and yet not disrupt the equilibrium or the course of the pregnancy.

Jan Sultan
Advanced Rolfing Instructor

A: My experience related to working with women during pregnancy and postpartum taught me to 'do less, sense more'. During pregnancy and postpartum, there is inherent wisdom in honoring the magnitude of the change that is already taking place without adding an agenda beyond supporting the mother in her process on this gravitational planet. By coaching her to allow her weight to release into the table, you encourage her to fully exhale and plant the seeds for deep rest and restoration. When your touch is to listen first, receive second, and follow third, you educate her touch to foster attunement with her baby. By letting her experience that 'good posture' isn't about holding, but about intrinsic motion, you help her adapt to her changing soma with increased ease and speak directly to her baby's developing sensory network. When you ask how is it when the carpet comes up to meet her feet, when she moves into the space above her head, or when she imagines the air caressing her neck, you awaken her curiosity and heighten her sensory awareness so that she is able to find and renew reliable support in harmony with her environment. When you receive her with respect, compassion, and acceptance before information and technique, you both may have the opportunity to share in the experience of life creating itself.

Rebecca Carli
Rolf Movement® Instructor

A: After delivery, women sometimes suffer from incontinence caused by a prolapsed uterus, particularly in activity that needs a certain stability of the pelvic floor – for instance running (after their children!), coughing, or even laughing. Working with those clients led me to the question of a 'stable working' pelvic floor. As a physical therapy student I learned exercises based on isometric contraction of the pelvic floor – which helps a not-moving pelvis to recover the contractibility of the pelvic floor muscles. But what happens in movement? It's obvious that walking is difficult when we contract the pelvic floor isometrically, as then movement of the legs cannot find corresponding movement in the pelvis. This matches reports from many clients – even though they try to stabilize the pelvic floor with isometric exercises, the stabilization is not sufficient in movement.

The question leads directly into the theme of 'core-stabilization'. From my point of view, dynamic stabilization of the pelvic floor is based on a stable core from bottom up. Practically, we look for structural limitations in the lower limbs and in the pelvis (piriformis, gluteals) that prevent the establishment of an inner stability through the pelvis into the spine (transversus, multifidii). Very often feet are a central issue in disbalance – not only in terms of the stability of the arches, but in terms of sensorial connection to the vestibular system and eyes and consequent tension patterns. These clients benefit from a well-balanced combination of structural and functional work.

Jörg Ahrend-Löns
Rolfing Instructor

A: To begin with, it certainly helps to have experienced pregnancy in my own body. The slow transforming of the shape of one's body can be either magical and elating or difficult and uncomfortable. It can be all of those also at various times. As Rolfers™, we need to be intelligent about the anatomy of a woman's body in those changing phases.

The first three months can be tenuous in keeping the fetus attached to the uterus. Work, but work smart and cautious. Midwives over the years have taught me trigger points to avoid as they can induce labor or spontaneous abortion: ankle points, places around the thumb, and of course the pelvis in general should be avoided in those first three months.

If the client is new, I would do an abbreviated Ten Series with the needs of her changing body as the focus. The main places to attend to are the rib cage; the upper back and spine in general (compromised, and facing demands for change and to respond to increased weight on the front of the body); diaphragm; and costal arch. Please relieve them! Also, increased breast size puts pressure into the upper back and neck.

Sacrums move and need pelvic lifts that ease the strain. My daughter-in-law had me keep my hand on her sacrum through the entire labor. I literally felt my granddaughter move and ripple like an earthquake over the sacrum and my hand as she moved down and out!

I view the postpartum period as anywhere from two months after birth to five years after birth because a woman breastfeeds and then carries the child on a hip or her body and doesn't sleep much, etc. Reclaiming her own body is the best gift Rolfing SI can give to her. The psoas muscles need attention: they got pulled off track from the belly increase and leaning back to counterbalance. Finding her 'Line' – the whole goal of Rolfing SI, coming back to ourselves in gravity – will find your postpartum client in ecstasy.

Valerie Berg
Rolfing Instructor

A: The pregnant women I have worked with were already clients of mine who became pregnant and came because of discomfort due to pregnancy: sciatic pain, tension between the scapulae, back pain, etc. I work gently, with them sidelying or in the Sims' lateral recumbent position, avoiding areas such as adductors, pelvic floor, sacrum, and obviously the belly. It helps to realize that the breath can release the lumbar spine, the chest, and the shoulders.

After delivery it is imperative to receive Rolfing work – the client needs to get her body back. You will sense this and it's what my postpartum clients ask for! A rule of thumb used to be that it is better to wait until the mother is ending breastfeeding, but as it's very common nowadays to breastfeed twelve months or more (at least in my country, Italy), I start work with postpartum women when they ask for it, as new mothers need work. I did work with one client, who was also a friend, the day of the delivery: she asked me to stay with her all afternoon, and I did it chatting, working, resting, drinking tea. She felt held and cared for, and I was very happy to be part of this beginning.

Pierpaola Volpones
Rolfing Instructor
Rolf Movement Instructor

A: Pregnant women already have a lot of change going on. My work with them is to help their bodies to adapt and find comfort, as much as possible, with all the changes. I find that work with radial decompression is a good way to do that. Also, it's important to understand the role of the adductors in helping with stability when the pelvic floor

is under so much pressure and the extended belly cannot offer much help in stabilizing the spine. With this understanding, I don't feel any urgency to work with the adductors, even when the client complains of discomfort and sometimes pain there. Rather, I explain to my clients why that is happening, and that helps them make sense of the sensations and feel the stabilizing function.

There is always a need for movement education during pregnancy, particularly to help clients release tension in the back and connect to their feet. I also educate for postpartum needs: positions for breastfeeding, and what to pay attention to in their babies in terms of motor development – which most of the time brings the kids to my office.

Raquel Motta
Rolfing Instructor
Rolf Movement Instructor

A: When we teach the Ten Series, we often treat every person and his or her pelvis in a similar way. We are constantly working to horizontalize the pelvis, and – at least at first – we are mostly talking in the language of muscles and tendons. Over time, we get more familiar with the ligaments of the pelvis, and then, with further study, we begin to include the organs and their fascial systems in our awareness and interventions. We are aware, from the beginning, that males and females have differences in their pelvic structures. As our practice matures, we may find ourselves addressing more specific needs of the female pelvis either directly (because women come in with a concern or a question about it) or indirectly (because we find that the unique structural relationships of the female or male pelvis are involved in that horizontalization process).

For these reason, I find learning the differential anatomy of males and females useful. Just paying attention to the bony differences under your hands is a good start. From there, more formal education about the anatomy of the visceral structures that contribute to pelvic structure and stability is a good step. Learning to work both directly and indirectly with the ligamentous structures and the fascias of the organs will take the results of your work to a deeper level.

Once a practitioner has attained a comfort with working (externally) with the internal structures of women's pelvises, he/she might want to take on the further study of working with pregnant and postpartum women. These populations benefit tremendously from careful intervention. Expectant moms need help adjusting to the new shape and weight of their bodies as their babies develop, and new moms tend to need some care in helping their bodies adjust to carrying their babies in their arms or in baby carriers. Additionally, new moms generally could use some new information about their pelvis, legs, and feet after a birth: even with an uncomplicated birth, there was a lot of rapid change in the pelvis to accommodate moving a human through it, so the postpartum period is a great time to help with reestablishing those connections. In the case of complications to a vaginal delivery or a cesarean birth, of course there are more factors to consider, including a certain amount of medical trauma and exhaustion.

My hope is that all Rolfers gain a sensitivity to differences in pelvis structures, including male/female differences, whether or not you choose to take on the specific issues of pregnancy and/or postpartum care.

Duffy Allen
Rolfing Instructor

Concerns and Considerations for Rolfing® SI During Pregnancy

By Jeffrey Burch, Certified Advanced Rolfer™

The dictum *Primum non nocere* or "First, Do No Harm" is often attributed to the Greek physician Hippocrates. While Hippocrates made statements similar to this, the exact phrase is attributed to French physician Auguste François Chomel (1788–1858; Wikipedia: "Primum non nocere").

While originally written for medicine, the rule to do no harm applies to our work as well. Before considering how to help, we must first consider how to prevent harm. *Primum non nocere* has special meaning during pregnancy. During pregnancy the stakes are higher in two ways: 1) there are two clients instead of one; and 2) pregnant women and, even more so, their unborn children are more vulnerable than most of our clients. Utmost caution must be exercised by the practitioner working on pregnant women.

This article first discusses some of the risks of Rolfing Structural Integration (SI) during pregnancy. There are two kinds of concern that will be discussed: physical/biological and emotional/legal. Next, the value of screening for such risks as a guide to whether or not to perform Rolfing sessions is discussed, and finally ways to proceed cautiously if a decision is made to do some Rolfing sessions.

Physical/Biological Concerns

Physical/biological concerns involve the 'baby' (whether fertilized ova, zygote, embryo, fetus, or baby), the mother, or the mother-baby unit.

Baby Death Rate: A large majority of fertilized ova die before reaching full term. Estimates of death before birth range for 67% to 90% of fertilized ova. Death of the zygote, embryo, or fetus can occur at any stage of development, and mortality is greatest in the early stages. A majority of fertilized eggs do not reach implantation. After implantation there are still lots of embryo and early fetus deaths. After the end of the embryo period at about forty-three days after conception, survival rates are higher, but there is still substantial loss during the first trimester. The longer a fetus survives, the more likely it is to survive yet longer; however, some babies are stillborn at term (Boklage 1990).

Mother Death Rate: Death rates in the United States among pregnant women from causes related to pregnancy have risen steadily over the past thirty years from 9.1/100,000 in 1980, to 18.4/100,000 in 2013. In developing nations, up to 5% of women die during pregnancy or delivery (Wikipedia: "Maternal Death").

Mother and Baby Hardiness: Some mother-baby pairs are quite sturdy with both members of the pair known to survive severe injuries or illness. On the other hand, one or both members of other mother-baby pairs are fragile in varying degrees ranging from mild to severe. As described in the previous section, a majority of fertilized ova, etc. do not survive, and some mothers die. Any physical intervention with a mother-baby pair must be considered as an added stressor, a potential last straw. It is therefore essential to consider risk factors and to proceed with the utmost caution.

Risk Factors

According to the National Institutes of Health [see entry in bibliography for more detail], risk factors for the pregnancy include:

- Existing health conditions
  - High blood pressure
  - Polycystic ovary syndrome
  - Kidney disease
  - Autoimmune disease
  - Thyroid disease
  - Infertility
  - Obesity
  - HIV / AIDS
- Age less than twenty or, for a first pregnancy, age greater than thirty-five
- Lifestyle factors (smoking, alcohol use)
- Conditions of pregnancy
  - Multiple gestation (twins, triplets or more; a majority of multiple pregnancies involve the death of at least one of the babies)
  - Gestational diabetes
  - Preclampsia and eclampsia
- Previous spontaneous abortion or stillbirth
- Lack of regular and sufficient prenatal care

Emotional/Legal Risks

Death of a child, even an unborn child, is one of the most painful of all emotional experiences (Rogers et al. 2008). Death of a spouse is a severe stressor (Watson 2015) – the most stressful life event on the Holmes-Rahe stress scale, rating 100 points [(Pain Doctor website (undated)].

If a woman and/or her baby come to harm and there is a healthcare professional involved, it is easy for the grieving survivors to blame the healthcare professional. For this reason, being an OB/GYN (obstetrics and gynecology) doctor is one of the ten medical specialties with the highest malpractice claim risks. About 12% of OB/GYN doctors face a malpractice claim each year, compared to 7% for all physicians and 5% for family practice (Jena et al. 2011). The average OB/GYN malpractice payout is about $350,000, and million-dollar claims are common. Malpractice insurance rates are correspondingly high. In some states OB/GYN doctors pay annual malpractice premiums approaching $200,000 per year. When we work with pregnant women, we become part of this risk pool.

Screening to Reduce Risk Factors

While there is no way to completely eliminate risk, there are ways to reduce risk:

- Screen for the risk factors listed above. Ask the woman if she is aware of any additional risk factors. The greater the number of risk factors a pregnant woman has, the greater our caution must be. A single risk factor may be enough to defer Rolfing sessions until well after delivery of the child.
- Make appropriate referrals for care other than, or in addition to, your work. Get to know the healthcare community in your area so you can make targeted referrals.
- Screen for emotional sturdiness. Do not take the woman on as a client if she appears in any way to be 1) in emotional distress; 2) prone to large mood swings; 3) emotionally fragile; or 4) a litigious-oriented person.

- Communicate clearly and consistently with your client. Listen attentively. Reflect in paraphrases. Ask clear questions. Describe what you are doing. Ask for paraphrase responses to check if your client understood. Watch your client's response to your communication. Adjust your pace, tone, and vocabulary to achieve clear communication.
- Never use high-force techniques. There is no need for knuckles and elbows with body weight behind them in working with a pregnant woman. That is both potentially unsafe and unnecessary.

Considerations for Rolfing Work During Pregnancy

Relaxin Hormone

Relaxin hormone levels increase during pregnancy (Wikipedia: "Relaxin"). These hormones soften the connective tissue of the pelvic joints to facilitate the birthing process, and also soften all other connective tissue in the body. This generalized softening of connective tissue is sometimes quite troublesome to a woman late in pregnancy, giving her a generalized hypermobility resembling a temporary case of Ehlers Danlos syndrome (Wikipedia: "Ehlers Danlos Syndrome").

Some good news for Rolfers and their pregnant clients is that the relaxin hormones make tissue much easier to change, allowing us to use truly gentle techniques to make tissue change, such as unwinding, first-barrier load techniques, and Harold Hoover DO's centralizing technique.

Signs of Distress

Constantly watch for signs of autonomic arousal or any sign of distress. Signs include:

- Skin color changes
  - Reddening
  - Going pale
- Piloerection (body hair standing up)
- Breathing rate changes
  - Breath rate speeding up
  - Marked slowing of breath
  - Stopping breathing
- Pupil dilation changes
  - Wider
  - Narrower
  - Unequal between the two eyes
- Dizziness
- Confusion

At the same time you are vigilant, express calmness and confidence in your manner and voice. Besides watching, ask your client to tell you of the slightest distress. She may feel things that you cannot see. *Stop* at the first hint of a problem.

Work Smarter Not Harder

With a pregnant client, we want to work smarter not harder. Keep sessions shorter and spaced further apart. Weekly is too much input for a pregnant woman. Do not overwork the client.

During pregnancy the abdomen is not safe to work on, and the adductors of the leg are highly questionable to work on, particularly more proximally. Thus surface-core relationships cannot be addressed from the deeper layers. Therefore, the Ten Series is not possible during pregnancy.

The growing baby expands the mother's body from the center, so providing space at the periphery will often provide comfort-producing accommodation. Work to provide ease and comfort as the pregnancy evolves. Working on the lower legs and feet, on the arms and hands, and cautiously on the neck often provide ease and comfort.

Specific Training

Get specific training in working with pregnant women. Quality training for working with pregnant women is available from Carol Gray (www.carolgray.com) and Carole Osbourne (http://bodytherapyeducation.com/about-body-therapy-education/instructors/carole-osborne). The methods taught by these teachers are gentle and precise. While they are not Rolfers, their methods are quite useful to achieve the goals of Rolfing SI, and Rolfing SI has always been defined only by goals, not by any particular method. In one famous anecdote, Ida Rolf agreed that if the goals of Rolfing SI could be achieved by whistling a popular tune, that would be Rolfing SI.

Get training in osteopathic listening and related assessment methods. These assessment methods nicely complement the visual assessment methods taught in the Rolfing training. If we but know how to listen, the body has a great deal to tell us about where and how to work safely and efficiently. Training in listening is available from The Barral Institute (http://shop.iahe.com/Workshops/Listening-Techniques1-An-Integrative-Approach-to-Evaluation-LT1) and the author (www.jeffreyburch.com/study-with-jeffrey/functional-methods-for-manual-therapy-3/).

Conclusion

In summary:

- Know and assess for pregnancy risks
- Work smarter not harder
- Assess well, and from multiple perspectives
- Use only the most gentle techniques
- Stop at the first hint of distress in the mother
- Space treatments farther apart

Jeffrey Burch was born in Eugene, Oregon in 1949 and grew up there except for part of his teen years in Munich, Germany. He was educated at the University of Oregon, Portland State University, and the University of Pavia, Italy, earning bachelor's degrees in biology and psychology and a master's degree in counseling. Jeffrey received his Rolfing certification in 1977 and his advanced Rolfing certification in 1990. He trained extensively in cranial manipulation with French etiopath Alain Gehin, and in craniosacral therapy with the Upledger Institute. Jeffrey trained to the instructor level in visceral manipulation under Jean-Pierre Barral and his associates. He has made substantial innovations in visceral manipulation, particularly for the thorax. Jeffrey has also developed groundbreaking new joint-mobilization techniques. He practices in both Eugene and Portland, Oregon and offers continuing education courses at several locations including Eugene, Oregon; Longmont, Colorado; Chicago, Illinois; and Newton, Massachusetts. For more details see www.jeffreyburch.com/biography.

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Pregnancy, Postpartum, and Rolfing® SI

An Interview with Pilar Martin

By Shonnie Carson RN, BS, ANP, BCSI℠, Certified Advanced Rolfer™ and Pilar Martin RN, Midwife, Certified Advanced Rolfer

Shonnie Carson: Would you discuss your thoughts on when and how it is appropriate to do Rolfing Structural Integration (SI) for a client who is pregnant, what work is appropriate and what is not, and what things practitioners should be cautious about?

Pilar Martin

Pilar Martin: I think of Rolfing SI with adults as more of a refinement process of development and embodiment. I do not feel it is appropriate to do any series work during pregnancy, as the body is going through such enormous changes. I apply the midwifery approach to pregnancy, which is you don't do anything that is not necessary. I tell my pregnant ladies, "If you are having any pain or problems come and see me. Otherwise just have your pregnancy but for sure come and see me after your delivery to make sure everything comes back to where it should be." I tell them, if they have no problems, come and see me about a month after the pregnancy. If they have problems with pain or incontinence, then call me and I usually go to their house. Sometimes during birth the symphysis pubis gets dislocated and it is very painful. It is very easy to normalize when you work with it early as opposed to much later.

You do not want to do work on or relating to the pelvis during the first three months of pregnancy. This is not because it would pose a particular risk, but rather because the highest incidence of miscarriage is during the first trimester (three months), and you would not want a woman to think the miscarriage resulted from your manipulations. It is for your protection as a practitioner.

SC: I often see questions on practitioner forums like, "I have a new client who is pregnant and wants to do the Ten Series," or "I have a client who has had the first two sessions and has discovered she is pregnant; what should I do?" How would you respond to those questions?

Shonnie Carson

PM: I always tell women who want to have the Ten Series that is it not appropriate to do that work during pregnancy. The purpose of the Series is to help the person orient more successfully to gravity. You cannot do the series work on a person who is shifting in shape and volume and has a constantly changing relationship with gravity. If you wish to do some symptomatic relief work on the neck, shoulder girdle, ribs, or lower back, that would be appropriate to help her body accommodate to the changes. After the seventh month, any work should be done in sidelying position.

SC: Are there any other precautions you would like to mention?

PM: Yes, you know often there are discussions about manipulating the perineum just before birth. Unless you have had specialized training (and have appropriate licensure) you should not be doing this. The perineal tissues are very enlarged and thinned and full of fluids and you could really make a mess. If you do a lot of manipulation you could create more swelling. So, if you are not a midwife and know exactly how to do it, you should not do it.

SC: What kinds of activity do you recommend postpartum?

PM: Walking is great, swimming if you like to swim, and Pilates is excellent.

SC: The only thing I caution people about with Pilates is to not be tucking their tail under all the time.

PM: Absolutely. You have to find a really good Pilates instructor. I also recommend The Gyrotonic Expansion System® Method, that is great. I usually have a team of people I can refer to like a good movement person, Pilates, Gyrotonics, a good pediatrician, and others I can refer mothers to for specific help.

SC: What other things would you like to address?

PM: Teach them how to carry the baby. In the front in the beginning and then in the back. Use one of those carry slings for both.

SC: Great! What else?

PM: I teach them to keep a sense of their internal 'Line' and posture while breastfeeding. Using pillows, finding a good position in bed, etc., will help with this. If the mother is comfortable, the baby will be more comfortable. Remember, the first experience of gravity for the baby is through the hands of the mother, so this is important.

SC: Oh, that is such a beautiful thing to say.

PM: So, if the mom is breastfeeding in a position that is not balanced in gravity, it will transmit that to the nervous system of the baby. Other animals get their first experience of gravity through the legs by standing, but we get it from the mother holding us.

SC: That is just a great statement. What kinds of activities do you recommend for mothers after a C-section or tears of the vagina, perineum, rectum, those kinds of anatomical disruptions?

PM: In the first few months just walking, because they will not like to do anything else. This is not the right time to push. When they start to indicate they are feeling better, then that is the time to start increasing activity. You have to use common sense and pay attention to the mother.

SC: What do you recommend in cases of postpartum depression?

PM: Whew, that's an interesting one. Well, first they need to have their hormonal levels checked. If the hormones are dropping too fast the woman will go into depression and may need help regulating hormone levels. This is something for the physician to address. Check the position of the coccyx. It may have been displaced by the baby's head and that affects the craniosacral system and may result in depression. So, check the coccyx and the balance of the craniosacral system. Of course, there could be other reasons such as the conditioning of the mother and other factors, but the two most primary ones are hormonal levels and the balance of the craniosacral system.

Another issue I often see is with mothers who are very determined as athletes and have learned to be very strong willed. These are mothers who have a lot of investment into being in control. You know the whole process of pregnancy and birth and raising children is a lot about *not* having control all the time. They often have to learn to let go and not try to be in control. So very carefully you need to guide them in how to find support without trying to control too much. How to find well-being without having to fight too much. Trusting, you know, all that.

And then there are the mothers who feel so 'loose' that they start wanting to get fit and work out a lot, and you have to guide them to not overdo and hurt themselves. Many women want to know how to recover abdominal strength and tone. What many people do not realize about 'core strength and stabilization' is that core activation occurs through the extremities. For example, in pregnancy women spend months trying to balance the weight in their abdomen by leaning back. After pregnancy, you need to help them find their core balance through the feet. With engagement through the core of the feet, balance travels into the abdomen; then they regain abdominal tonus that is not only from control. When a woman only has tonus from control, then she only has it while she's thinking about it. The hands are the same. Look at yoga – always pushing with the hands like downward dog, sun salutations. The moment the weight travels from the hands the movement goes directly into the core. At the moment that the hands and/or feet engage, if any of the diaphragms cut the flow, then there is no possibility of core tonus.

SC: Can you talk about your intention and purpose in your female pelvis workshops?

PM: I teach about 'emptying' the pelvis. I talk about the locomoting, visceral, nervous-system part of the pelvis. That many of the holdings in the pelvis are not in the tissue, but are in the 'gesture' in response to invasions/intrusions. Sometimes holdings are actually confusion about support and stabilization, how a woman's feet connect and what is stability. When women start to find their embodiment and connect well to their extremities and their own space, the feminine power starts to come through very fast. When you change the soma you make changes in the psychology but there is no drama. It's beautiful, and I really like seeing women gain their own power. It is a fluid power that is very unique and very powerful.

SC: Would you like to talk about working with the female pelvis outside of pregnancy? Such as problems with incontinence, fibroids, dyspareunia (painful sexual intercourse), vaginal or labial irritation with aging, and so on.

PM: As Rolfers we can help a lot. For example, with incontinence, with aging the bladder drops down, and engagement through the feet will help lift the bladder. With fibroids, they are often heavy, and we can help with mobilizing them so the woman can find her own space and create less compression and downward pull. Dryness and thinning of the vagina and labia can be helped with hormonal creams or different oils but is not something we can help with manipulation. With dyspareunia, it depends on the cause. If the cause is from uterine pain, that probably should be referred to a gynecologist. If that has been cleared, then again it is usually from needing to connect through the feet and learning how to relax and let go and still have the power to decide when and how through the body. The specifics are better discussed in the workshops rather than in this interview.

SC: Yes, I agree. Do you have any additional comments you would like to share?

PM: No, I think we have pretty well covered it.

SC: Well, Pilar, thank you so much for sharing your expertise and insights.

Pilar Martin, RN, midwife, Certified Advanced Rolfer was born in Spain. She became an RN-midwife in Spain at age twenty-two. She was introduced to Rolfing SI in 1988 by Peter Schwind's first book on Rolfing SI, the only one translated into Spanish at that time. Her initial Rolfing sessions were with Sammy Frank in Barcelona. She trained in Munich in 1991 with Peter Melchior and Bill Smyth, and met Jean-Pierre Barral at the same time and studied extensively under his guidance for many years. Pilar has also studied with Hubert Godard, and that has been an important influence on her work. She did her Advanced Rolfing Training in 1994 in the US with Jan Sultan and Jeffrey Maitland. Pilar has a private practice in Santa Cruz, California. She works with mothers pre- and postpartum and babies, and with the craniosacral system in infants. She has been teaching workshops on the female pelvis in both Europe and the US for fifteen years. She can be contacted at pilarrolfing@cruzio.com or pilarmartin.org.

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Rolfing® SI After Cesarean Section

By Dorit Schatz, Certified Advanced Rolfer™ and Rolf Movement® Practitioner

Introduction

All over the world, the legal and traditional regulations around pregnancy, birthing, and postnatal care are changing. I live and work in Germany, where, both by tradition but also by law since the 1930s, a midwife must be present at every delivery. Only in emergency cases are doctors alone allowed to help. Even in the case of a planned C-section, a midwife will be present in the operating room, firstly to take care of the woman, and then taking care of the baby. Frequently it will be the midwife, not the doctor, who carries out post-operative care. I received my training as a nurse and midwife at the university hospital in Würzburg, and this was the way I had worked for a decade when I started my Rolfing Structural Integration (SI) training almost twenty years ago. I witnessed about two hundred C-sections as the midwife in charge, and many more during my training and a one-month deployment in the operation ward.

Nowadays, in the US, Canada, and Europe, 23%-50% of deliveries are planned or end up as C-sections. Indeed, in more affluent socioeconomic groups in the US and South America, this percentage goes as high as 70%-90%. As the long-term effects and outcomes of C-sections become more apparent, authorities are now trying to encourage vaginal births. In Europe, the prevalence of birth by C-section is around 25%-40% and rising (some hospitals have a rate of 70%!), and equivalently there are increasing calls to return to more natural birth settings. But for the time being, we need to be able to work with the high number of women who have had a C-section.

Around 15% of women do not have children (depending on cultural and religious backgrounds, this figure may vary between 5% to 20%). Thus 85% of women have at least one child, and indeed many of them will have two or more children. This means that 30% to 70% of women who show up in our Rolfing practices have one or more C-sections in their history.

Many people think that the cesarean (or caesarean) section was named after Julius Caesar, the Roman emperor, and that he himself was born that way. But cesareans were actually already being performed (and called by that name) before he was born. The word comes from the Latin *caedere*: to cut. Women in those times did not survive a C-section. (Happily, we know that Caesar's mother did live for many years after his birth, having given birth to him vaginally.) Abdominal cuts to save a child's life were only performed when the mother's life was already fading and could not be saved.

In the nineteenth century, rickets became very common due to malnutrition and the practice of keeping children indoors. It caused severe pelvic deformities, and many women died during labor at full term due to tearing of the uterine musculature. The medical alternatives then available were of little help: inducing labor prematurely might lead to death or handicap of the child, or the fetus might be killed in the womb; cesarean sections caused maternal death in 45%-60% of cases. In general, the mother's life was saved over the child's, and women were advised not to get pregnant again.

Only after the introduction of chloroform and antibiotics in the early twentieth century did C-sections become safer. Yet it is still the most common reason for maternal death in delivery (indeed, almost the only reason now in places like Germany). Today, the maternal mortality rate differs from 1:6600 live births in industrialized nations to as high as 1:250 births in underdeveloped / Global South countries. For the child, it also remains the case that a C-section is not the safest way to be born: breathing and blood-sugar regulation problems are just two possible adverse effects of being born by C-section. When these aspects are considered, it is possible that C-section threatens as many lives as it saves.

C-Section Procedure

Until the 1960s, the abdomen was cut lengthwise in a C-section, and the uterus opened transverse at the corpus; that is, at the cranial end. Sometimes even the uterus was cut open lengthwise. The standard method was formerly to cut all layers to the full extent of the opening required, and in the end suturing up every single layer one by one. Both ways caused large scars in the abdominal wall and, since the uterus was cut through the thickest part of its musculature, it would frequently rupture in later pregnancies and during labor. For this reason, it was recommended that after a C-section there should be no further pregnancies (requiring abstinence in those days). Later, with the advent of improved suturing, this advice was changed to: 'once a C-section, always a C-section', definitely the safer way to go.

From the 1960s onwards, surgeons began to prefer a suprapubic transversal cut of the abdominal wall (within the bikini zone), with a longitudinal cut of the muscular layer in the fascia, and then a supracervical transversal incision to the uterus. In this lower end of the uterus there is little musculature, and post-surgical ruptures are accordingly fewer. The materials used for suturing have improved considerably, and wounds heal much better, to the extent that a woman today might have a first child by C-section before going on to have three vaginal births.

The Misgav-Ladach method is also mainly used nowadays as it is considered less invasive and conducive to faster healing. In this method, it is only the outer skin layer that is cut all the way through; all the other layers are cut minimally ('edgeless') and are then opened by tearing or pulling. Only the uterus, abdominal fascia, and skin need to be sewn up afterwards; other layers (such as the layers of muscle and the peritoneum) are left open. The surgeon sometimes repositions these before suturing the next layer.

Preoperative Preparation

The following is standard preoperative preparation for a C-section:

- Administration of sedative
- Shaving of the lower abdominal area and pubic symphysis
- Fitting of intravenous drips; for example, to fill the circulatory system with liquids, medication to stop contractions, or (more rarely) blood transfusion
- Continuous blood-pressure monitoring, attached on one arm
- Continuous oxygen monitoring, attached on one finger
- Fitting of a urethral catheter
- Local anesthesia, such as an epidural or other spinal anesthesia
- Positioning of the body on the operating table
- Washing of the body
- Covering of the legs and belly with a sterile drape
- Erection of a screen at the level of the thorax between the woman and the operation area, so that she will not be able to see what is happening, nor who is there, but which still enables the surgeon to see her face
- If necessary, general anesthesia with intubation. This involves stretching the neck far back, the insertion of a tube, and then leaving the neck in a slightly more neutral position afterwards while maintaining the tube in the throat.

Operation

A C-section operation consists of:

- Transverse opening of skin and subcutaneous fat cut from right to left
- Widening and tearing of the incision
- Insertion of abdominal spreaders to maintain the opening
- Incision and tearing of the muscular layer lengthwise at the midline along the fascial layer
- Opening of parietal peritoneum with a small incision and tear; this is a very thin and elastic layer
- The 'stuffing away' of the intestines with wet cloth (lots of pieces of cloth, perhaps three to eight pieces depending on size, which must be counted in and out). This takes times, so some surgeons will not do this.
- Incision of visceral peritoneum on top of the bladder
- Dissection of the bladder away from the uterus
- Incision and tear of the transverse opening of the uterus in the supracervical area (behind the bladder)
- Opening of the amniotic sac
- Suction of amniotic fluid
- Taking the child by the head or butt
- Pressing on the upper abdomen in order to build up pressure to enable extraction of the baby
- Clamp and cutting the umbilical cord

These steps are achieved with a lot of hurry and stress, because all of this needs to happen within one to two minutes from the start of the operation to avoid anesthetic and other medication getting into the child's circulation. After the child has been separated from the mother's circulation, the pace of the operation usually becomes more relaxed. Nevertheless, the operation continues to be potentially life-threatening for the woman.

The baby's vital signs will be checked; in the past, the child would be taken away to the neonatal ward (nursery) and brought to the woman maybe a day later, or even days later, when the mother was able to walk over to the nursery. Nowadays, the baby will be checked and brought to the mother straightaway and placed on her upper thorax so she can see and feel the baby. Only later will the baby be brought to the nursery for a complete check-up. If the baby has problems, the mother might not see the baby until she is able to walk or be brought to the neonatal intensive-care unit.

The operation continues:

- Further suction of amniotic fluid and blood
- Manual extraction of the placenta, with suction of blood
- Taking the uterus out of the abdominal cavity to suture, and repositioning into the abdominal cavity
- Re-attaching the bladder to the uterus (some surgeons do this; some don't)
- Laying the visceral peritoneum over the uterus and bladder, with optional suture of peritoneum
- Removing the pieces of cloth, and counting these back to ensure that everything has been removed
- Insertion and sewing in of a drainage mechanism
- No procedure to parietal peritoneum
- Suture of the fascial sheet under the musculature
- In the past: suture of the muscular layer (nowadays, this is not done)
- In the past: suture of the subcutaneous fatty tissue (nowadays, this is not done)
- Suture of the skin (in the past, via clasping or stitches; nowadays, via intracutaneous suture)
- Application of sterile bandage

Postoperative Care

Next we have the postoperative care procedures:

- Removal of coverings
- Lifting woman over to a movable bed (along with urinary catheter, drainage, and IV)
- Infusion of medication to support uterine contraction

- Patient taken to a monitoring or intensive-care unit
- The urinary catheter and drainage will remain for at least a day
- Blood-pressure and oxygen monitoring will be removed at differing times
- Pain management

Recovery

While all these steps are carried out for good reasons, many of them may have long-term effects on the body. In pregnancy and delivery, the body's own capacity to heal and reposition itself in space and gravity is abundant. (One example makes this brilliantly clear: surgeons used to combine some C-sections with sterilizations, but stopped doing this after they found that – compared with the usual refertilization rate of 0.1% – sterilizations carried out in the two weeks after birth have a refertilization rate of up to 10%.)

Nevertheless, the woman's body and being have a lot to do (not forgetting childcare!) after an operation as major as this. How well a woman heals after a C-section will depend on a number of factors, including her physical state prior to the birth and the resources available to her after the operation. It may be easier to recover from a C-section that was planned, but this also depends on whether her expectations of recovery were realistic. For women who chose to give birth vaginally, but found themselves overrun by emergency and hospital procedures, there will be a need to process the psychological themes of their experience alongside the physical effects (and all of this while caring for a newborn). This can be absolutely overwhelming. A great deal of tender and empathetic support is needed for many weeks after the operation.

There are five typical stages of recovery:

Phase One: In the first few hours, immediate survival is in the foreground. There may be shocked numbness. Basic body functions are important; thinking may be too demanding.

Phase Two: In the first few days, the numbness dissipates, and the focus shifts to pain management, relearning to walk, re-engaging bladder control, and the resumption or normal bodily functions. Managing pain around daily activities will be a challenge, and emotions start to show up (sorrow, disappointment, anger, and feelings of guilt may be among these). The typical 'baby blues' often marked by excessive crying may emerge at around the third day.

Phase Three: Awareness. The period after getting home and until around eight weeks after delivery is a hard time for all women, especially after a C-section. The round-the-clock care needed by a newborn inhibits a normal recovery from a big operation. Doubts, recriminations, and judgement (by the woman or by others) around the decision to have a C-section, or the question of how it might have been avoided, are foreground. For many, this can be a very emotional and intense phase, as women try to negotiate whether they or their medical team were at 'fault'.

Phase Four: Medium-term resolution. In the period two to twelve months after the birth, women try to make sense of their experience. They may recapitulate what happened from different aspects, and try to settle on the facts. This is often the time when they begin to seek help with the outcomes of their experience (meeting Rolfers and other practitioners, restarting exercise, finding groups to talk about their experience, etc.). Some women may nevertheless suppress the reality of the operation and try to get back to a body image from before the pregnancy.

Phase Five: Resolution. Acceptance and allowing the experience to be an integrated part of their lives.

Let's go back to the physical part of the C-section. I will point out common effects of many of the steps listed above. Of course, this list is not, and could never be, complete, and will not be true of every woman you meet in this situation. Women may experience one or several of these side effects, and may not be able to name or give words to some aspects of their physical state. The following is presented as a prompt to help you better identify, understand, and evaluate your clinical observations.

General Themes for a Rolfing Body Reading

Based on what has been discussed above, there are many aspects Rolfers can consider in the structural and physical assessment of a client who has undergone a C-section, depending on their scope of training and other licensure. Some of these include:

- General alignment
- Spatial relationships
- Breathing
- Areas of inhibition or avoidance
- Layers (fascia, musculature . . .) – are there disrupted layers of tissue, observed in scars, imbalanced tonus, areas of numbness or hypertonus, adhesions to other layers/structures?
- Blood flow: is it even throughout the body? Are there areas of increased or lessened blood flow, or congested/empty areas?
- Lymphatic flow: are there areas of congestion, swelling, or emptiness?
- Nerve connections: are nerves connected throughout? Are there areas of numbness or hyper-reactibility?
- Reactions to medication: liver, spleen, and kidney areas; increased blood flow; areas of the body that may be swollen, tense, tender, stiff, or non-reactive
- Reactions to suture material: may lead to scars with secondary healing (see below)
- Meridians: general flow, congestions, emptiness, imbalance
- Scars: primary healing (i.e., the body was able to reconnect all sides without disruption) or secondary healing (disconnecting scar tissue in between, causing interruptions, deviations, etc. of blood flow, lymphatic flow, enervation, fascial connections, meridians, coordination, body image, body schema and meaning)
- Adhesions: they act like scars with secondary healing

Common Reactions to the C-Section Procedure

In general, pregnancy hormones result in tissue that is more elastic and less able to recoil. This means that dislocation can occur more easily and be harder to heal. These hormones are active for several weeks after delivery and throughout breastfeeding. While it is easy to affect the body through Rolfing SI during this time, it is also easier to dislocate joints or overstretch tissues, and beneficial effects may not be lasting.

Anaesthesia used during a C-section may be local or general. With local anesthesia the lower part of the body will be numb, while in general anesthesia the patient will not feel dislocations and strains to joints and tissues. (Of course, this is true for every operation, not only C-sections.)

The intravenous drip is usually placed on the right arm, and this arm will be fixed in place during the operation so that any

unconscious or inadvertent movements will not tear out the access to the blood system. The arm will be held in place for the duration of the operation (thirty-five to sixty minutes on average). Very often, the arm is not fully comfortable during the operation, and this can lead to slight dislocations, ligamentous overstretching, and muscle contractions that may afterwards cause inhibitions in the right shoulder. The oxygen sensor is placed on one finger on the same side.

Blood-pressure measurement is done on the other arm. The sphygmomanometer stays in place for the whole operation and for some hours afterwards, and can cause inhibited movement in the arm and shoulder.

During the operation, the body is fixed on the operating table in lithotomy/dorsosacral position (on the back with flexed hips and knees and legs splayed), and also in the Trendelenburg position, meaning slightly turned to the left, to avoid vena cava syndrome. Reclining fixedly in this position for more than half an hour, with a twisted sacrum, can distort the whole lower spine and especially the sacroiliac joints (if there is preexisting misalignment, you can imagine the effect). The surgeon will be located on the left side of the body, with a helper on the right side. Another medical assistant may also be standing at the end of the surgical table, between the patient's legs. With general anesthetic, the neck may be overstretched, and vertebrae may become fixated or misaligned.

After the operation, the woman will be placed in a regular hospital bed, but this may be achieved a little carelessly. As it is hard to move one's own body immediately after an operation, all sorts of 'minor' misalignments may occur.

Over the coming days, patients are mobilized quickly, with a view to discharging them from the hospital and allowing them to be at home with their new baby. However, this is achieved with a lot of painkillers that enable the woman to get out of bed at a time when she should still be in recovery. Not infrequently, women experience secondary infections due to wounds reopening, and may even need another operation to clean out infected cavities or remove excessive scar tissue and adhesions.

Other Reactions

There are other reactions to treatment that are often neglected or not immediately obvious.

- Placement of the urethral catheter (which can be in place for at least one day, and sometimes several days) can cause irritations and inflammations. These can cause constrictions in the urethra, so the woman starts to 'squeeze' in order to urinate. Over time, this will weaken her pelvic floor. (This also happens with men who have a prostate problem.) Weakness of the pelvic floor sometimes causes incontinence in all areas.
- When the surgeon starts to make the incision, there is very often a physical reaction by the woman, as though she wanted to run away. This is a factor even in general anesthesia, because the body is not numb: it is only the connection to the brain that is inhibited. There can therefore be an unconsciously registered experience of physical violation, and reactions that accord with this. Strong bodily memories – of feeling suffocated due to intubation, of being strongly pushed on the ribs, of someone leaning on the inner thighs, and of voices and other fragments of the surgical experience – may show up in dreams.
- There are strong pushes and pulls to the intestines and the mesentery, and potential irritation to the vertebrae. Strong back pain in the lower thoracic and lumbar vertebrae is quite common.
- Due to suctioning of bodily fluids in the abdominal cavity, there can be local dryness, leading to adhesions later on.
- The upper belly and lower thorax are pushed in order to squeeze out the baby. Bruising and slight dislocation of the ribs are common.
- The uterus is displaced within the abdominal cavity in order to be sutured. This generates strong pulls on the posterior ligaments, and also often on the lateral ones, and both these pulls and subsequent compensations can dislocate the sacrum. The outer lining of the uterus becomes dry in this procedure, and can be prone to adhesions afterwards.
- The inner opening of drainage mechanisms is affected by general physical movement, and can end up in a less-than-ideal place. Its constant suction pulls on surrounding tissue, which may cause lesions, and not infrequently the removal of the drainage mechanism is both extremely painful and may result in further lesions.
- The abdominal wall is cut through, and with it the nerves that supply the area. Very often there is numbness for several months in the skin of the lower abdomen, and also in the area of the pubic bone. If there is insufficient or inhibited proprioception in this area, pelvic tilt and shift may not be correctly felt and represented. This will influence the whole body, especially the inner front line of the legs down to the toes, and thus have an effect on the push-off of the big toe. Front-to-back balance may be dysregulated, both in in standing and moving.

How the Ten Series Supports Recovery from a C-section

There are many ways a Rolfing Ten Series can support a woman in recovery from the effects of a C-section. If you are in any doubt that a client's presentation is within a normal range, do not hesitate to refer her to a physician prior to working with her.

Session One can help address the effects of both pregnancy and delivery on the breath. During pregnancy, the lower ribs are pushed outwards to make space for the baby, with pregnancy hormones working to soften ligamentous structures. This may mean that the ribs are not in place, or that the diaphragm needs to return to normal function. During delivery (and especially an attempted vaginal delivery), the breath may have been used to try to push the baby out.

Session Two can address the effects of pregnancy on plantar support, as well as the mobilization under stress of trying to 'kick' a perceived aggressor or 'run away' from the situation in the hospital.

Session Three can resolve issues in front-to-back balance that may be due to internal strains on the pubic symphysis and dysfunction of the lower abdomen.

Session Four can help with irritations to the pelvic floor created by internal pulls, and with squeezing the pelvic floor due to trauma, numbness, and feared or real incontinence.

Session Five can really help with finding space for the abdominal organs and psoas, as well as with issues with both body schema and body image with respect to the belly.

Session Six can address issues around sacral dislocation and the effects of internal pulls on the mesentery.

Session Seven can resolve issues from the positioning of arms, shoulders, and neck during the operation.

Sessions Eight to Ten, the final three sessions of the Series, help to re-establish fascial lines and transitions throughout the whole body, and help the client to address issues with both body schema and body image.

Conclusion

I hope that this article can contribute to a better understanding of the aftermath of C-sections and help us, as Rolfers, to resolve the difficulties they create for our clients. The Rolfing Ten Series is wonderfully designed, and applied carefully it may help with many of the effects of a C-section.

Dorit Schatz trained as a nurse and midwife in Würzburg, Germany, completing her training by state examination in 1991. She worked in hospitals for ten years, spending her spare time training in shiatsu, craniosacral therapy, reflexology, homeopathy, and other modalities. In 1998, she left the hospital to complete her Rolfing training in Munich. Dorit completed her Advanced Rolfing Training in Santa Monica in 2002, and her Rolf Movement Training in Munich, also in 2002. Dorit has assisted several Basic Rolfing Trainings, and was a participant in the European teacher training. She lives and works in Munich. In her practice she mainly works with 'regular' Rolfing clients, but additionally specializes in themes around pregnancy, postpartum, and pelvic-floor issues.

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Changing the Trajectory of Life, Part 2

By Briah Anson MA, Certified Advanced Rolfer™, Rolf Movement® Practitioner, BCSI℠

Editor's note: Part 1 of this article, concerning Rolfing® Structural Integration (SI) for children, was published in the September 2017 issue of this Journal.

Introduction

My exploration into working with pregnant women came about as a direct result of the admonition that Ida Rolf put in the first edition of her book. This was a quote from Gautama Buddha:

> *Do not believe in anything merely because it is said, nor in traditions because they have been handed down from antiquity: Nor in rumors as such: Nor in writing by sages because sages wrote them: Nor in fancies that we may suspect to have been inspired in us by a deva: Nor in inferences drawn from some haphazard assumption we may have made: Nor in what seems to be an analogical necessity: Nor in the mere authority of our teachers and masters. Believe when the writing, doctrine, or saying is corroborated by reason and consciousness (Rolf 1977, 8).*

This advice led me to seek out mentors in the SI world, look for scientists doing research that illuminated the Rolfing principles, and to push my work into areas that were not usual for us, just to see if the Rolfing principles could be effective there as well. For many years I studied with four teachers trained by Dr. Rolf, among them was Stacey Mills from Hawaii. I integrated their approaches and perspectives on the Ten Series into my own work. Rolf was adamant about studying and focusing solely on the Rolfing Ten Series for five years as a way to truly understand its depth. It was after that length of time that I started branching out into other areas, and I also found the work of Dr. A.J. Ayers, an occupational therapist doing research on fetal and childhood development. I was looking for other paths of reason that corroborated (or didn't corroborate!) with Rolf's assumptions.

The wonderful paradigm of Rolfing SI is that our work holds a different premise than the predominant paradigm of our culture that focuses on alleviating symptoms. We have the power of a whole-system process that establishes the proper relationships within the body and between it and gravity. I cannot emphasize enough the underlying

magic of applying the goals of the Ten Series.

One of the major principles that I have discovered and keep in mind is that, as practitioners, we must stay organized – organized in our approach to the client's body, and organized in our own. One of the ways we become disorganized is by simply not having taken the time in our early practices to just do the Ten Series and discover what Rolfing SI is all about – particularly these days, when most of us are under state licensing that requires annual continuing-education credits and the mushrooming bodywork world bombards us with technique workshops promising to fix every structural element a doctor can diagnose. It often looks like a relief to us to see classes that take on the particular ailments our clients walk in the door with, because our training can leave us feeling like we don't know nearly enough. We are on shifting sands. But – we're supposed to be! Until we really get it that we are working with the more fundamental and all-encompassing factors that affect structure, we can be easily enticed by the one-day fix-it technique class. Our profession offers something that is still relatively rare, and it would be a shame if we were to cave in to the pressures of symptom-educated clients, insurance requirements, and our own insecurity.

I say all this as a preface to taking on the Rolfing SI of a pregnant woman and her fetus. I have worked with women during all stages of pregnancy, which for me includes pre-pregnancy through postpartum. With the exception of the first trimester, which can be a very delicate time for the fetus, Rolfing SI can help in different ways throughout this whole cycle.

Pre-pregnancy Work

Let's start with the women who have being unsuccessful at becoming pregnant at all. It has been my experience, as well as that of many other Rolfers, that for some reason the problem of infertility may disappear during or after a typical Ten Series. Now, I never advertise that or tell an infertile woman that Rolfing SI is going to solve this problem, because we just don't know that for sure. But in my experience, about 80% of these seemingly infertile women are pregnant within a year of experiencing a thorough Series. Usually after the seventh session or later, they are suddenly able to get pregnant and go to completion, delivering the baby with no trouble at all.

It is impossible to know why infertility is happening. It might be an effect of birth-control medications, a system that is too acidic, or a structure or biochemistry that is too far out of a normal range to allow pregnancy. These things have to be looked at holistically with all factors taken into account to create the best possibility for an embryo to take hold and grow.

There are many reasons to work with women before they become pregnant. It is not just about making it easier to carry the growing fetus structurally, although that's a big issue, but it can also have a beneficial impact on the child itself. In the 1980s, Ayers finished some important research on the relationship between touch stimulation and neural organization, especially that of the vestibular system, in a developing child. The skin and the nervous system both develop from the same embryological germ layer, the ectoderm, hence the relationship between touch and the development of an organized neurology (Ayers 1989, 39). In-utero stimulation is the only touch an embryo and the later fetus will have, consisting of the mother's circulating fluids, her structural pressure, and the force of gravity. Is the mother's fluid flow interrupted or diminished by stiff, thick, or pressurized fascias? Is her thorax slumped heavily onto her lower abdomen creating excessive weight onto her uterus? What happens to fluid or oxygen circulation and pressure when the mother is in chronic pain because her own structure was not ready to carry this extra load? These are all situations that can be cleared up by pre-pregnancy SI.

Rolf's writings have been a reminder to me about the necessity of good structural alignment for the unhindered flow of fluids that supply nutrients, oxygen, hormones, and other proteins, as well as taking waste out of the system. Rolf understood that unrestricted flow was not just a molecular phenomenon, but also an energy exchange (Rolf 1977, 179-180). Effort is needed to move through a gravity field. When a structure is unstable it becomes heavy and ponderous in its structural relationships. Vital energy is used up just staying upright or even sitting. Rolf was aware that spatial organization often equated with psychological behavior and emotional state (Rolf 1977, 286). This has been my experience as well, and one has to wonder what affect a mother's sense of well-being and vitality (or lack thereof) has on a fetus. And what might be the ramifications for postpartum depressions that are so terribly debilitating? We don't have researched answers to these kinds of questions, but our understanding of how structural stability has a direct bearing on quality of life does not make it difficult to connect the dots.

Women come in for pre-pregnancy work for a variety of reasons. Some are already having chronic low back or neck problems and were worried about those problems impacting the pregnancy or their bodies. Some of these women have had at least the Ten Series already and know how important an aligned structure is. A psychotherapist once referred her client to me because she did not feel like her body was a part of her and could not experience well-being. She had the Ten Series pre-pregnancy to prepare physically and spiritually. Another mother of two came in before her third pregnancy to deal with physical abuse issues from her childhood. Their stories vary from needing physical comfort to an emotional makeover. In every case, I work to get their structures at ease with gravity and am still surprised at the ramifications of this work on the totality of their systems and on their babies.

Rolfing SI During Pregnancy

As an example of a client who used Rolfing sessions as a way to help her through her pregnancy, I'll relate my experience with Carly, a large mesomorphic woman, very athletic all-American soccer player, and very tight and muscular. She had been through the whole Ten Series, had advanced work, and then at thirty-seven she had a few more sessions to prepare for her pregnancy. Three months after she became pregnant she returned for a little work, and found that if she had no Rolfing sessions for two or three weeks she became very uncomfortable in her lower back and neck. She delivered her son naturally and brought him in for a session when he was one month old, and then again at three months. His development was incredible. At only four months old he looked like a little boy – no random movements and very organized in his gestures, very strong, calm, and mobile, and aware of everything going on.

I've had similar experiences with many women and their newborns. Mothers who have used Rolfing work to help them through pregnancies often bring their newborns in for work as a way of working through birth trauma. It is not uncommon for mothers with older children who hadn't had the advantage of a 'Rolfing pregnancy'

to see that this latest baby was born with a noticeable difference. One mother put it to me this way: "Oh my goodness, this child was born already looking conscious, looking so awake, so alive."

This has been very interesting for me to observe because as I have worked with the mother through the pregnancy that baby is already receiving stimulation and organization. Getting the mother more structurally sound and comfortable has allowed that baby to grow more comfortably in a confined space.

With my pregnant clients who have already had the Ten Series I like to introduce the idea of receiving work after the first trimester to sort of 'let out the seams' – just make them more comfortable in their bodies so they could avoid back pain and be in better alignment. This goes back to Rolf's idea that the better aligned a woman is through the whole pregnancy the easier it will be for her to deal with gravity. Gravity is constantly shaping us, and as the baby gets larger the pelvis tips forward more and the gravitational pressure on the low back and front of the pelvis can get extreme. If women can maintain or continue to hold their alignment as they get larger with the fetal growth in front, it allows them to have a lot more length and space for that baby to grow in – not to mention more space for the mother's own organs which get quite compressed during pregnancy. I always ground my thinking and explanations in gravity – it makes sense to people.

I find it important when working with a pregnant woman to be consciously aware that there is another being that I am contacting through my touch. I am first working with the mother, opening up more spatial freedom to carry the baby more comfortably. But I am also expanding the container that the baby is growing in, so that all of its developing systems can grow with the most optimal relationship to gravity. Two beings are being touched and contacted in a way that is significant for each of them individually, and also as a mother-and-child unit. I hold that intention, knowing that it is in fact two beings that I am working with. I am often asked to work with these babies shortly after birth, and am very aware that there is a soul and I can feel an energetic and spiritual connection between the child and myself. They very quickly become comfortable with my touch and with my assisting them to release trauma from their births.

Issues from Delivery

C-sections are a problem that mothers and babies face more and more often these days. They have become very routine, and have consequences for both mother and child. For the mother, they leave a legacy of abdominal scarring that can have terrible structural consequences years later. I have studied scar-tissue work with Sharon Wheeler, and find that addressing the different kinds of connective tissue through the abdomen has helped to resolve a lot of chronic low-back issues and free women of all that C-section trauma.

Turning to the baby, there can be developmental problems for the child that did not ever have to travel through the birth canal, a process that stimulates the cranial system. Some of these C-section babies have a lot of birth trauma that needs to be released. This trauma expresses often as constant crying or anger. After that first post-birth session they become much more at ease in their bodies. It is very important to know how to do some mouth work and cranial work to help stimulate the cranial developmental process, with a focus on how this relates to the whole structure of the child.

Another disruptive factor is that after a C-section the woman is now a mother and needs to take care of an infant. She has a lot of pain from the surgery, and is going through a lot of adjustment herself while holding this little being. Energetically, all of that has an impact on the child. In sum, I believe those operations are a huge trauma for both the mother and child.

Postpartum Work

Everyone who has been pregnant knows that every single piece has been pulled, stretched, tugged, and put in positions of great stress. Postpartum work gives women a feeling of empowerment as well as structural relief. It helps to release whatever sort of trauma they may have gone through.

I usually have women wait a bit for postpartum work – something I learned from Stacey Mills. She would tell me to let everything settle and after about six weeks they'll come back in. As every single piece of a woman's anatomy has been affected by her pregnancy, helping her re-establish her 'Line' and open up her breathing again is huge. My clients receiving postpartum work have all been able to feel the changes emanating from everywhere and to everywhere (which is very informative about the systemic impacts of our work). Often many of these women wait a few months and then come in to go through the whole Ten Series again. I think that is very appropriate, because then everything can be addressed systemically and systematically. Women often tell me that they feel like they get their bodies back.

Conclusion

People have a lot of expectations about how a birth process should happen, but the truth of the matter is that you do not ever know how it is going to go. You can do everything in your power to prepare, but the woman's body, the child, and their interaction during a very powerful process has a life of its own. They have to be able to adapt and be ready for anything. And nothing facilitates adaptation like Rolfing SI.

Being able to work outside the symptom-oriented norm is a huge service to women and the developing child. Very few professions can offer this kind of support. In 2017, as we are more and more pushed into working symptomatically, Ida Rolf's advice to us via Gautama Buddha becomes even more important than it was in 1977. The pregnancy process is an event that has a beginning, middle, and end – it is a process to follow and support, not a symptom to alleviate.

Briah Anson, MA, is a Certified Advanced Rolfer and Rolf Movement Practitioner with over thirty-eight years of experience. She is a pioneer in the field of Rolfing SI author and publisher of Rolfing: Stories of Personal Empowerment *(1991/1992). She also produced and directed* Growing Right With Rolfing *(1996), a documentary featuring her work with children under the age of four. Briah has a private practice in St Paul, Minnesota. Continuing her evolution as a healer, Briah completed her training and certification in 2001 as a practitioner of Frequencies of Brilliance – a form of quantum energetic bodywork. To date she has completed twenty-five levels of this transformative healing work. Briah is also presently pursuing a four-year program in classical homeopathy at The Northwestern Academy of Homeopathy in Minneapolis, Minnesota.*

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A Doula's View of Rolf Movement® Integration in Pregnancy

A Conversation with Monica Caspari

By Heidi Massa, Certified Advanced Rolfer™ and Rolf Movement Practitioner and Monica Caspari, Rolfing® and Rolf Movement Instructor

Heidi Massa: Monica, before you became a Rolfer you worked as a doula for nineteen years. How did you get into that?

Monica Caspari: Though my academic training had been in nutrition, when I was about twenty-five years old, my nineteen-year-old brother was dying of cancer in excruciating pain. You know, back then, about forty years ago, we did not have the potent painkillers that we have these days -– so he begged me to *just do something*. I had no clue what to do, so for lack of a better idea I started rubbing the place in his back where the horrendous pain was. It did not take very long for him to start relaxing and go to sleep. After that, I got good results for other people with various health issues, so I learned that my hands were good for something. Around the same time, many people started asking me to touch them. Some, like my brother, were dying – including my gynecologist – and others were pregnant women. It seemed that my hands could help them through these transitions of being born, of giving birth, and of dying. Anyway, it was the gynecologist who started sending her own pregnant patients to me, and so I became a doula.

Monica Caspari

Heidi Massa

HM: Tell us how you would help these pregnant women. Did you assist only in childbirth itself – or did you help them beforehand?

MC: I worked with them beforehand, as well as during delivery. I would have three different groups of pregnant women, each of which met once a week for two hours. It gave them the opportunity to ask questions, check in with their feelings and anxieties, and practice yoga stretches I taught them. To better serve these women I studied and practiced various body techniques, including Hatha yoga, of which I became an instructor. And again, to better serve those women who despite the yoga classes still felt discomfort or pain in their back, legs, etc., I studied massage specific to pregnant women.

HM: As a doula, was there anything uniquely challenging about practicing in Brazil?

MC: Certainly. Here in Brazil we have the world's highest rate of cesarean section. It is part of the culture here, so women who want vaginal deliveries – not to mention having natural methods of assistance – need a lot of courage. Being their ally and encouraging them to take charge of their processes was part of how I helped my pregnant clients.

HM: When you were a doula, were you familiar with Rolfing Structural Integration (SI)?

MC: No – not for most of the time I was developing myself as a doula. But my work as a doula was the gestation that eventually gave birth to the Rolfer in me. And – because it was working with these women that taught me how to work with groups – it was also the gestation of my career as a Rolfing teacher.

HM: How did you make the transition from being a doula to being a Rolfer?

MC: Well – it wasn't necessarily smooth . . . I started Rolfing training in 1989, in the old days when candidates for admission to the training program were put through a grueling interview process. I remember being right there in my admissions interview with my pager going off because one of my clients was in labor. Of course, I had to answer the page and take care of the client – and the admissions committee's attitude was, "She is so arrogant . . . . Who does she think she is, anyway?"

HM: Has that attitude changed over time?

MC: Not really. Some people still feel that way about me – but I don't mind. They have the right to think whatever they want.

HM: How should we even begin to discuss structural and movement integration in pregnancy?

MC: We should start with the context. After all, the mysteries of pregnancy and birth are surrounded by taboos. More than just biological processes, they are socially significant events – and social needs often take priority over biological needs. We see an example of this with the prevalence of cesarean deliveries in Brazil – but it has been so throughout human history.

HM: We differ from the animals by emphasizing the social context of pregnancy and birth?

MC: Yes. There is not much evidence of just how prehistoric deliveries happened, but some anthropological studies (Arruda 1983) suggest that from 500,000 to about 30,000 BC, a female in labor left the group, gave birth, cut the umbilical cord, buried the placenta, and went back to the group with the baby in her arms. Because the

females did not have stable partners, they did not know the origin of pregnancy and males were not interested in assisting birth. And most likely, back then the females gave birth not in the laying position, but in the vertical position – just as is done even today among some isolated populations such as the Yanomami in Brazil (Sabatino et al 1992).

HM: So in pre-human times, females had control over what was a more purely biological process?

MC: Exactly. But as time went on and our body structures evolved, women came to need assistance. From 30,000 to 18,000 BC, as our hominid ancestors became Homo sapiens, we became truly bipedal. During this time, the human pelvis also changed: the bones got thicker, the pelvic floor stronger, and the birth canal narrower. And – at the same time the volume of the newborn's brain and head approached the limits of the birth canal, so that the baby had to twist and turn quite a bit to navigate its large head through the limited space of the birth canal. And to make things even harder, when most babies start to be born, they are facing their mother's backs. This position makes it more difficult for the mother to breathe and to push the baby out. So – sometime in the Neolithic period (the Stone Age, approximately 18,000 to 5,000 BC) now-stable male partners began to assist in childbirth (Faria and Sayd 2013).

HM: So when did the doula originate?

MC: Being a doula might not be the oldest profession – but it's close, going back as far as the *metal* ages in the more populous areas of Greece (Sabatino et al 1992). By the *middle* ages (fifth to fifteenth centuries AD), childbirth was assisted by registered doulas who used special chairs that put the mother in the vertical position (Faria and Sayd 2013). Only later did physicians get involved in childbirth.

HM: I'm starting to see a theme of verticality emerging here . . .

MC: Well, more like abandoning verticality in favor of horizontality; and that's paralleled by social demands prevailing over biological needs, and body image emphasized over body schema.

The huge technological and medical developments of the last 150 years or so allow doctors to assist in difficult childbirths to save the lives of mothers, as well as premature or delicate babies. We have arrived at the age of maternity wards – areas of hospitals or even whole hospitals dedicated solely to childbirth. The dark side of this is that today, broadly speaking, the woman is separated from her family members and immobilized. Her uterus and vagina are palpated by strangers. And – she is usually stuck in the horizontal position, exposed with her legs apart, enduring lots of unpleasant and undignified procedures. These days, unfortunately, anyone who wants to assist the mother-to-be has to navigate or work around the technology used to direct and control the delivery.

HM: How much of this has to do with eliminating pain?

MC: A great deal. In today's medicine, it is taken for granted that women should avoid pain in delivery, and that a woman should not wish to have the possibly painful pleasure of a natural experience. But it is also true that ancient methods of assistance reduced pain. And today, many alternative or complementary approaches – such as relaxation and deep-tissue massage, acupuncture, *do-in*, shiatsu, watsu, Continuum™, music therapy, aromatherapy, reflexology, and yoga – either alleviate pain and general discomfort or promote overall conditions of ease. But the medical establishment questions both their general efficacy and their safety during pregnancy.

HM: What about SI? Do you feel it is safe during pregnancy?

MC: Pregnancy can present many high-risk situations where structural work is inappropriate, and the practitioner should be cautious even in normal pregnancies. A structural integrator who wants to work safely with pregnant women should have a firm understanding of the physical and psychological effects of pregnancy. The work can help pregnant women, but practitioners have to know what they're doing, which requires training well beyond their SI training.

HM: So – structural integrators should generally *not* be part of the pregnant woman's care team?

MC: Generally not – while she is pregnant. But since pregnancy is a big physical undertaking, SI before pregnancy can help her a lot.

- The more integrated her body, the more easily she will accommodate the physical changes of pregnancy.
- The more balanced and supported her body, the less back pain she will have.
- The more oriented she is to the *up* and *down* directions, the better she is supported in space.
- The more integrated she is, the better she can assist the birth process rather than hindering it.
- The more she is aware of her body and the power of her sense perceptions, the more likely she will embrace her sensations and give herself over to the immediate physical and sensory experience of labor.

And of course, an SI series can be very helpful some months after a pregnancy to decompensate the woman from the stresses of the pregnancy and rebalance her structure.

HM: In your own Rolfing practice, do you work with pregnant women?

MC: I do. As a Rolfer, movement is what interests me the most. I want my clients to experience delicious movement – not just to look better, but be like ancient Greek statues. Based on my many years as a doula, I believe that Rolf Movement and the theory of tonic function, were they more widely known, could really advance the way we care for pregnant women and prepare them for delivery. It could help women to become and feel more competent, and to re-take control of their process and their experience.

HM: Give me an example of how you use this in your practice.

MC: I often see women who are horrified by the idea of giving birth to a baby who is bigger than their pelvis. Usually, a few pelvic-girdle movement sessions can calm their fears of being too tight or too small to give birth. This is work with perception and coordination to change the woman's body image. As another example, many women, not able to move freely in the pregnant body, feel trapped. Following a Ten Series done with a functional approach, these women feel more mobile and less like prisoners in their own bodies. Another functional pattern I see often is postpartum: the twenty-four-hour-nonstop-crying baby. In my experience, the baby's distress comes from the tonus of the mother, who supports herself and holds her baby with her extrinsic muscles. Once the mother learns to use her intrinsic muscles, the baby calms down.

HM: It sounds as if we've come full circle, back to the importance of touching others in the right way.

MC: Yes, I suppose that's true. And in my own practice as a Rolfer, the same as when I first started touching others and as a doula, I still help my clients to make those big transitions. According to the Dalai Lama, our primary purpose in life is "to help others."

Monica Caspari lives and works in São Paulo, Brazil where her practice emphasizes better movement through the theory of tonic function. For more than twenty years, she has taught Rolfing SI and Rolf Movement Integration in her native Brazil and throughout the world – in Japan, Australia, the US, Argentina, Ireland, Germany, and South Africa. As an avid traveler, some of Monica's special interests are the differences among cultures and how to adapt Rolfing teaching and practice to particular cultural milieus.

Heidi Massa, a Brazil-trained Certified Advanced Rolfer and Rolf Movement Practitioner, has been guiding the somatic adventures of the discerning, the curious, and the brave since 1994. She has served on the Rolf Institute's Ethics and Business Practices Committee for twenty years, and has been an editor for this Journal since 2000. While Chicago is home to both her Rolfing and complex business litigation practices, as well as to her architectural and interior and landscape design interests, Heidi travels frequently to Colorado, where she maintains a fine pre-War home in impeccably original style, hikes in the mountains, and dances the tango.

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Rolfing® SI for All Stages of Pregnancy

By Christi Mueller Caspe, Certified Rolfer™

Rolfing SI Before, During, and After Pregnancy

Rolfing Structural Integration (SI) is an invaluable resource for pregnant and postpartum women. Through Rolfing SI we can help women be more comfortable and in control of their bodies throughout their pregnancy journey. We can empower them by educating them with the tools and information they need to understand their bodies well enough to able to make better-informed decisions about their healthcare and delivery process. Our manual skills, knowledge of anatomy, biomechanical information, and movement work can be utilized at any time during pregnancy from the planning stages to postpartum.

Rolfers can use our unique perspective and holistic approach to fill in the gaps left by standard healthcare. A typical prenatal checkup for a healthy pregnancy would consist of blood work, weight and blood-pressure checks, recommendations for vitamins and flu shots, and 'rules' about not drinking alcohol or eating certain foods. These measures, while vitally important, do not consider the body as Rolfers do from a holistic or structural point of view. These components leave out how pregnancy feels in a woman's body, how the body physically supports that pregnancy, and how many times nature can do an amazing job of carrying and delivering a healthy baby when biology takes its course and healthcare providers only use dramatic interventions when they are medically necessary.

Additionally, although it is beyond the scope of this article, the healthcare system in the United States seems to have dissociated the biological, emotional, and structural components of a person and tends to look at them as separate parts. Elements of basic knowledge that could assist women in the healthcare decisions they make for themselves and their babies may be lacking. And culturally and socially, women often are made to feel ashamed for discussing their reproductive processes or are told that their bodies will experience irreparable negative changes post-pregnancy.

How We Can Help

Regardless of our specific skill sets, we can probably all agree that we have two main objectives when working with our clients: to educate people so they gain a deeper and more informed connection and understanding of their bodies, and to manually assist their body's structure, nervous system, and energetic body. These objectives can be so incredibly valuable when applied to women who are considering becoming pregnant, are already pregnant, or have already had their child – whether recently or decades earlier.

As Rolfers, our goal should be to facilitate a healthier pregnancy, labor, delivery, and postpartum period. At each stage we can prepare the woman's body, to carry and deliver the baby, and we can provide information for clearer knowledge and better strategies beyond just coping. We can consider the health of the woman from a whole-body perspective, possibly preventing or easing conditions that are entirely normal and should not cause shame, like pelvic-floor weakness or prolapse, problems with sexual intercourse, and frequent urination or incontinence. And finally, we should ensure that our clients receive the best care possible and consult and collaborate with the client's healthcare providers.

Pregnancy Planning

Rolfers can help a woman with pregnancy planning by teaching her the basic anatomy of her pelvis and reproductive organs. Guide her through sensory exercises so that she can begin to feel where these areas are and establish clear relationships with them. If she is more sensitized to the abdomen and pelvic region, she may be able to track her fertility and ovulation cycles more accurately.

Teach her to differentiate her levator ani and muscles of the urethra from the pelvic-floor muscles. This serves as great preparation for pushing the baby out, and helps with strength and stability for carrying the baby during pregnancy. Note that Kegel exercises are the standard recommendation, but often people are not able to accurately isolate the correct muscles without guidance.

Assess the position of the uterus and ovaries. For clients experiencing irregular menstruation or infertility, anecdotal evidence suggests that Rolfing SI could be of use as a first and less-invasive step before other interventions.

First Trimester

Dr. Rolf always said to start with the breath. Since we want to be extra cautious with women in early pregnancy (especially before detection is possible) and abdominal work is not advised in the first trimester, this is a good time to work with the breath at length in preparation for the rest of the pregnancy and to revisit later to practice for labor. Helping your pregnant client to breathe more freely and deliberately through gentle rib work can also assist in the management of discomforting sensations like pain and nausea. If you decide to only work hands-off at this stage, it can be beneficial to give visualization exercises to access and feel the breath in different areas of the rib cage.

The hormone relaxin, which helps soften the ligaments and cervix, is at its highest levels during the first trimester (and during labor), so be mindful of working the pelvis or any joints and ligaments as overwork here may reduce pelvic or body stability.

Help the client to better connect with her body; learn where her sit bones (ischial tuberosities) are, where her pubic bone and pubic symphysis are, and what a healthy spine curvature looks and feels like with breath and movement.

Second Trimester

Teach your client about the ligaments around the pelvis and uterus – like the sacrotuberous, sacrospinous, and round ligaments – because as they slowly stretch, there may be discomfort or instability. Work with these before the pregnancy; during the pregnancy, work directly or indirectly, but only if appropriate. Descending through a better-aligned pelvis would certainly make things easier on the baby and mom during labor.

If there is instability or discomfort in the pelvis, teaching the client at-home care will become increasingly important as the pregnancy progresses. Use a wedge or a bolster with blocks under one end to create an angle so she's reclined (a pregnant woman should not be on her back for long periods of time in later pregnancy since the weight of the extra fluid and fetus can affect the blood flow between the lower

Figure 1: Sidelying work around the pelvis.

and upper body). Have her lie semi-seated with her spine on the bolster and pelvis on the floor. Let her pelvis rest as evenly as possible on the floor and help her establish a balance between the two sides by bringing awareness to her sit bones, iliac crests, and pubic symphysis. She can keep the legs either bent with feet flat in a generous parallel or with knees touching, or legs extended on the floor. Additional blankets or pillows for support for her head or pelvis may be needed.

Teach your client supported sleeping positions in sidelying with healthy spinal curves since trying to find a comfortable position to sleep during pregnancy can be a challenge. In this position, bolsters or pillows can be placed between the knees to keep the top leg supported to prevent sciatic irritation. Also, to support her growing belly, she can place a pillow under the side of her belly and torso.

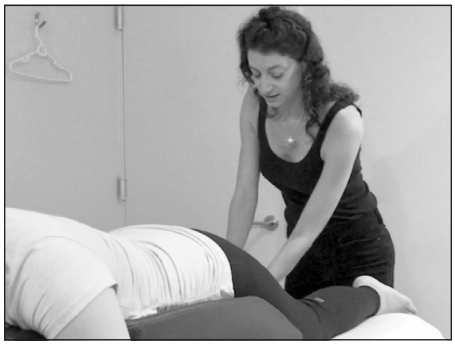


Figure 2: Supine work can be done with body support cushions designed for pregnancy.

To reduce stress on the fetus and mom, you do not have to do direct work on the abdomen to affect the baby's position in the mom's belly. If the baby's position is breech, or has been in one area of the abdomen for a long period of time, or is positioned on the mom's bladder, teaching your client how to do gentle, supported inversions with her legs up on a couch or stairs, letting her belly hang, could encourage the baby to change its position.

Third Trimester

Remind the expectant mom about healthy spinal curves and help her find support for the added weight her body is now carrying. As the baby grows, many women will let their bellies hang from the weight and become hyper-lordotic, increasing the likelihood of low-back pain and shoulder and neck discomfort. Also, a belly that is not supported or is stretched and weakened by the carrying of the baby could result in diastasis recti, the tearing of the linea alba in the rectus abdominus.

Work on the client's legs and feet to maintain function and support and help her keep healthy walking habits to avoid sinking into a waddle. She may begin to feel her pelvis widening more dramatically now, or feel that the baby has dropped deeper into her pelvis, so again help the client's pelvis feel stable and connected by contacting the sit bones on a chair and finding evenness in the two sides. Our focus in this area may also help mom determine when it is really time. And do not forget back work. Giving mom back work will be critical to her overall comfort in the home stretch.

Labor Prep and Delivery

Teach your client sensory exercises to prepare for the pain and mental marathon of labor. A clear connection from the awareness of the woman to her body can assist what is naturally occurring. As a result of your guidance, mom may be able to explain more accurately what is happening during the various stages of labor, which will help her birth team assist her more appropriately.

Figure 3: Seated back work with a pregnant client.

Have the client practice activating the different pelvic floor muscles so that she's familiar with them and ready to go once labor begins. During the pushing stages, if mom cannot access her pelvic floor properly she runs the risk of putting undue stress on the structures of the pelvis, possibly causing prolapse. Be sure she knows where and where not to push from.

Get the woman's birthing partner involved so that s/he can provide mom with help when the Rolfer is not there. Teach some simple hands-on assists to relieve and soothe – like basic shoulder work or ways to hold mom's pelvis so that she feels supported when laboring.

Postpartum

After labor mom will be tired and her body will be sore, so just holding space for her might be the most appropriate work in this period. Allowing her to be in her body and to process and acknowledge all that happened could be the most helpful and restorative for her, especially if she had a tough labor or delivery.

Once she has had some recovery time and clearance from her obstetrician, appropriate visceral work (if you have training in that field) could speed recovery. She may be suffering from hemorrhoids, frequent urination and incontinence, or a weakened or distended pelvic floor.

Help mom learn how to hold her baby in supported ways. Whether they are breast- or bottle-feeding, rocking the baby to sleep, or just giving cuddles, parents spend countless hours holding their babies and need to learn to do so without stress on their backs and shoulder girdles. Giving easy cues like remembering to find their backspace can really make a difference for comfort and fatigue.

Teach mom to create healthy habits for her baby early on. For example, changing a baby's head or pelvic position in the seat or bassinet can prevent conditions such as torticollis. Learning supported movement and postures from the beginning will help the infant for the rest of his life.

Conclusion

Use the skill sets you have as a Rolfer to help your client through this life-changing journey, but remember that Rolfing SI is never a substitute for medical treatment. Women should be concurrently seeing their gynecologists, obstetricians, fertility experts, and medical providers as appropriate. Do not do anything with your client that is illegal in your state or that you do not have the proper training or licensing for.

It is critical that practitioners inform women about Rolfing SI's role in a whole-body-approach to pregnancy because we can serve as a unique resource for them not only with their pregnancy but also for other women's health-related issues. It is also imperative that we inform the birthing community – including doulas, midwives, and pelvic-floor specialists – that our tools are a vital piece of the pregnancy-care puzzle and that our contribution will only facilitate and enhance the awareness and skills that nature has already given women.

Christi Mueller Caspe is a Certified Rolfer practicing in New York City. Since the birth of her son, Ati Bodhi, in January 2017, she has become inspired to help women have safer, more embodied pregnancies and deliveries with healthier and more supported postpartum periods. Her website is www.iNeedRolfing.com.

A Compilation of Stories on Pregnancy, Postpartum Issues, and Balancing Motherhood with a Rolfing® Practice

The Ten Series and Conception

By Szaja Gottlieb, Certified Advanced Rolfer™

I had heard stories from colleagues – clients who had difficulties getting pregnant experienced success conceiving after going through Rolfing® Structural Integration (SI). There was even a paper I had come across citing anecdotal evidence theorizing that the change in the position of the pelvis aided fertilization. Around 2008 I had two female clients who, prior to receiving a Ten Series, mentioned that they were trying to get pregnant but were having difficulties. I cited the anecdotal evidence in a nonchalant way without really expecting to help. Interestingly, both clients had cases of moderate scoliosis. I began the Series with one of the clients in October of that year, and it was in December, around the holiday period, when she entered my office and pointed her finger at me, saying, "You made me pregnant." Without skipping a beat, I replied, "I really don't remember." In both cases, the husbands called, enthusiastically thanking me, and even came in for sessions. Both are still my clients and come in regularly.

Szaja Gottlieb is a Certified Advanced Rolfer living and working in San Luis Obispo, California.

The Rolfing® Process and My Recovery from Pregnancy

By Mélanie Holt, Certified Advanced Rolfer™

Rolfing SI has helped me through challenging pregnancies and postpartum trauma and illness and continues to be a

Mélanie Holt with her children Adèle and Elliott

big factor in my recovery. From individual sessions and continuing education classes, I have uncovered more pregnancy-related issues than I imagined I had. Addressing those issues has made me feel better, but also helped me become a better practitioner. I believe that every challenge life throws at me makes me a better Rolfer.

In 2011, my first pregnancy was easy. At around five months I had a little bit of back achiness and was happy to get a Rolfing session from my friend Luca, and that was the end of it. Even one week overdue, still exercising and in 95-degree heat, no problem. Despite what everybody told me, I didn't have an easy delivery, and I still pushed for three hours! Then my placenta would not come out and I hemorrhaged. I was going into shock when they finally took me to the operating room. I had an emergency D&C, a blood transfusion, spent the night in the intensive care unit, and twenty-four hours later I was reunited with my hungry baby and forgot all about it. Several months after giving birth, I learned that the thing in my abdomen that didn't feel quite right during my pregnancy was a diastasis recti. It has become my arch nemesis . . . I did crunches every night for months on end, following some advice I found online, to get rid of my diastasis. I can't say it was working, but it didn't matter; in 2013 I was pregnant again.

That second pregnancy was very different. I couldn't do anything. Even going on a walk induced light bleeding. I could work (I was living in the middle of nowhere in Southern Oregon, so I was less than part-time) and do whatever needed to happen in the house, but not much more. I was huge and uncomfortable; the baby's head was up and would not turn. My ribs were killing me. Then I got sick at thirty-two weeks. I had a fever, lost my voice, and had horrible reflux. I coughed so much I tore something in my abdominal muscles. I think I cried every time I coughed after that.

Then at thirty-four weeks I went into labor. They took my son out via emergency C-section. He was almost dead and subsequently spent a month in the neonatal intensive care unit. I wasn't thinking about my recovery or my body; I was an afterthought to myself. I was pumping every three hours around the clock to feed him milk through the feeding tube. Five days after he was released from the hospital, I was diagnosed with cancer. After two life-threatening hemorrhages, and a no-less life-threatening sepsis, I cruised through sixteen weeks of chemo. During my treatment, I received a couple of visceral manipulation sessions from Jeff Ryder. I was also bringing my infant son to be treated, since he had horrible reflux too. I started working again two months after the end of chemo. Retrospectively, these were definitely not my best sessions as a Rolfer.

About six months after the end of chemo, I received a three-session series. I was ten or eleven months postpartum and had been bedridden for five months; I was recovering from the port surgery and dealing with the emotional toll. After the series, I felt good enough and left it at that. I could exercise and run for an hour. In December 2015 I took Lael Keen's Rolfing SI and Trauma workshop. She helped my healing when she did a demo on me that I fully credit for un-freezing my ovaries and getting me out of the chemo-induced menopause I was in.

The following year was full of ups and downs and I felt like I was reaching the limits of what my body could do way too early. Then in December 2016, I took a Mary Bond workshop. And *wow*. I think I finally had a glimpse of how much I had been ignoring my trauma and my body. I started to reconnect with my body at a deeper level. In January 2017, I started my Advanced Rolfing Training in Portland. That was the most Rolfing work I'd had in years. It was also the beginning of a long-overdue journey into self-care. I started Pilates this spring, and the compounding effect of Pilates and Rolfing work has allowed me to reclaim my body; I feel like my body is mine and not some old woman's body.

My son turned three in April and my daughter five in May, and I can say I am just now recovering from my pregnancies. But they are so intertwined with trauma and sickness that it's probably a little out of the ordinary. After my daughter was born I had decided *not* to use her as a guinea pig to practice Rolfing work with babies (which I had always loved to do). And she was perfect anyway. And I stuck to it. Now she loves to have her back rubbed and sometimes will ask me to "do the thing I do." She knows the difference in touch, and she can express what she wants or not.

My son still has high needs, and some physical 'stuff' going on. His sacrum seems to rotate, his feet took turns being problematic. He used to trip on his left foot when he was just learning to walk. Lately his right foot was pronating so badly it pushed his big toe toenail in the skin, but with a mix of Rolfing work and chiropractic, and a growth spurt, he seems to be better. I am not the one giving him Rolfing sessions though. I can rub his back, massage him all I want, and he's happy with it. But if I change my intention from nice rub to Rolfing touch, he pushes me away and sometimes starts screaming. He can feel the difference in my touch so much it's incredible. He has more tolerance for other practitioners, as long as they're quick!

Mélanie Holt is a Certified Advanced Rolfer with a practice in Portland, Oregon. She grew up in France under the influence of truly holistic osteopaths. After a fun but useless BA in English literature and translation, she moved to the Alps to surrender to her love of the mountains. Life and love brought her to the US in 2006, where she discovered Rolfing SI and was finally given a chance to do something meaningful. She believes in the transformational power of SI and is dedicated to helping her clients discover how they can become who they want to be.

About a Postpartum Client

By Deborah Weidhaas, Certified Advanced Rolfer, Rolf Movement® Practitioner

A client had been through the basic Rolfing process with me and came back for a tune-up about fifteen months after giving birth. I was very surprised with what my hands experienced when they touched her belly, because I hadn't noticed it before. The right side of her belly (costal arch to pubic bone, surface to deep) was very taut, and the left side was slack. As I worked, I stayed in a high state of curiosity in order to perceive what was going on; to sense where the whole belly needed my assistance in order to find integrity and become coherent, and to provide what it needed. After about twenty minutes, I shared a bit with the client of what I was doing and why. Then she told me more of the story. The delivery of her child had been long and painful, including being placed on a table that was painful to lay on; yet, she was on it for a couple of hours. The nurses were frustrated with how long her delivery process was taking and, because of this, one nurse pushed with her own hands and body weight into my client's left belly and kept pushing, farther and farther, for a long time, in an attempt to make the baby come out. "Well," I thought, "now I completely understand why the left belly is slack and the right belly is hyper-activated." My sole approach in this session was to work with the entire belly as scar tissue. My client and I are indebted to Sharon Wheeler's scar-tissue workshop for the results. By the end of the session, the whole belly had integrity and was coherent, with both sides participating equally in structure and function. My client had a peaceful, yet energized, smile on her face. The shift in structural vitality was obvious.

Deborah Weidhaas is a Certified Advanced Rolfer and Rolf Movement Practitioner, recently relocated from California to Richmond, Virginia.

Motherhood and Being a Rolfer

By Lina Hack, BSc, BA, Certified Advanced Rolfer, Somatic Experiencing® Practitioner

My first week of being a professional Rolfer in my first downtown office was timed perfectly to match the release of my article about Rolfing SI in the local wellness magazine. To my pleasant surprise, the phone rang the first day the article was out, and by the end of the week I had a full month of work. As clients called I would make myself available to them at any time: during the workday – yes, no problem; evening – yes, no problem; and weekends – yes, no problem. My professional life rolled along with full abundance for four years.

I was so excited when I finally became pregnant because it took some effort! During sessions however, I held back from telling my clients, despite my heart wanting to declare my happiness to them. Announcing a pregnancy would naturally follow with questions and presumptions that I needed time to consider.

I'll never forget how, during a session, a male client of mine asked, "So when are you due?" We looked at each other with shock. I was only weeks into the pregnancy and I thought he was commenting on my size. He said, "Didn't you just tell me you were pregnant?" I didn't think I had said anything; I had, however, been telling myself repeatedly to be quiet about it. After that experience, I realized how intuitive my clients were and I slowly started to mention my growing family.

I was able to hold onto my strength as a Rolfer well into my eighth month of pregnancy. There was a distinct and anticipated moment, however, when it was clear that I was the client, the very pregnant client, and I was not able to be the practitioner for a window of time. The birth of both of my babies was a peak experience of self-actualization. Yet this was paired with sadness for pausing my Rolfing practice in order to focus on being a grounded mom for my little ones.

Motherhood has been a welcomed benchmark for me and I took all the time I needed to establish balance with a healthy growing little one before I returned to my practice. I took eighteen months away after the birth of my first child before I started seeing clients again. I took two years with the second babe.

What a humbling experience to put a full stop to my Rolfing practice twice, and then cold call former clients, asking for their interest to shine again on my work. I put effort into my community, my yoga-instructor friends and massage therapist friends, letting them know "The Rolfer is back to work after having her baby . . ." and generally getting myself out and about to remake those professional contacts. This was incredibly humbling because many clients booked without hesitation and we picked up our structural work where we left off. Some clients had moved. Some had moved on. Each story with each client felt deep, like motherhood had softened and deepened how I experienced all my bonds with people, even the professional bonds.

I must sing the praises of the continuing-education classes that our Rolfing faculty and colleagues are offering all the time. For us parents who step back to create new human beings, it is wise to get ourselves back into the big tent of Rolfing SI by getting back into classes. To my great benefit, an Advanced Rolfing Training launched near my house three months after I returned to work after my second babe. It was just the updating of my files that I needed. My internal narrative quickly became confident with my maturity and life experience. The Advanced Training initiated a new wave of professional momentum that can only come with time in the session room with clients.

Yet once back in my session room, I wasn't able to be the 'available-at-any-time-Rolfer' I had been before. There was an intricate puzzle of pieces that had to be put together to allow me to be in my office for a few hours: childcare, school hours, lunches made, and grandma on standby. And I now can really only offer my work during standard work hours – no more evenings, no more Saturdays. It is true to say new clients, who often wish to have their Rolfing sessions after work and after the workweek, can find my time restrictions a disappointment. I keep my humble heart firmly planted on the earth and explain, "I'm a mom with small children and at this time I have limited hours. Hopefully our schedules can overlap to have our meeting." And you know what? People find a way to make their schedule fit a Rolfing session when the Rolfer is available.

Lina Hack has been a Rolfer in Saskatoon, Saskatchewan, Canada since 2004.

A Collection of Pregnancy-related Experiences

By Patty Murphy, Certified Advanced Rolfer™

The Pelvic Floor and Postpartum Body Awareness

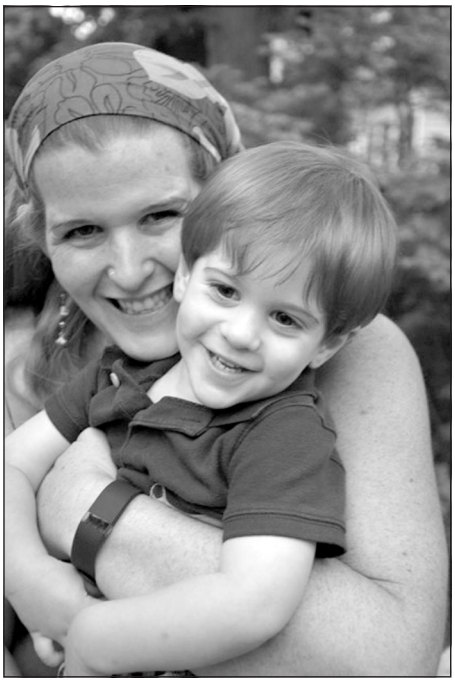
In the Rolfing® Structural Integration (SI) training, you learn a lot about your own body. I felt like I was so in tune with my

body by the end of it, I knew how to use and connect through my body, I knew how to connect through my pelvic floor. Going through my pregnancy was not a problem, and I believe that having all that body awareness and knowledge of body mechanics made working through pregnancy easy. I worked up until about two weeks before I had my son Liam. It was afterwards that I found trouble bouncing back.

Giving birth to my son was a traumatic experience and postpartum experience didn't get much easier. I was induced at about one in the morning after my water had been leaking slowly for well over twenty-four hours. After about twenty-one-and-a-half hours of slow labor, my son finally arrived but was not breathing. They got him breathing fairly quickly, and it seemed we were in the clear. Then at about seven the next morning, they came to tell me that his bacterial levels were high and they would have to take him down to the neonatal intensive-care unit (NICU). I followed my son and moved myself into the NICU also, sleeping in a recliner for the next ten days. They poked and prodded him for a few days because his veins kept collapsing, until they finally decided to go through his umbilicus. He was supposed to come home after five days of antibiotics, but after two days they said his stomach was distended, he was lethargic and wouldn't eat, and his intestines were completely backed up. On day four he tested positive for Hirschsprung's disease; Liam was born with no ganglion cells at the end of his colon. On day eight they did surgery to remove about six inches of his colon, opening up around the anus, and pulling through until they found nerves, and then reattaching it at the anus. Those were some of the most trying days of my life.

Two days after the surgery, they finally sent us home. Then began the journey of trying to figure out life with a newborn. You spend your days and nights sitting, nursing, and carrying around this adorable screaming baby with little sleep and no time to think about anything other than being tired and what the baby needs next. That might be seem a little dramatic, but you really don't have time to think about yourself, or what you or your body needs, or even realize that your whole sense of self has changed – or in my case seemed to have disappeared.

Looking back now, I don't think I even noticed I was that far removed from myself until about six months later. It took about a year before I started finding my body again and feeling like myself again. Things started to shrink back into place. As the baby got a little bit older, I had a little more time for myself, and it was then that I started to have more body awareness. And it was also then that I realized I could not connect with my pelvic floor. My pelvic floor had up and left me, or at least that's how it felt. Something that was so obvious to me before was nonexistent.



Patty Murphy and her son Liam

So how did this affect my work? Since having my son, I have found it hard to walk clients thought certain movements and teach them how to make certain connections, like how to settle in the pelvis. It is hard to show others when you don't know how to make the connection yourself. A lot of the movement work we were taught was lost to me, because I couldn't find it in my own body.

I attended Advanced Rolfing Training when Liam was about a year and a half, and that is where I finally found a fighting chance at getting back what I had lost. During a session with my practitioner, instructor Jan Sultan came over and did pelvic floor work with me. It felt different from what I had been taught initially in my training. As opposed to just going on the edge of the pubic ramus, he used his forearm to sink well past that, and for the first time in over a year, my pelvic floor began to open. That made a huge difference, but wasn't the only change. During the next session, we found that my pubic symphysis was off, and Jan reset it. During pregnancy, with all the hormones, especially the relaxin, ligaments relax and allow the pelvis to open more easily. The pubis spreads to make way for the baby coming through the canal, but mine didn't come back correctly. Having that bit of pressure relieved, I felt that one day I would be able to not only connect to, but strengthen my pelvic floor again.

Pregnancy, but mostly postpartum, was a big learning experience for me, both as a woman and new mom and as a practitioner. I learned that you get some of your body back, but you don't get the same body back. I don't how many people really consider that aspect of it. I expected to be heavier, I expected things to be looser, but I still expected to know where my body was in space. My son is three now, and I'm still discovering this new body, and only recently have gotten the strength back in my pelvic floor. It was a long progress, but every time I look at my son, I know it was worth it. Now in my second pregnancy, I have a better understanding of what to expect.

Working with Pregnant Women

Since my pregnancy, I've been amazed at how many clients have walked through my door pregnant. Most of the work I do with women who are expecting is simply getting them comfortable in their ever-changing bodies, as any preexisting imbalances seem to be exacerbated during pregnancy. In the very early stages of pregnancy the work may not look much different, but you need to be mindful of positioning and keeping them comfortable. I carried small in the beginning of my first pregnancy and was able to lay on my stomach longer than others, especially compared to second- or third-time moms, but even I had my limits.

I work to stabilize the pelvis and ease restrictions, resetting them each time, and being really mindful as the joints are more relaxed due to the hormones released during pregnancy. During the later stages of pregnancy, along with keeping the pelvis balanced, it is important to create room through the rib cage. As we lose the abdominal muscles, we get short in the back. Working to open the back and bring some of the tissue forward gives the ribs the ability to move, and can make all the difference in the world for an expecting mom.

During the first trimester of my first pregnancy, I received work from an SI practitioner, and I could tell he was very

uncomfortable working with a pregnant woman. Having been through pregnancy myself now, I realize that a pregnant woman is not that fragile, and the work can make an important difference to her ever-changing body. When working with a client during pregnancy, it is important to be more attentive to positioning so that she is comfortable on the table. Be more mindful of how things are moving, and take a moment to recheck more frequently; make little movements, check, little movements, check again. That might not include having the client stand up, because if she's farther along in her pregnancy, getting up and down can be hard. It is also important to check in with the sacrum and consider how her system is integrating the work. Communication is essential during sessions. What a person's 'normal' is can change from day to day. Some days a pregnant woman can be exhausted, while other days, she's fine. Continue to check in with the client and modify your work as needed.

Working with Postpartum Women

Postpartum work was my steepest learning curve. In early postpartum work, you need to have some of the same considerations as with pregnancy when it comes to work around joints, since some of the hormones may still be present in the body, especially in moms who are breastfeeding. As I learned in my own journey, it is important to get the pelvis rebalanced and to bring more awareness to the pelvic floor and to have her try to connect with it.

There are some different considerations with C-sections versus a vaginal birth. Having a C-section may not result in losing your pelvic floor, but you can lose the use of your abdominal muscles and your core. Working to naturalize some of the scar tissue and working viscerally is important not long after the new mom has healed. I believe that we as practitioners are more aware of the imbalances that come from a C-section, but we often overlook the imbalances that can happen during vaginal childbirth; at least that was the case for me.

There are also upper-body issues for women with a baby in arms, particularly with breastfeeding. More than the shoulders, the issue is the head drop. You spend so much time with your head tilted, staring down at the child. If the baby's sleeping with you (co-sleeping), you've always got the baby on your arm and you don't actually fall asleep as well or sleep as deeply. Another issue with postpartum women is that they are exhausted! While she is receiving work, her system only has so much resource to shift. That's why it was about a year after delivery before I started to at least figure out that I had a body again. It's about that long before you get a chance to breathe again and when the baby finally sleeps through the night. For my son Liam it was over a year before he started sleeping through the night.

Patty Murphy has been practicing for ten years and has recently opened her own wellness center in Patchogue, Long Island, New York. She practices full-time while balancing life with a three-year-old and preparing for a new arrival in February.

The Female Pelvis

Igniting a Transcendent Portal

By Carol Agneessens, Rolfing® and Rolf Movement® Instructor

> *To lose confidence in one's body is to lose confidence in oneself.*
>
> Simone de Beauvoir

> *And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom.*
>
> Anaïs Nin

> *My belief is in the blood and flesh as being wiser than the intellect. The body unconscious is where life bubbles up in us. It is how we know that we are alive, alive to the depth of our souls and in touch somewhere with the vivid reaches of the cosmos.*
>
> D.H. Lawrence

> *We have been thoroughly deprived of trusting the inner wisdom which each person holds in him or herself. There lies a great unused richness in us, which we gradually have to dig out and develop. When you get to it, you will be astonished by what comes into the open which you didn't know was there.*
>
> Charlotte Selver

In her classic text, *Rolfing: The Integration of Human Structure*, Dr. Rolf questioned if current scientific knowledge would concur and justify the "preeminence" of the pelvis and sacrum. She called the sacral complex a sacred bone and the seat of the physiological soul. She went on to say, "The pelvis . . . is the physiological locus for personal emotional factors of sexual satisfaction and fertility. Ancient Indian Tantric physiology recognized the pelvis as the area housing fundamental energy, the seat of the fabulous Kundalini" (Rolf 1977, 82).

The pelvic and sacral complex were continually highlighted in Rolf's vision. Pelvis and sacrum are the earth-oriented channel of structural alignment with cranium atop. With Rolf's focus lighting the way, this exploration centers on the female pelvis and the complex labyrinth of neurological/hormonal communication that streams through a woman's body. Beyond the structural and physiological integration of bones, soft tissues, organs, etc., there exists a dynamic reciprocity between the resonant pulsations of brain, heart, belly, and vagina (the mammalian channel of passage into this world). It is through this neural tapestry that a biological spirituality emerges through the sensorium of one's own body.

In her groundbreaking book, *Vagina*, Naomi Wolf states that the anatomy and physiology of the vagina is essential to female wellness, inner confidence, creativity, initiative, bliss, and transcendence. She says, "To understand the vagina properly is to realize that it is not only coextensive with the female brain but is also essentially part of the female soul" (Wolf 2012, 4).

The intermingling neural fibers of the vagina, belly, heart, and brain are essentially one system within a woman's body. This physiological tapestry ignites a spark of inner knowing, instinct, and intuition.

Often the release that accompanies deep meditative experiences, orgasm, or those moments of communion within the natural world are defined by a loss of ego or a melting of boundaries and may be described as an oceanic feeling of limitless expansion. Neuroscientists concur that these states produce changes in the brain that correspond to experiences of a divine existence and are

accompanied by greater feelings of love, compassion, self-acceptance, and perhaps a deepening intimacy in relationship with self, other, or a numinous emptiness. William James explored transcendence in his book *The Varieties of Religious Experience*, published in 1902. Within its pages he addressed the role of neurology as the substratum for mystical experiences.

A woman's physiology innately possesses a milieu that bolsters an ability to enter into this mystical dimension. The prominence of the vaginal cascade along with neural counterparts that integrate heart-brain-vagina are key to experiencing this dimension of ecstatic knowing.

> *The vagina is part of the female brain, and thus part of female creativity, confidence and even character. It serves as a medium of female self knowledge, creativity, and courage, female focus and initiative; female bliss and transcendence.*
>
> Naomi Wolf

Neural Reciprocity Between Brain, Heart, and Vagina

In 1994, Dr. Stephen Porges introduced the concept of the Polyvagal Theory based on the phylogeny of the vertebrate autonomic nervous system. This theory led to the recognition of additional circuits that regulate the autonomic nervous system. The newest system is based on a ventral vagal nerve flow. Porges discovered the vagus nerve had two separate nuclei in the medullary brain stem, each with differing functions and tracts.

He also expanded the functional meaning of the vagus nerve and its role in regulating the muscles of the face, heart rate, voice, and breath, as well as yielding essential feedback to the brain. The ventral vagus is a myelinated pathway, arising from the nucleus ambiguous; consequently, impulses flow more quickly. There is rapid two-way communication between the heart and brain, belly and vagina. This distinctively mammalian circuit fosters what Porges calls "social engagement."

According to Porges, social engagement, in turn, tends to "down regulate" (calm) the sympathetic nervous system and the fight-or-flight response. The "new vagus" coordinates oxygen control in line with muscles of facial expression and is responsible for the release of *oxytocin*, the hormone of love and compassion.

For women, it is in large part through our facial expressions, heart, and brain in communion with vaginal and vagal feedback that we learn to temper our responses to interpersonal threats and challenges. This calming aspect of "social engagement," via the ventral vagus, is essential for deepening intimacy and presence in all encounters. The vagal pathway may in fact be considered an alternate spinal cord enhancing the ability to make decisions, supporting pro-social emotions, optimizing heart rate, and facilitating a way of shifting from sympathetic fight or flight to resourcing physiological balance and homeostasis (Keltner 2009).

The Dorsal Vagus

The more familiar branch of the vagus nerve, the dorsal vagus, regulates intestinal organs. It is unmyelinated and, therefore, nerve impulses move slowly. It is the longest nerve in the body and one of the most important: sending commands to and receiving information from the viscera. People actually have two vagus nerves, one for each side, running a roughly parallel course from the brain, around the heart, through organs, intestines, as well as innervating the uterus.

Recent behavioral and physiological evidence indicates that the vagus nerves conduct sensory information from the uterus and vagina to the brainstem (Collins et al. 1999). The pathway of the vagus nerve does not travel through the spinal cord but moves through the intestinal tract, and for women innervates the genital complex. This is crucial information as women who endure spinal-cord injuries to nerves feeding the pelvic organs and pelvic floor are able to climax in orgasm due to vagal innervation.

It is thought that genital information may be sent via the vagus to supraspinal centers and that afferent vagal pathways are involved in the feeling of orgasm in women with spinal cord injury (Goldstein et al. 2005, 169). Until recently, researchers didn't know that it passed through the pelvic region at all (Freeman 2008).

Both evolutionary aspects of the vagus nerve serve women's health and wholeness by supporting social interaction, intimacy, and providing both sensory stimulation and relaxation.

To recap:

- The branches of the vagus nerve serve different evolutionary stress responses in mammals. The more primitive dorsal vagus is instrumental in activating the 'shutdown' of the body seen in cases of overwhelming trauma and elicits immobilization behaviors like feigning death and freeze responses. This is a much older part of the nervous system.
- The ventral vagus, the more evolved branch, is linked to social communication and self-soothing behaviors.
- These functions follow a phylogenetic hierarchy where the most primitive systems are activated only when the more 'progressive' functions fail. These neural pathways regulate autonomic state and the expression of emotional and social behavior. Thus, according to this theory, our physiological state dictates the range of behavior and psychological experience.

John Cottingham, PT, Certified Advanced Rolfer, along with Stephen Porges and Kent Richmond, conducted a study linking the effects of Rolfing SI on pelvic angle and vagal tone. The results of their research showed that shifting the angle of the pelvis to increase horizontal alignment/function along with the technique of the 'pelvic lift' greatly improves vagal tone (Cottingham et al. 1988). Tonicity is key to activating the parasympathetic nervous system. Vagal tone is measured by tracking your heart rate alongside your breathing rate. Your heart rate speeds up a little when you breathe in, and slows down a little when you breathe out. The bigger the difference between your inhalation heart rate and your exhalation heart rate, the higher your vagal tone. Higher vagal tone means that your body can relax faster after stressful encounters. Vagal tonicity is known to improve many body systems: better regulation of blood sugar, a reduction in the risk of stroke, a lowering of blood pressure, an improvement in the production of digestive enzymes, and a lowering of inflammation within the body. Emotionally a higher vagal tone is associated with balancing mood swings and anxiety.

Exploration 1: Love Your Vagus

Sit in a comfortably upright position, and sense the sole of each foot imprinting the floor. Notice your breathing and become aware of your whole body, breathing, as you soften and relax your belly.

Gently bring attention to your pelvic diaphragm and your vagina as an opening to the field of the earth. Earth's resonance is not just below your feet but all around you.

Sense your immersion with the support of earth's field.

Breathe into your back-body. Become aware of the broad soft weight of your occipital bone, mastoid processes, sit bones, and tail, and the space that exists behind you.

Visualize and sense the jugular foramen, the cranial exit for the vagus nerve. This paired aperture is in the base of the skull and is formed anteriorly by the petrous portion of the temporal bone and behind by the occipital bone.

Breathe into this opening.

Imagine the descent of the paired vagus nerves passing through the foramen and into the carotid sheath between the carotid artery and the internal jugular vein as the vagus descends through your neck and toward your heart.

You might experience a sense of a neural cascade streaming as the vagus flow wraps around the heart and threads through the organs of your belly (all of them except the adrenals). The vagus continues its flow innervating your uterus and vagina. You might notice a sense of security and serenity warming through your body as you bring awareness to the vagal movement through your body.

The Map and Territory

The late Hilde Feldweg described the pelvic diaphragm as a meeting place between inner and outer worlds. In her 1990 article, "The Pelvic Floor," she describes the relationship of smooth and striated muscles weaving the fabric of the pelvic floor.

For example, "the sphincter ani internus is the continuation of the circular intestinal muscles of the gut. It relaxes involuntarily as the increasing tension in the gut-wall triggers the defecation reflex . . . and is not subject to voluntary control. The outer ring of the sphincter ani externus consists of striated fibers and has to be relaxed voluntarily" (Feldweg 1990, 28).

Exploration 2: Easing the Sphincters That Bind

Take a moment, sensing the expanse of your own pelvic floor. Feel into its anterior (pubic bone to perineal node) and posterior (perineal node to coccyx) excursion, like a hammock spanning the rami of your pelvic bones. Gently bring your attention to the ani internus and externus. Notice any shift in relaxation and ease of sacrum and tail bud (coccyx) as you include these sphincteral muscles in your awareness.

Connect your release through these posterior pelvic floor portals to the neural webwork that innervates this area of your body.

Feldweg examined the conscious (striated) and unconscious (smooth) nature of these muscles and their "gathering" between the internal and external realms of body, which serve to balance intricate pelvic relationships. Couple Feldweg's understanding of the pelvic musculature of the posterior floor with its neural infusion that includes the ganglion of impar. This ganglion is the fused terminus of the sympathetic chain. It is the only solitary autonomic ganglion and lies retroperitoneally, anterior to the sacrococcygeal junction. It innervates the perineum, anus, distal rectum, distal vagina, and distal urethra.[1] Along with the vagus nerve traversing through the intestinal track (with its many alternate named branches), the posterior pelvic floor is abundant in neural innervation, communication, and responsiveness.

Rolf stated that many sects, both of today and those of thousands of years ago, regard the ganglion of impar as the seat of the soul (Rolf 1977, 82). Imagine a midline streaming of these neural impulses along the anal coccygeal ligament from the coccyx through to the perineal body and pubis. The identities of their branches change yet the flow of neural impulse is constant. It is a profound anterior-posterior thread of orientation and communication.

All of the genitalia contain a huge number of nerve endings (the clitoris alone has more than 8,000 of them), which are, in turn, connected to large nerves that run up through the body to the spinal cord. They perform many other functions in the body in addition to providing the nerve supply, and therefore feedback to the brain, during sexual stimulation.

Below are the nerves that innervate the pelvic floor and corresponding genital areas:

- The hypogastric nerve transmits from the uterus and the cervix in women and from the prostate in men.
- The pelvic nerve transmits from the vagina and cervix in women and from the rectum in both sexes.
- The pudendal nerve transmits from the clitoris in women and from the scrotum and penis in men.
- The vagus nerve transmits from the cervix, uterus, and vagina through abdominal viscera to the brain bypassing the spinal cord.

Exploration 3: Enriching a Sense of the Central Diamond

A rich sensory life creates joy and meaning. As you settle into this exploration allow your senses to open. Become aware not only of internal sensations but engage the sounds, smells, and touch of your environment as you explore.

You might do this exploration sitting upright with ease, or lying on the floor, a pillow supporting your head, with the soles of your feet touching. This floor positioning imitates the diamond shape of your pelvic floor with your legs resting open, knees apart (pillows beneath your knees if desired), and the soles of your feet meeting in line with core midline. Reach beneath each rami gently spreading them laterally.

The pelvic diaphragm is a diamond shape with anterior and posterior aspects separated by the perineal body. Notice the length from pubic bone to tail. Sense the excursion of your pelvic floor from side to side. Sense the weight of your pelvic bones resting into the chair or floor.

Bring your attention to your sacrum with an awareness of its shape, curvature, and anterior and posterior contours. With a sense of the anterior surface become aware of your coccyx at the tip of your tail. Notice any tucking or pulling to either side. Let your awareness rest on the inside surface of your tailbone. Notice the distance and depth of perineal tissues from pubis to coccyx. Allow the location of the ganglion of impar sitting anterior to this junction to enter your inner awareness.

Imagine the midline thread of the coccygeal ligament carrying the juices of ganglion impar communication along this ligament toward your pubis. Breathe into the spacious hammock of your pelvic floor, sensing the three gateways that open and close to the earth. Settle into and appreciate the responsiveness and fluidic tonicity of your pelvic ground. This hammock of tissues and portals is a neural tapestry infusing your pelvic floor with the strength of sensation and deepening awareness.

Revisiting the 'Kegel'

Years ago, *The Key to Feminine Response in Marriage* by Ronald Deutschm was required reading in Rolfing Structural Integration (SI) trainings. Fortunately, understanding of a woman's sexual response arousal or lack of sensory awareness has evolved since its 1968 writing. Guiding women in the

gentle practice of doing Kegel exercises can be included in Rolfing sessions, especially when addressing specific problems. Toning the pelvic floor can remedy ailments such as incontinence, a prolapsed uterus, and recovery of sensation and internal awareness of her vaginal passage. Often there is traumatic history and overwhelming pain endured by women to their body-mind through injury to this diaphragm affecting their physical, emotional, psychological, and spiritual health.

Whether from surgery (for a prolapsed uterus, an episiotomy), practices of female genital mutilation, vaginal 'enhancement' therapies, rape, sexual injury, prolonged labor, birthing practices, pelvic pain syndrome, etc., a woman's pelvic floor and especially the pudendal nerve are vulnerable to injury. Physical vitality is often diminished by physical injury to pelvic nerves and tissues. The suppression of one's essential nature may also result from strictly held religious beliefs or cultural mores that shame and disparage self-expression. Whether the 'dampening down' has origins in physical or psycho-emotional trauma, each serves to disconnect and dis-associate a woman from intimate self-pleasure and knowing. All systems of the body communicate, listen in, and respond to one another. A mantle of depression, rising from psychological, emotional, or neurological events, flattens affect, physiology, and attunement with one's own life force, laughter, and joy. When a woman's body, specifically her vagina and surrounding tissues, has endured trauma and pain (even after it is over), there is often a sense of an amputation of an aspect of one's core self. Hope, self-assurance, creativity, and an inability to experience pleasure are dampened or extinguished. Regaining emotional affect, pleasure, self-confidence, and a connection to a transpersonal sense of wholeness can be discovered again. It takes time, noticing patterns of dissociation, bringing gentle awareness to pelvic sensation, kindness, and compassionate therapeutic intervention.

When teaching a Kegel exercise, go slowly and sensitively. The Kegel is not a 'grabbing' movement; rather, it is a gentle spiraling of the vaginal muscles held for a moment and then released. Lying supine with knees bent and feet flat on the table or floor, coordinate this movement with your breath. On your exhale, sense the inner tissues of your vagina spiraling in and up toward your naval. Let go of the movement on the inhale as your pubic bone reaches toward the table. Do this movement consciously. On the inhale, the sacral base moves anterior as the pelvis follows into an anterior tilt. On exhalation the pubic bone rolls toward the navel and the base of the sacrum rolls posterior. Coordinate this movement with breath and the gentle spiraling of the vaginal channel. Notice the rippling effect through the vagina and possibly through your body's core. Often placing a soft cushion between the client's knees facilitates engaging midline and inner thigh muscles as she presses into the pillow on her exhale.

Head to Tail Luminescence

In addition to the neural tapestry embedded within pelvic tissues and orifices, consider the ganglion of impar and its 'upper pole' twin the ganglion of rebes. Rolf spoke of the ganglion of rebes as the neural bundle that could be considered the 'third eye'. It communicates with the ganglion of impar and brings into awareness the sympathetic chain of alignment. The relationship speaks to the *ida* and *pingala* of the caduceus. The ganglia of impar and rebes form a vertical axis of orientation and electromagnetic flow. It is along these connecting threads that kundalini rises.

Exploration 4: Engaging the Inner Caduceus

Sit in an easy and comfortably upright position. Soften any holding in your jaw. Sense the weight of the bone, your teeth, and the fullness of your tongue. Gently place the tip of your tongue behind your front teeth, resting its body into the shape of your palate. Take a breath through your nose. You may begin to sense the vomer and nasal septum; follow their diagonal path into your nasal bones and ethmoid.[2]

The ganglion of rebes appears nested in this area. With your tongue cradled by your palate, you might sense the balance of each side of your cranium. Notice this internal shaping as you breathe easily through your nose. Imagine the intertwining threads of this sympathetic chain descending from rebes to impar, sending communication between head and tail and back again. This flow is holographic, instantaneous, not sequential. Illuminate this neural pathway within your awareness.

Engaging the Female Midline

A sensorial tapestry of nerve, tissues, organs, and blood flow between a woman's vagina, belly, heart, and brain. This sensual and intuitive swathe is ever present yet often disregarded. An untapped reservoir of creativity and vibrancy is alive within our bodies. In Taoist traditions, the vagina is seen as alive; that is, expressing its own kind of will, preferences, influence, and agency (Wolf 2012, 268-269). The vagina possesses a way of seeing, communicating, and reaching out into the world that is often alien to western cultures. The vagina with its neurology and sensorial potential opens through an ever-unfolding growth, whether this is in response to a deepening intimate relationship with self, other, or the divine, or an indwelling expression of one's journey through this earthly dimension.

Understanding, sensing, and embodying the neural cascade flowing through vagal afferents, neural tissues, our genitals, and the caduceus of verticality unleashes an innate vibratory resonance of woman's creative power and presence.

Exploration 5: Breathing Through Midline

Sit in a comfortably upright position. Let your attention rest with your vulva, vagina, cervix, isthmus, and uterus. (The isthmus of the uterus is the narrow elongated passage connecting the inferior end of the uterus with the cervix. According to some osteopaths, the midline of the female body passes through this isthmus.)

Relax into a visceral sense of this 'organic cascade'.

With awareness centered within your 'vaginal midline', breathe into the umbilical area. Sense this connection. Gently move your attention to your heart center and sense the relationship through to your pelvic floor and the midline of the uterine complex. Breathe into this midline and let your awareness move to your throat. Become aware of your throat – voice – expression, connecting to your vaginal midline. Feel this connection through your breath.

Bring awareness to the third ventricle in the center of your cranium. Sense the connection from the center of your head through to your vaginal midline.

Experience the connection and the expansion as you honor this aspect of your unique physiology. You might even find yourself repeating the mantra: Vagina, Vagina, Blessed Be V!

Concluding Remarks

This article was written in response to the current political climate. The normalization of bigoted, racist, and misogynist behaviors has enabled the surfacing and unmasking of suppressed objectification toward both women and men. This article honors women of all races and cultures; their beauty,

unique physiology, somatic intelligence, and transcendent link to ancestral wisdom.

Carol Agneesens, the author of The Fabric of Wholeness, *has been exploring and practicing the art of Rolfing SI since 1982. She has been a member of the Rolf Institute® faculty since 1993. She also teaches foundational trainings in craniosacral therapy (A Biodynamic Orientation to Perception, Touch, and Treatment) and workshops in The Embryonic Journey: Embodying the Origins of Form.*

Endnotes

1. Information on the ganglion of impar from Sciencedirect.com.

2. This meditation was inspired by Lawrence Gold's Full Spectrum Somatics – the Tongue Mudra.

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Working Women

An Interview with Sally Klemm

By Anne Hoff, Certified Advanced Rolfer™ and Sally Klemm, Advanced Rolfing® Instructor and Rolf Movement® Practitioner

Anne Hoff: Sally, we've had a theme in this Journal (last issue) about working with children, and in this issue we have one about working with pregnant and postpartum women. However, I'm interested to talk to you broadly about female archetypes, the female body, and the whole idea of the *feminine*. Let's start with a piece of your personal history. You had a bad experience with your first Rolfer, a male who took a rather dominant approach.

Sally Klemm

Anne Hoff

Sally Klemm: My initial experience with Rolfing Structural Integration (SI) was with a male practitioner back in seventies; it was during the heyday of knuckles and elbows, and wasn't a good fit for me. I had only a theoretical notion based on what I had read, and went in for what I thought was to be a consultation; eager to learn from a practitioner what SI might do for me. I was caught off guard when the consultation shifted into application and suddenly there I was in my underwear, with my ribcage pinned to the table. I left there visibly bruised and not at all resonating with the experience. Ten years passed before certain life events led me to revisit the notion of Rolfing SI. By that time; I had relocated to Hawaii, and heard mention of Stacey Mills, practitioner and Rolf Institute® (RISI) faculty member. The thought of a female practitioner greatly appealed to me, and, even more important, she was rumored to have a gentle touch. After that initial traumatic session I felt it was important for me to work with a female practitioner. Coincidentally, I entered the Rolfing training at a time when more women were entering trainings.

AH: You've said that Stacey Mills was quite the *grande dame* of the Rolfing world (after Ida Rolf of course). She was your mentor and friend for many years as you were both living in Oahu. Say more about this relationship.

SK: I found Stacey's work both subtle and profound. She was a good listener and engaged me in way that felt safe. During our work together my senses and dream activity were enlivened. The fragrances of tropical Hawaii and the sensuality of being in the ocean were heightened and enriched.

As the sessions of my series with Stacey unfolded, she first suggested and then encouraged me to pursue training as a practitioner. After Basic Rolfing certification, I did 'supervision' with Stacey mentoring me. This was modeled after supervision in the analytical model, years prior to RISI developing its own in-house mentoring program. I worked on my clients while Stacey watched and afterwards gave me feedback. This I found invaluable to my nascent practice. Although Stacey sided with Emmett Hutchins during "the split" and taught for the Guild for Structural Integration, for many years we still met to exchange sessions. Eventually our roles shifted and I became Stacey's Rolfer. I joined

the faculty in 1995, just four years prior to Stacey's death at age eighty-three. It has significance for me that Stacey and I, two female Rolfers from Hawaii, should sit on the RISI faculty. At a time when there were many, many more male practitioners, Hawaii was a kind of bastion where there were quite a few women practicing.

AH: Gladys Mann was another early Rolfer in Hawaii, yes?

SK: Yes, Gladys and Stacey were both psychologists, both trained directly with Ida Rolf, and both practiced in Honolulu. Marianne Wassel, certified seven years prior to me, is another early female Rolfer in Hawaii.

AH: As you told us in the first part of this interview, published in the June issue, that Stacey encouraged you from the start to become a practitioner. For years, there were female Rolf Movement® teachers, but the only female instructors on the structural side were Stacey and Gael Rosewood [formerly Ohlgren]. When there was a move to make the faculty more gender diverse, you were part of a new wave of female Rolfing instructors that also included Carol Agneessens, Tessy Brungardt, and Lael Keen.

SK: Historically, it's well-known that Ida Rolf trained more men than women in the work. I feel fortunate to have been on the forefront of the wave that included more women. I've appreciated being among the four women that were trained as instructors back in the 90s, and consider it propitious that we now have both more women practitioners and instructors. Not that I haven't received excellent work from male practitioners, but women's bodies, and how women relate to them, are very different from males. I recognize that some clients will come to see me despite there being male practitioners nearby who might be able to see them sooner than my schedule will allow. Many women feel more comfortable with working with another woman. And to some extent also, men sometimes feel more comfortable with a female practitioner. It seems optimal to have practitioners of both genders available to suit clients' personal preferences. It's different to be in the room with a female client as a woman in the work, regardless of gender preference or whatever. Obviously our bodies are different. As women, we experience the world differently.

AH: Yeah, just on a physiological level, women have the menstrual cycle – that's something men know about but they've never experienced. It's a time when many women have different issues like body tension or migraines or sacral pain. Certainly a male practitioner can work with those things, but it's something he doesn't know internally from his own experience.

SK: So it is.

AH: So there is something when, as a woman, you go to a female practitioner. Your issue might be closer to her experience than to a man's. For some people that sense of shared experience is important for safety; for some it's important just for feeling seen or understood. So there are many things that can come up.

SK: Or even just in terms of modesty.

AH: Standing in front of the Rolfer in your underwear! Let's shift gears and look at some aspects of the Rolfing training. I imagine that as an instructor you can be particularly helpful to female students, helping them understand how to use body leverage as many women don't have the strength or body mass of a man. I can think of a number of things I've seen demonstrated in classes and workshops by male instructors that I've been unable to do, because I'm not as tall, or my hands are smaller, or whatever.

SK: You bring up an important and two-fold point here, Anne. Let's look for a moment at two relevant aspects of the Rolfing training. The first aspect is body use: the way the student uses her body to employ any given technique. The second aspect is technique. Practitioner body use gets a great deal of emphasis in my classes. There's so much going on during the Basic Training on so many levels, it's common for students to emulate the instructor. Understanding leverage versus strength and body mass entails recognizing habitual patterns of effort. Identifying when we go from ease to effort during our sessions is important self-care for the practitioner. Being relatively long and lanky, my demonstrations lend themselves well to practitioners of similar body type. But what about those who are not?

This brings me to the second point I'd like to make, which concerns *technique* itself and *why* it is employed rather than how. It's not *how* we do the technique but the concept of what's being shown that's significant. Finding a non-injurious way to intervene is the point – not miming the demo. When we understand the concepts behind technique, it's possible to adapt the technique to our own use, regardless of body type. One of my strong suits as an instructor is assisting student practitioners at the table.

I've seen many female students through the years come in with the notion that "I have to do it this way," which only makes the job harder than it has to be and takes a toll on their bodies. Although old myths die hard, it's been irrefutably shown by now that you don't have to be a big, strong guy to 'get in there' and get the job done. I ascribe to the notion that depth is not a question of either speed or strength. Assisting students to find their own way with their particular bodies is part of the ongoing fascination I have with the work.

AH: Have you worked much with pregnant women and with children?

SK: A fair amount, yes, probably more so in the early days of my practice than of late. During the clinical phase of my training in the mid-80s, our clinic included men, women, and children. Toward the end of the training, we were able to work with a number of pregnant women and address how their bodies change. It was a rich experience that was brought into the classroom. Post certification, I was active in the free Children's Day clinics, traditionally held on Ida Rolf's birthday, May 19th. I organized a number of these in Hawaii, and also participated Children's Day in Boulder and in Brazil. In my early years as a practitioner that was always a featured day.

AH: I'm interested in whether there's a unique stance to working with pregnant women. I remember another Rolfer once said to me that you are really affecting two beings with your work, the mother and the baby, and that it's useful to remember that there is someone else in there.. Do you have any thoughts on that?

SK: More the orientation is to the mother carrying the child and the structural influences of the pregnancy and the changes in the center of gravity and so on.

AH: What might be some goals you would want to address around that? I was taught that when you're working with a pregnant woman you don't want to do anything that's going to dramatically change the orientation of the body. You might do things that will help accommodate the changes that are happening with the pregnancy, so that there's more ease for the woman in her

body and more space and adaptability for the growing baby. Is that still pretty much the way things are taught?

SK: It's my understanding that work during the first trimester is contraindicated, especially in the Fourth-Hour territory, because of the changes going on. What comes specifically to my mind for work after the first trimester is easing the center of gravity as it shifts, orientation to the ground, and front-back balance – particularly in terms of the lumbar fascia, in order to accommodate the tendency for the belly weight to cause the lumbars to arch forward. Postpartum work is relevant for re-establishing the Fourth-Hour line, the midline of the legs, and the relationship from the base of support up through the pelvis, into and through the pelvis.

AH: Do you remember the Advanced Training on Maui in 1999, with you and Jim Asher teaching?

SK: Yes, I remember that training very well as a very rich, cross-cultural experience.

AH: Postpartum work was very key for one of the students. Her body had not really come back to itself after delivery of her child, even though it had been some time. Re-establishing the midline of the legs was a big piece of work for her, very pivotal in bringing her sense of her body back to her. She had been sort of stuck in the pregnancy and delivery shaping of her body.

SK: I do remember; the implications of the psychobiological taxonomy loom large in that memory. Giving birth is rite of passage for women and they are forever changed by the experience. How the experience is integrated is very individual for each woman. I feel our work can serve to bridge having given birth in the past with re-entering the present moment. Clients who are mothers have often shared with me that it has taken them awhile to come back to feeling whole again, and how they've found a Rolfer's sensitive touch to be a support to their process.

AH: I'm also remembering one of my classroom clients from that training. One of the pieces that I worked with her was that she had had a C-section with one of her children. This woman was very intuitive, rather psychic. As I was working something around her abdomen, she had a very clear image that, energetically, her abdomen was still open and the organs kind of spread out, like she imagined they did to get to the uterus to do the C-section. So while her body had healed fine, there was almost an energetic imprint of the surgery and of still being opened up. Do you remember that at all? I think you came over to the table and worked with us.

SK: I remember the psychobiological taxonomy as being particularly relevant for the women clients during that class. Well, let's face it; it's increasingly relevant for all of us at any given time. But to return to our theme, in my private practice I do see many postpartum women with a forward pull, both in the adductor compartment and in the lumbars. I learned a lot about rebalancing the sacrum and lumbars in postpartum women from working with Jim Asher during that training. Other input I've found helpful for work with clients postpartum has been the study of visceral manipulation and Sharon Wheeler's scar work, particularly with Cesarean scars. I've had occasion to work on a number of Cesarean scars, both in class and in private practice.

AH: Another rite of passage for women is menopause. The whole question of whether to do hormone-replacement therapy or not is a fork in the road. There's your personal choice, and there's also the influence of the culture.

SK: When women clients ask me for advice, I encourage them to move toward what is right for them rather than be swayed by the latest 'craze' or trend, be it hormones, diet, or exercise. I've thought a lot about personal choice and the influence of the culture – not just in regard to hormones or aging, but in general – throughout my Rolfing practice. We're irrefutably conditioned by our culture and, currently, our society is fixated on youth and appearance. How to feel secure or supported when our collective orientation is ever moving away from the natural world in favor of social media is a dilemma we all contend with every day. Personally, I'm more apt to regard gravity as an ally rather than the enemy and attempt to come 'home' to my feet on the ground rather than relying on the 'experts' in the cosmetic or pharmaceutical industry. But that's my personal bias.

My thoughts about aging are mixed, as are my thoughts about 'science'. I'm fascinated by science and eagerly await the developments in science and technology that substantiate our work. I also recognize that science is invested in 'truth' and a consensual reality that is not there as of yet. We would all like definitive answers but scientific answers are changing all the time, just as we and science are changing. In Ida's time the efficacy of our work was thought to exist solely within the realm of fascia, but that's no longer the case. For me personally it kind of comes down to the difference between *quantifying* data and *quality* of experience. Optimally our research would include statistics from all practitioners' clients on increase in range of motion, flexibility, coordination, etc. This would help a lot in terms of measureable gains from our work. And it also goes without saying the quality of the experience from a potent session is hard to quantify.

AH: What about cultural or religious elements that interface with being female? I've had Muslim clients who wear the head scarf, or bring their husbands along to their sessions. And there was one American man who had become a Muslim, he brought his wife to his session because it wasn't appropriate for him to be alone in that context with a woman other than his wife.

SK: Oh interesting! I've had women accompany their husbands to sessions, and vice versa. And I've worked on folks in the Hawaiian community who did several sessions before they would even consider taking off their *muumuu* [the traditional flowing Hawaiian dress]. Speaking of Hawaii, it is a culture and an environment that is very feminine in many ways – it's verdancy, for example, and the goddesses of the culture emphasize the feminine as the creators and the nurturers. Stacey was an important embodiment of that for me.

AH: A client from Hawaii showed me a picture where he was standing in front of the Hindu temple on Kauai; he was wearing a pink sarong. It seems there's a broader range for masculinity there. On the mainland U.S., and in some other countries as well, you would not likely see a man in a sarong, and many men wouldn't even wear pink shirts. Hawaii is a place where the 'feminine' seems more embodied by both men and women, although of course there are strong expressions of the masculine as well.

This takes us to 'feminine' and 'masculine' as archetypes, like yin and yang. In these archetypes, the feminine is dark, receptive, intuitive, mysterious, while the masculine is light, penetrating, logical, known.

SK: In our work, we know more and more about what goes on. I was enthralled to

go to the First Fascia Research Congress at Harvard Medical School in 2007. I just thought that was a coup. And also, I'm still just stunned by the mystery of all that we don't know. It really retains that mystery bordering on the magical and the miraculous to me that this work can't be explained within the paradigm that we have in science right now.

AH: There's the masculine and the feminine right there.

SK: In my movement training, Viviane Jaye made references to this being called upon within any individual. If it's a male practitioner, to somehow include his yin side or female into the equation that he brings to the table. For women, there's a certain audacity also that is being asked for, to have the audacity to penetrate someone's tissue is pretty yang.

AH: I think we're seeing, as a culture, that gender is not binary, and yin/yang are also not strictly one or the other in a binary fashion.

SK: We draw these arbitrary lines and limits, and it's much more amorphous than that. We had some transgender clients in the Berkeley class I taught as a Teacher in Training with Michael Salveson as lead instructor. Initially there's a current of puerile curiosity that segues into focusing on the task at hand. And ultimately what transpires is dealing with the structure of the person on the table. Part of our personal maturation process as a practitioner is to bring into our awareness and neutralize our various beliefs and biases.

AH: What are your thoughts about aging for yourself and related to female clients you've worked with?

SK: At sixty-seven I'm definitely *feeling* my embodiment differently than at the start of my Rolfing practice when I was in my thirties. I can empathize more with clients my age than I did when I was younger. I can feel their desperation as they struggle with painful knees, loss of memory, and the rest of the seemingly inevitable issues that go with the territory of aging. Yet I'm often taken aback to work on younger clients who are physically worse off and in more pain than I. These feelings have definitely impacted the way I approach people of all ages. The presenting issues shift too, from sports injury and integration postpartum for example, to increased emphasis on coordination and balance.

I find too that my regime of personal self-care is vital and gets continually tailored to meet the needs of my aging body. If sessions I receive now aren't quite as dramatic as those of my initial series, the work registers and resonates on a deeper level of ongoing appreciation. My practice changes with time, just as I change with time.

Sally Klemm is an internationally recognized Rolf Institute instructor who teaches worldwide while maintaining a private practice in Honolulu, Hawaii. A native of Berkeley, California, Sally is a graduate of University of California, Berkeley's College of Letters and Science. After a four-year sailing voyage around the world, Sally was introduced to Rolfing SI by Stacey Mills, who convinced her to stop trimming sails and start aligning bodies. She has called Honolulu home since 1983. Sally's private practice includes Visionary Craniosacral Work© as well as Rolfing SI and Rolf Movement Integration. Her extraordinary ability to blend an organized cognitive style with deeply intuitive understanding reflects her fascination with the unity of the psyche and the soma. Sally joined the Rolf Institute faculty in 1995.

Anne Hoff is a Certified Advanced Rolfer practicing in Seattle, Washington and the Editor-in-Chief of this Journal.

A Meta Perspective on Working with the Female Body

By Libby Eason, Rolfing® Instructor, Rolf Movement® Practitioner

The first contact in my office with any prospective client, male or female, is a full-hour consultation. I spend an hour (and charge for the time), which allows me to get a complete history and start 'connecting the dots' in the client's history. I also get out the anatomy book, show pictures of fascia, and explain the logic of the Ten Series. People are intelligent, and when they understand that a comprehensive change will give them more than just working where it hurts, they tend to stay through the Series to enjoy the full benefit that is available. So my approach is about working with the person, and I don't think of working with 'the female body', but that initial interview will usually surface elements of personal history that are unique to that person's gender.

Training in The Feldenkrais Method® of somatic education has added a great deal to my understanding of developmental movement, and how it shows up in infants, children, and adults. A child learns a movement, and stops developing that movement not when it's ideal, but when it will suffice to get to the next stage of developmental movement. It is possible to make that movement more ideal at any stage of life, hence the importance of continuing to discover and use self-awareness.

Developmental movement becomes structure. Whether a pattern is acquired in infancy and first years of life, or through habitual use, injury, or any other necessity later in life, every structure is a result of repeating forces that develop their own harmony with gravitational forces. Fascia is a slow-moving river, with swirls and eddies that are evident in structure, and can be detected as we move.

One example is a woman who was a track athlete; hurdles was her event. I always ask, "Which leg did you use to push off, and which went over the hurdle first?" This will give me a picture of how that particular repetitive use is embedded in her structure. The push off foot, the reach through other leg, the follow through with the push-off foot, now with knee forward, the landing on the forward foot – those forces all drive into her pelvis while it is still twisting. Unwinding that pattern will be more successful if we take those moving patterns into consideration. As Ida Rolf asked – how did that pattern get there?

Later she is in the office, with children who are two, five, and seven years old. The pregnancies, carrying babies (usually on one hip), other daily home and work activities, perhaps working at a computer several hours a day, will have created other patterns that are overlaid on the original hurdling movements. Differentiation and integration will first involve following the more superficial pattern through her

feet/legs and pelvis into her torso, arms, and neck.

In the eighth session, today, she reported still having pain in her right leg, hip, pelvis, and low back. During the session, in sidelying position, I tilted first her knee, then her ankle, toward the ceiling. It was much easier for her femur to go into internal rotation with the ankle toward the ceiling. Using indirect technique combined with movement, I took the myofascial structures further into the internal femoral rotation. Then in supine position I worked with her lower leg, which more easily went into external rotation. Work in her right iliopsoas relieved more of the pattern (this is her landing foot). During the back work on the bench, much more density was evident on the right, and so more focus went to that area. She experienced more relief, and an absence of pain, than had occurred in the first seven sessions.

Differentiation of layers has to be done with care, allowing a woman to sense what is happening and have the opportunity to participate. As you allow her to be in charge of the pacing, she will be more able to explore deeper connections. In those layers will also live her personal and family history, and many other life experiences that may have never been really consciously articulated at the time they 'grew into and with' those layers of fascial structure. Allowing her to determine the pace of unfolding will allow you as the practitioner to go more fully into the patterns. As you can allow the process to evolve in every moment of the work, you can have trust and partnership, emotionally as well as physically. Comprehensive and coordinated interventions become the dance that spirals in the same directions that evolved to create the patterns.

Women will also frequently see the usefulness of the work for one or more of their children. I have worked with a woman who has one child with a previous hard fall onto concrete when he was five. He was having physical issues that none of her other six children has had, including migraines. In the course of working with him, now age eleven, it has become clear that there is a very significant rotation in his spine and pelvis. Whether it came from a fall or from other experiences, I do not know. I was able to help him become aware that he can turn to the left, but not to the right. Besides the obvious structural restrictions, I worked with his head to see where movement was easy or restricted. I also checked his torso by lifting under each shoulder, one at a time. His pelvis, with similar lifting to test, will only rotate in the opposite direction. There are no x-rays, so I don't know if there is a clinically diagnosable scoliosis. But the pattern, as it presents itself, leads to the appropriate interventional strategies. I also checked his eyes, and noticed that he appears to see with only one eye at a time, which would significantly change his organization so that eye would be more in the center of his field of vision. That has to be accounted for in the work, since that kind of organization can't be changed. His mother can take him for visual-field tests if this pattern persists. So far, he is curious, accepting of work, and I am trying to ask for significant change, but not too much too fast. His mother is always in the room. They share a connection that I am happy to accommodate. I try to be careful to allow any and all relatedness between the two, and not intrude on that in any way. All the time, I am listening with my hands and sensing with myself to see, hear, and sense what is going on in his system. His mother is seeing change, and he is also seeing change and staying engaged. This is integrating for both of them.

There are situations unique to the female body. Work during pregnancy helps provide support and relief. Generally, more superficial work is appropriate. Since miscarriage occurs in about 25% of pregnancies within the first trimester, I do not work with clients until they are in the fourth month. By this time, a woman is beginning to feel the increased weight of the baby and relaxation of ligaments altering her structure and movement. Easing superficial structures in her feet and legs, lateral ribs and diaphragm area, neck / shoulder girdle / arms gives her a place to rest and more fully accommodate the changes.

Postpartum work in the pelvis helps a woman to reclaim her body. It will never be the same as it was prior to pregnancy, but can feel a lot more familiar, much more quickly, with structural and movement interventions. The uterus has regained a more normal size by about eight weeks, so work directly in the psoas/iliacus, and relationship into legs/feet and spine/ribs/neck, is possible and helpful to integrate her structure into something that she can recognize and rely on.

Of particular importance with working with women and children is the possibility that there may be history of abuse and/or trauma. Sometimes this history occurred at a preverbal age, and she does not have vocabulary to articulate the experience or feelings. This can feel very confusing, and may trigger a reaction to stop the feelings. I never try to act as therapist: even if I were a therapist, I am not that client's therapist, and that is not part of the contract. There are, however, ways to engage a woman in allowing the feelings, even if she needs to hear that it is okay to wait until she feels she is in a safe place (such as home or with a trusted therapist or friend) before allowing them fully. This gives her some space to avoid shutting down and allows for full expression at a later time.

Emotion is movement – e-motion. It is always moving, however fast or glacially. When I am aware of my own state, and listening to the other, I am able to work with the tide, so to speak, and that allows both differentiation and integration to flow. Both can be happening at once, if the pacing is appropriate. Another aspect of movement is its role in creating, and maintaining, the structure we see. Movement is happening in many rivers, streams, and eddies in everyone. Daniel Siegel described consciousness as having parallel, simultaneous streams. Our being, and its expression through movement and structure, is consciousness. We are working with "what we can get our hands on" – to paraphrase Ida Rolf. And we are working with the person who owns those hands – ourselves. It is in this dance that the magic of the session happens. And the longer we practice, and the more we continue our education within and outside of strictly structural work, the more we move into this stream and dance with the other's structure and being. It is, in my experience, what integration is about.

Libby Eason was first introduced to Rolfing SI in 1975. She was immediately impressed by the transformation in physical structure. In 1992, Libby graduated from The Rolf Institute® of Structural Integration (RISI). She completed her Rolf Movement training in 1994 and Advanced Rolfing Training in 1997. She began training to be an instructor in 1998 and is a current faculty member with RISI. She completed the Feldenkrais training in August 2016. Libby has served as president of the Ida P. Rolf Research Foundation since April 2012. She is past president of the International Association of Structural Integrators®, and served on its board of directors for ten years.

Remembering Tim Law: The Man Behind the 'Little Boy Logo'

05/25/1954 - 07/06/2017

By Jan Marie Alarcon, PhD

From the Editor-in-Chief: It is accepted in the Rolfing® Structural Integration (SI) community that the Little Boy Logo is based on the body structure of a little boy then known as Tim Barrett and later as Tim Law. Tim, who was invited to the Rolf Institute® in 1996 on the occasion of the hundredth-year anniversary of Rolf's birth, passed away from cancer this past summer. Here we remember Tim's life, with the story of the work with Ida Rolf and the logo as it comes to us through the childhood memories of Tim and his brother John. (Variants of the story are extant, particularly one told by Dorothy Nolte; see endnote). I am particularly grateful to Jan Marie Alarcon for reaching out to the Rolf Institute® with this generous sharing from John and Tim.

The year was 1959. Dr. Rolf, in a "grandmother house with big flowers on the walls," provided structural integration to brothers Tim and John Barrett (see Figure 1), ages five and seven. Dr. Rolf was working with Tim to help with issues caused by Legg-Perthes Syndrome; John was getting sessions "most probably so I wouldn't feel left out."

John remembers Dr. Rolf taking side-view pictures before and after the ten sessions. "She leaned us against the only part of her wall that was white." The change in Tim's structure was so dramatic that Dr. Rolf asked Mrs. Barrett's permission to place Tim's profile in her logo. "Dr. Rolf hired an artist to draw pictures based on Tim's photographs, using blocks out of alignment for the 'before' picture and blocks in alignment for the 'after' picture." The result became the Rolf Institute's most enduring icon, The Little Boy Logo. In Figure 2 we see Tim some months before his death holding the logo poster. He took time out from his last family reunion at the house he built in Kalapana, Hawaii, to pose for this picture. He wanted everyone, especially carpenters with body issues, to know that Rolfing SI can free you from pain.

How It All Started

John and his wife Pam are my beloved neighbors. I asked John and his brother Tim if I could interview them when I learned about the connection between Tim and the Little Boy Logo. I was concerned that otherwise these first-hand accounts of a valuable piece of the Rolfing community's history would be lost forever. Both heartily agreed: they wanted the world to know how grateful they were. Both John and Tim shared their memories of Dr. Rolf with me before Tim's passing on July 6, 2017.

"My brother was diagnosed with Legg-Perthes Syndrome," John told me. "We are Scotch-Irish. This syndrome is very common in Perthes, Scotland." Tim's impish humor is apparent in his next playful comment: "You get this from being with sheep. That shows you what kind of relatives we had."

John remembers that "one of Tim's legs was shorter than the other. He could ride a tricycle alright, but he had to stretch his arms out straight to keep his balance when he walked." Tim recalls, "Doctors told my mother I needed to be in a body cast for years and would probably end up in a wheelchair soon anyway."

Mrs. Barrett would have none of that. Fortunately, her friend Helen Spencer, who "accepted a lot of alternative ideas," was acquainted with the work of Dr. Rolf. "We drove all the way from Manhattan Beach to Pasadena to meet her."

"Tim and I knew her name was Ida Pauline, but even my mom always called her Dr. Rolf." John put his hands together and rocked side to side, imitating her higher-pitched voice, "You must call me Dr. Rolf." For a just a moment, I saw in John the seven-year-old Dr. Rolf had known. I couldn't stop grinning.

Tim's strongest memory of Dr. Rolf was of "a large lady chasing me around the swimming pool." His only explanation as to why was, "I had a lot of energy, and so did she."

Tim continued: "I only had ten sessions because that's how many you're supposed

Figure 1: Tim and John as children and as adults. On left, Tim, age one, in front of John, age three, on a tricycle, Redondo Beach, CA, 1955. On right, John (L) and Tim (R) on a road trip to The Tree Circus, Gilroy, California, 2006.

to have. The sessions were long but I never fell asleep. Dr. Rolf never got mad at me, but sometimes she would get mad at my hip. She'd grunt and her fingers would get really hot. Not too hot. Nothing really hurt – well it might have hurt a little – but I didn't care; I knew she was going to make me better."

"When she was done she would say, 'Okay, that's all for now,' and you knew she was done. Really done. It was time to get off the table. Then she'd work on my brother. While I waited, I would just lie on the couch and rest, too exhausted to play with my toys or anything."

John, being two years older, has more vivid memories of the house and sessions. "Dr. Rolf was an older lady when I met her. She lived in a bungalow-style house with stairs in the middle leading to a big front porch. The living room had a big table with a chandelier above it. I would sit at that table waiting for Tim. Dr. Rolf left papers and crayons so I could draw. The kitchen was off to one side and smelled like cookies. She had a special room filled with books set up for treatments. It looked like a library." [Editor's note: John assumed this was Rolf's house. Rolfer™ Jan Sultan believes it was the house of one of her early students, perhaps Hadidja Fielding (Lamas).]

"Tim was able to walk so much better after each session – that's because she elongated his muscles. I didn't mind her working on me. It just kind of felt like massage or something. Well, maybe just a little more uncomfortable than that."

John remembers a set of follow-up sessions they both had with Dorothy Weber, a student of Dr. Rolf's. "It was about six months later, Dr. Rolf had to move on to another project. Dorothy would come to our home. She swam every day in the ocean near the Hermosa Beach pier to get her exercise. She was a nice lady and tried to act just like Dr. Rolf."

Tim told me that he walked without any difficulty after completing the ten sessions. In addition, "Dr. Rolf took all my pain away. My leg gave me no problems until I was fifty-five" – at which point he received a hip replacement due to a deteriorating joint. "But I never felt any pain even then. All thanks to her."

John agrees that Tim never appeared to be in pain after meeting with Dr. Rolf, but he remembers his brother walking with a pronounced limp. "His right leg was always shorter than his left so he'd push it forward using the ball of his foot." Tim never used a cane or a wheelchair. "In third grade, they gave him a lift for his shoe; but he didn't like it and refused to wear it after a week." John was relieved to hear that Tim was never in pain. "I was never sure. He is not the complaining type; he'd rather suck things up."

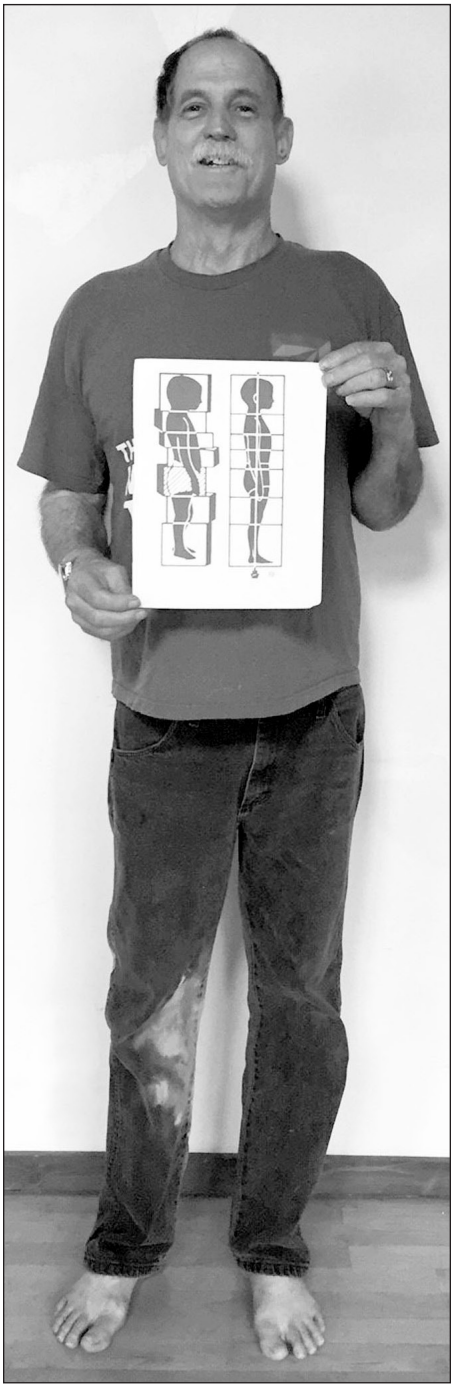

Figure 2: Tim holding the Little Boy Logo, March 2017.

Tim also asserted that Dr. Rolf saved him from what could have been a life of substance abuse. "I knew so many people at work [other carpenters] whose bodies were in so much pain that they would use drugs and alcohol just to make it through the day. I never had to do that. Thanks to her I was able to support my family, myself and my children."

John introduced Tim to surfing when he was in the eighth grade. "I thought it would help him – be good for his joints. The water would buoy him up." Tim took to it and became a smooth and powerful surfer (see Figure 3). The bigger the wave, the better. He never held back. "I am a happy man today – thanks to surfing and Dr. Rolf." And carpentry.

Tim fell in love with working with wood in high school, thanks to the efforts of a talented shop teacher. He spent his adult life honing his carpentry skills and building his own houses. Tim had a message he wanted conveyed to the Rolfing community:

> *Rolfers, please let the unions know how much Rolfing [SI] can help carpenters. Their bodies can hurt so much, and drugs and doctors are not doing a thing for them. Thanks to Rolfing [SI], I was able to work harder, faster, longer than all of them. I want their bodies to feel as good as mine does.*

Tim told me about his visit to the Rolf Institute in Boulder, Colorado for the 100-year celebration of Dr. Rolf's birth. [Editor's note: contemporaneous reportage and photos are in the August 1996 issue of Rolf Lines® (Vol. 24, No. 3), pages 54, 56, and 57.] "When they found out Dr. Rolf had worked on me, they all wanted to touch me. But I told them I didn't have any money." Tim declined sessions even after he was told there would be no charge. "Dr. Rolf did enough for me. I was still just fine." However, a few years later he did avail himself of a few sessions with a Rolfer on Maui and found it extremely helpful, "She was just like Dr. Rolf all over again."

Tim died this past summer at the age of sixty-three of a brain tumor. He told me weeks before he passed, "It's okay. I've had a good life. I was deeply loved by my brother and children."

John spent a week with him during his last days. Tim would take John's hand repeatedly and make him promise that he'd take care of his children. John would reassure him and then rub Tim's fuzzy

Figure 3: Tim surfing in Maui, November 1977. Photo by Dana Edmonds, used with permission.

chemo-head. "I just kept touching him and telling him how much I loved him. We talked on the phone daily. I miss him so much."

Tim is survived by his children Keone, Jasmine, and Nalu, and grandchildren Harper and Jackson, who were the light of his life. Jasmine told me that "when I called to tell him I was pregnant, he couldn't stop screaming." His ashes are scattered on both sides of Hawaii's Big Island at two of his favorite surfing haunts.

Tim's last name was changed to Law when he was adopted by his stepfather at the age of nine. Dr. Rolf would have known Tim as "Tim Barrett"; the Rolfing community at Tim's later visit would know him as "Tim Law." John, who was older, chose to keep Barrett as his last name.

*Jan Marie Alarcon, PhD, is a licensed clinical psychologist and freelance writer. She received her PhD in clinical psychology from Rosemead School of Psychology in 1991 and specialized in treatment to marginalized and underserved populations. Dr. Alarcon met John Barrett the first week she moved into Shandon, California – population 1,230, the land of affordable housing – in 2003. John gave Dr. Alarcon a jump when her battery died in a church parking lot. Pam, John's wife, noticed the Little Boy Logo on the back of a book Dr. Alarcon was reading (*Ida Rolf Talks*, edited by Rosemary Feitis) and exclaimed, "That's my brother-in-law; really truly, that is my brother-in-law." Dr. Alarcon is recovering from a major car accident that resulted in numerous broken bones. SI sessions have helped her walk with more ease and regain feeling in her right foot.*

Endnote from the Editor-in-Chief

The exact details of the story of the Little Boy Logo used by Rolfers are shrouded in the mists of time. Most of the adults from that time – who might remember definitively – are no longer with us. This version of the story comes from two people who were there, but they were young children and perhaps not cognizant of all that went on. Particularly, we have here some variations from the account Linda Grace wrote on her blog, "Rolfing® Structure and Movement Talk" (rolfinggrace.com). Some we can parse out; others we cannot.

In her blog post (www.rolfinggrace.com/2010/07/the-story-of-the-rolfing®-logo/), Grace relayed information she heard by old-time Rolfer Dorothy Nolte present at a Rolf Institute membership conference in the 1980. Based on this, Grace named Nolte as Tim Barrett's aunt and the connection to Dr. Rolf. Upon my query, John Barrett relayed through Jan Alarcon (personal communications, 10/10/2017 and 10/11/2017) that Nolte was not an aunt, but rather was the first wife of Durwood Law. Mrs. Barrett, mother to Tim and John, later became the second wife of Durwood Law, thus Tim having his last name changed to Law. Alarcon says John believed that Dorothy Nolte was not part of the decision to go to Dr. Rolf, but she comments that it just may not be part of the story as he knows it.

Other differences are that Grace relates that the work on Tim Barrett was done in a classroom setting, while Tim and John remember it being done in a private residence and offer vivid details on the décor and events. Here, it seems appropriate to trust the firsthand memories of the children.

Grace also says that Rolfer John Lodge did the drawing of the Little Boy Logo. According to Grace (personal communication), Lodge in 1983 claimed the drawing was done at Rolf's behest after a first session done in a class. The Barrett children do not remember a class, and only remember that permission was asked for an image to be created. As these recollections by all parties were given some decades after the event in 1959, we are again facing the obscuring 'mists of time'.

'The Blind Tailor' and Biotensegrity

An Interview with Luiz Fernando Bertolucci

By Anne Hoff, Certified Advanced Rolfer™ and Luiz Fernando Bertolucci, MD, Certified Advanced Rolfer, Rolf Movement® Practitioner, Rolf Institute® Faculty

Note from Anne Hoff: Luiz Fernando Bertolucci visited Seattle this autumn, where a group of local structural integration (SI) practitioners were able to see a demonstration of his Tensegrity Touch® method of practicing Rolfing® Structural Integration (SI). This brought to life for me the concepts he'd written about in the December 2016 issue, in his article "Manually Evoked Tensegrity and Pandiculation, Part 1" (Bertolucci and Lobo 2016), and inspired this interview.

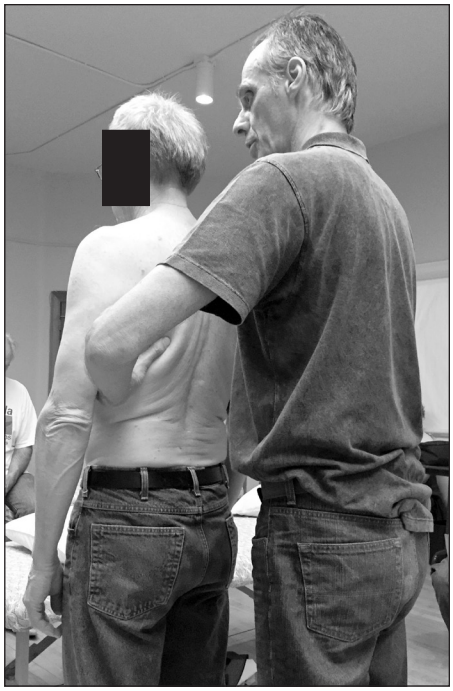

Figure 1: Bertolucci demonstrates the "blind tailor" assessing the draping of the soft tissue.

Anne Hoff: So, Fernando, you are here on a visit to Seattle, and I got to experience your work, which you call Tensegrity Touch®. I was very curious about it after you wrote for our theme on biotensegrity in the December 2016 issue. We had various authors talking about tensegrity and biotensegrity, and what struck me was that you seemed to have a way to take this directly into your practice. You weren't just speaking conceptually – we all have heard for years about Rolfing SI and tensegrity; you were implementing it in a unique way of working. Now that I've watched you work and experienced your work directly, I want to comment on various things, and ask you to share more about Tensegrity Touch.

One of the first things I noticed is that your assessment of the person standing is more about touch than the usual Rolfing assessment, which is often dominantly visual. Your hands are on the person's tissue, and you're moving it, feeling for resistance. Your metaphor is that you are a "blind tailor" and you're feeling for how the tissue drapes on the body. How did you get to this kinesthetic assessment?

Luiz Fernando Bertolucci: It really goes back in time to trying to help people who had very severe movement restrictions and impairments. I trained as a physiatrist, and I used to see patients and prescribe physical therapy that somebody else would do. But then I trained as a Rolfer, and when I put my hands on people, I realized how powerful it is, and how much the manual input can change peoples' movement conditions. I was really awed at first, with this possibility. So having those very restricted clients coming in, I was trying to help them somehow. Most of these patients had already undergone surgery, so that was not an option, and I was trying to find ways to help them through exploring ways to accomplish *more effective* manipulation of the soft tissue. I don't remember well, because it was a long time ago, but I have the image of, for instance, working in the hamstring area because of a hip condition, and I felt I needed firmer support – a firmer counter-pressure to my pressure. Perhaps this was the beginning. One of the main aspects of this tensegrity work is loading the tissue, shearing it. This really brings about a sense of firmness as a platform for the practitioner's hands. Maybe I was searching for something steady and firm to give me back a base of support for my touch.

It was over time – years, actually – of experimenting and empirically researching how to characterize this work that this way of really assessing the whole system came about. The diagnosis and the treatment are the same thing, in a sense. For instance, using this example of working on a client's hamstrings, I was at the same time both assessing the restrictions to tissue mobility and also treating. When you are assessing, even with the person standing, you are somehow relating parts in different ways and the body is already changing, especially if you consider specific neurological responses that may arise. That was how this assessment method, little by little, came about. I started to use my hands more, and my eyes less.

AH: You didn't quite realize how you were diverging from the way you had been trained in Rolfing SI.

LFB: Exactly.

Luiz Fernando Bertolucci and Anne Hoff

AH: In your earlier article, I loved the story of how other people had to say to you, "What you're doing is different; what are you doing?" Then, you had to go through this process of inquiry to actually understand the difference, because it seems like it just developed very organically.

LFB: Yes. I was doing something, but I was unaware of what I was doing. My focus was on the client. I was trying to help and trying to get the tissue to move, etc. All the rest was development out of this, in a sense.

AH: In your demonstration, you described the tissue restrictions you are feeling for in your "blind tailor" assessment, and the firm platform you are creating by shearing tissue around bone. In both assessment and treatment, you are moving tissue, moving parts, until you find *where the movement of a part engages the whole*. That gives you the firm platform. Another way to say it is that it gives you a 'handle' onto the biotensegrity of the structure. You are no longer relating to local tissue or to just one segment, you have engaged the whole.

LFB: Right. It is interesting how shearing and pressing tissue in a particular way unites body segments in a single unit. The underlying mechanisms, though, of how this takes place is still unclear. I guess the touch integrates segments – and creates tensegrity – by two discrete actions: one mechanical, that happens thanks to the myofascial force transmission, and another neurological, possibly related to reflexes fired by the particular proprioceptive input produced by the touch. We observed that when you start a maneuver, you often get a certain degree of tensegrity, which unites some but not all segments. As you continue the maneuver, more segments are progressively engaged, increasing the degree of tensegrity. When we performed EMG measurements, we noticed that it takes a certain amount of time, often minutes, for the spontaneous muscle activity to ensue and that it gets progressive higher. From this, I believe the mechanical component is present already from the beginning of the maneuver and the neurological component slowly kicks in, bringing more segments together in the tensegrity unit.

AH: Watching your work, I really saw the principle of holism (one of the Principles of Intervention) in action. I know that you know anatomy really well, and that you teach anatomy for the Brazilian Rolfing Association, but your way of working is not driven by anatomical structures. Rather, you're coming at it from biotensegrity, from the sense of the body as one unit. In a way, you are asking "How can I activate the holism of the body so that my intervention is an intervention to the whole, rather than to some particular anatomical structure?"

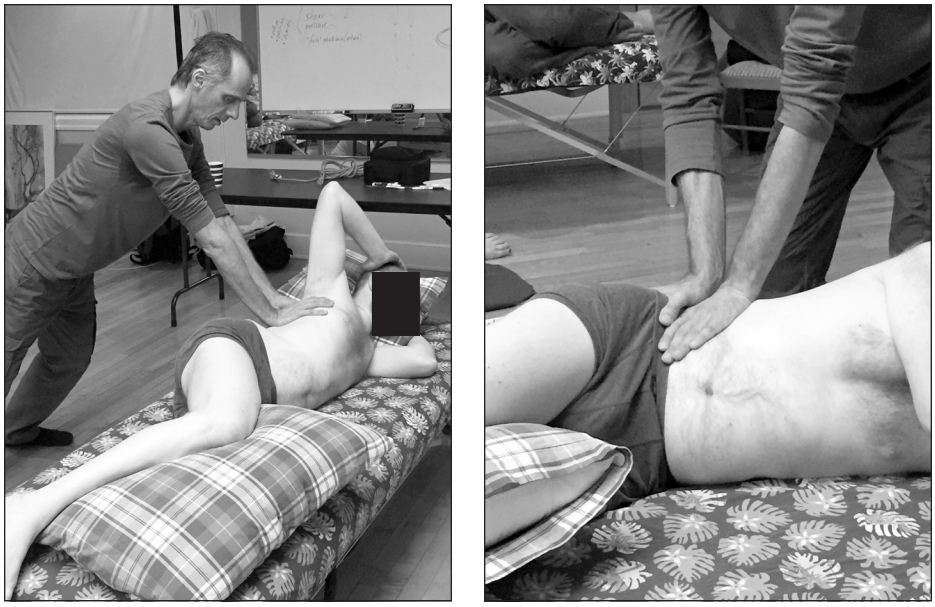

Figure 2: Tissue shearing as Bertolucci builds tensegrity to unify segments.

LFB: Exactly.

AH: I think this is what makes your way of working particularly potent and the results dramatic. Even if you're working the hamstrings, you're putting this tension in so that in the moment the hamstrings are intimately relating to the whole as a biotensegrity structure. I think that Rolfing work always spreads through the fascial web, but the way you affect the "pre-tension" of the whole system seems to make it easier for the body to take your intervention and do with it whatever it needs to do.

LFB: Anatomy cuts and separates to study. I love anatomy, and I love science altogether, but I joke with my students. "Is it important to know anatomy? – Yes, it's important to know anatomy. But as important is to forget anatomy when you're working in this fashion." You're not 'doing' with your will, with your cognition, your voluntary drive, so to speak; you're not doing something to a particular structure. When you load and shear the tissue in Tensegrity Touch, you are, as you said, working the whole and sensing for the *relationship* of parts, rather than the condition of the parts themselves. If you think about anatomy, it can be disruptive, actually.

We are working at a deeper *felt level*. I think there is something that's already built in our systems that allows the client to know when something's out of place. We, as helpers,, can also sense when there is something out of place. And then, from both perspectives, client and practitioner can also sense when things are going toward the right way, so to speak. I believe this probably comes from something that's embedded in our nature to care for each other. I joke about the "catch-bug" reflex in monkeys, how they groom each other. Both share a sense of *rightness*, based on interoception, much like it feels right to drink water when we feel thirst.

AH: This recognition in the client of what feels right is the 'beneception' you talked about in your article.

LFB: Exactly. Yes. This is the biological reward, so to speak. When I'm working, I'm not thinking of anything, I'm sensing more than anything. The sensation of 'rightness' is probably the guiding star. Then, when the tissue starts to move, you can 'fill in the gaps', so to speak, with anatomical information, physiological information, biomechanical information, whatever, in the search to understand cognitively what is happening. So anatomy helps, but it can also disrupt this sensing state that has a kind of recognition that is not analytical; it's more a sensitive, kinesthetic, and sensory driven state.

AH: I noticed, when you worked on me, sometimes you're using a lot of pressure, but a lot of the time, you're not. And either

way, it wasn't really like you were *doing* something – in the sense of a targeted intervention. It's more that you were *setting up* conditions that the body can make use of.

LFB: Exactly.

AH: It can go incredibly deep without you, as the practitioner, deciding, "I am aiming at this particular deep structure and trying to change it."

LFB: Yeah. I think that's really what it is. You first artificially – with your will, so to speak – create biotensegrity, a heightened sense of the connection of all the parts in a whole. This will evoke responses on the client's side. So my guess is that when you create/enhance biotensegrity with your hands, you invite the system to participate, through pandiculation-like reflexes, as well as with additional autonomic-mediated homeostatic maintenance reflexes. So yes, there are phases during an intervention. You first invite, 'knock on the door', so to speak – creating tensegrity. And then you wait – just maintaining the condition you set up through shearing and pressing. You just maintain it, just maintain. You see that a certain stillness then comes about, and right after that you often get what probably are autonomous autoregulatory responses like breathing and consciousness state changes, involuntary muscle activity – which we have measured – and even involuntary movements. As the practitioner, you're just maintaining that shape, so to speak, and the client's system responds to it. So it seems that the client is working from the inside out, and you from outside in. I believe such a blend of actions is one of the reasons that makes this style of work effective.

Another common response to the touch is a push, an expansion the practitioner can feel coming from the client's system. This action is probably also caused by tonic involuntary muscle activity. In this condition then, the practitioner should just give a push back, maintaining the tensegrity form, and giving it *containment*, if you will, so that this freeing from inside out occurs. It seems that such containment gives support so that those reflexes produce deeper, faster, and more powerful, or more comprehensive results as compared to anything the client could do on his own. We are evoking spontaneous self-regulating motor activity. In fact, many different modalities can bring about these kind of responses, such as yoga, styles of qi gong, and also hands-on work. But we are bringing together something that's done by the therapist and something that's done by the client's system, somehow helping and boosting this built-in self-regulatory motor maintenance system, of which we consider pandiculation a prototype. Something like that.

AH: The autonomous responses have some similarity with what can come up with craniosacral unwinding, but are also very different. Unwinding generally goes in the direction of ease, whereas with Tensegrity Touch you're building into the direction of tension, because that's what creates the stable platform and engages the holism of the body's biotensegrity.

LFB: Yes. Many students ask if I was trained in craniosacral and stuff like that because they see similarities. I think there are some similarities, possibly this spontaneous motor activity is similar, but the way you get it is different, as we evoke it through manually evoking tensegrity. And also once such responses are present, the manual input is different: here, you go against the ease, so to speak. Actually, you are challenging the system. You are asking if the system can do something different than it's been doing, so you are going in the direction that gives you the resistance.

AH: While both Tensegrity Touch and craniosacral unwinding have an autonomous regulatory effect, my experience is that the effect is not the same. This challenge you're giving seems to have a stronger effect on the fascia. With craniosacral unwinding it more feels that the nervous system unwinds or relaxes, tissue softens, but with Tensegrity Touch I feel structural, fascial changes as well as profound and dynamic autonomous re-regulation.

LFB: That's a good point! I'm not sure, but that is my guess from applying and receiving Tensegrity Touch, from clients' and assistants' reports of sensations during the maneuvers, and from the resultant structural changes, that indeed fascial changes are taking place. One curious observation in that direction is a sudden 'snap' that may happen during a maneuver – that can even startle both practitioner and client! – which seems to correspond to an abrupt change in the relative position of myofascial compartments. What I envision occurring is links within areolar tissue changing to a point in which the compartments can adopt a new – or renewed – mutual spatial relationship. More dramatic postural and functional changes follow such 'snaps', and I hope to be able to show this kind of change using ultrasonography in our next research project. So, yes, I think we are challenging parts to internally move in new ways and such effects are presumably happening in the fascial web. Such effects seem to take place in Tensegrity Touch because the 'unwinding' has something to relate to, as the practitioners' manual input somehow mirrors what is happening within the body, anchoring the spontaneous push or expansion. In this condition, presumably, the shearing vectors are steered to the interfaces where tissue differentiation is most needed.

AH: The fullness and expansion seems to be the sense of biotensegrity, and that allows the body's recognition of its wholeness.

LFB: Yes. I think so. The sense of fullness and expansion seems to show when the spontaneous tonic function of muscles arises so as to connect body segments, forming a single unit.

AH: You have renamed this work over and over again, as you described in your article, and it seems that as you understand more what you're doing, a better name comes forth, each one more accurate to what actually is going on. Your first name was "Surgical Rolfing [SI]." And it is true that there can be this feeling of surgical precision, work being done at a deep level, but that initial name didn't reflect the way that the work engages the holism of the body.

LFB: Right.

AH: Your next name, "Muscle Repositioning," said something about how tissues were moved, but it again didn't capture the holism, it sounded more particularized. The latest name, Tensegrity Touch, expresses what's unique about the touch, the way the touch relates to the body and what is activated in the body. I find it interesting that your process of understanding the work leads to these new names that get more and more precise.

LFB: Yes. They're progressively more comprehensive, in a sense. There is still, as you said, a 'surgical' feature, so to speak, and also the muscles are probably changing their relative positions, as we mentioned, so both, surgery and muscle repositioning seems to occur through tensegrity. Another way of conceiving the work is as 'assisted pandiculation'. You are assisting the

system, the system's wisdom that comes about in pandiculation. I imagine there is a whole class of involuntary movements that help the maintenance of the system. Some are very common, like the pandiculation expressed in yawning and the so-called 'morning stretch', but I think it goes beyond that. I once read that yoga was not an invention but a discovery made by monks in meditative states that invited the system to move in whatever ways were needed as maintenance. Seen in this way, yoga poses are something that's natural, that are aimed at maintaining homeostasis.

AH: Some yoga poses set up similar conditions of biotensegrity felt through a tensioning of the tissues.

LFB: Absolutely. I believe, there are two types of movements: one that is species-based, movements that are pretty much forms that repeat, like yoga poses and pandiculation patterns. But unique patterns can also arise, that can go into different kinds of expression, apparently more related to issues in the client's history, patterns of movement that seem to arise uniquely suited to the circumstances. Vocalizations and interesting breathing patterns can also come about. I see both in my practice. I think the system can work everything; in a sense it is customized, tailored for the need and the possibility of the moment.

I also see that there is a certain progression and the movement patterns change over time. I've seen this in my body, and also in my closest assistants and clients, that the patterns evolve in a certain way. Perhaps the areas that most need tissue differentiation or movement are called on first, and then another, and then another, and so on. I believe that you can pretty much always enhance your quality of movement. It's always possible to go further and develop another level of integration in movement.

AH: When clients get up off the table after receiving your work, there is often a process that needs to complete with movement. They are not done yet. It's not the person actively or consciously sensing into what's changed from the work, rather the body itself is still actively reorganizing, whether it's through swaying back and forth, or some spontaneous movement in a certain direction. It seems that it's vitally important in your work to allow adequate time for that to happen, because it may be quite a process. I remember one piece of work you did on me: when I stood, it was as if my feet were glued to the floor, and there was an imperative to stay exactly in that spot and let something happen. It took maybe ten minutes. I had to let my body experience swaying, little micromovements, all involuntary. It would have been wrong to stop the process and end the session because something was recalibrating that was very, very important. The embodiment piece is always important in Rolfing SI, for the client to stand and sense. With the deep autonomous responses that are triggered in Tensegrity Touch, it seems particularly important that there be time allowed for that and more.

LFB: Yeah. I like the way you described the experience as 'an imperative to stay', because this certainty, or rightness, is one of the features of the 'homeostatic drives'. When we are thirsty, there is no doubt about it, is there? As for the movement, I envision that the mechanoreceptors, embedded as they are in the body, are used to being in a certain mechanical environment that I guess is now changed from the manual input. Such a change in the mechanoreceptors' input will call for some sort of reset of the sensing system. It's very common, for instance, that when the client stands, he feels that his body is in a certain position, but it's not. The reading of the proprioceptors probably needs to reset and it's very important to give time for that. It's interesting, because the movements you witness in the person standing are, in a certain way, similar to the movements that we produce during the table work. In Tensegrity Touch, we put the body in a 'unstable balance', that's one of the concepts of the work that we haven't mentioned yet. You torque the tissue, and you put the system in a condition of instability, and this seems to be what we see with the person standing, for instance, the body may sway back and forth around a point of unstable balance. It's the center – of the whole system, and the centers of rotation, so to speak, of joints. This condition of instability will actually give the most powerful sense of both ground and axial extension reflexes.

I believe that stability is always dynamic; something that's still in a living body will never be stable, in a sense. Being still means that you already have a tendency. If you are in neutral, really in neutral, so that you can move in any direction at any given time, you should be unstable, in a sense. When we see those spontaneous movements, they seem to do exactly that – go to one side, go to the other side, past the center, and then back again, kind of swaying, and the center is in the middle. You see segmental organization of parts until you get the whole body working as a unit going, again, around a center.

AH: You have a strong background in medicine and research. Last year you went to the Fascial Research Summer School in Leipzig in Germany, right? Did you demonstrate your work there, and did you get any insights from other people's understanding or discussion of your work?

LFB: Absolutely. I remember one Rolfer noticed that, somehow, the tensegrity condition created with the touch was like grabbing the 'core', to use Rolfing jargon. It's like grabbing the core, the center, in a sense.

AH: That makes sense, because as you shear and shear and shear some more, you're taking out the slack between the layers, so eventually you do have this really strong grip on the core. Which means the work can penetrate to the core easily too.

LFB: Yes, absolutely. The practitioner may apparently anchor the touch in superficial structures yet clients often describe tissue moving in deep structures, it's very interesting!

In Leipzig I could further note how each modality views our nature from a certain perspective, each having its point of view; yet similar concepts are shared and, I believe, these shared concepts strengthen ways of describing our nature. For instance, some aspects of Tensegrity Touch can be seen in martial arts or in yoga or in craniosacral work, or whatever. I like that. Our nature is so complex, we cannot grasp everything so we're going to grasp parts of it. As different people in history see our nature from different perspectives, little by little this builds a more and more comprehensive view. I like talking to people who bring similar concepts, and this happened some in Leipzig. For example, I met an osteopath who does a kind of reflex work based on osteopathy, awesome work with some similarities to Tensegrity Touch as related to the spontaneous activity of the body.

AH: I'm curious about your practice. As a medical doctor, you can practice rather differently. You told me that you mostly work with patients with very, very complicated situations these days. Give us an example.

LFB: I most often get people with musculoskeletal conditions, often where doctors want to operate. With our work, many of them can, at least to a certain point, avoid surgery. I think that points to our capacity, really, to change and adapt the body. We can change much more than we are aware of. Healthcare, in general, is aimed at correcting what is wrong. In this urge to correct what is wrong, you may overrun nature and not give the time or a chance for the client's system to change.

I've seen how disruptive surgeries and traumas can be to the balance of the body, even surgeries done for aesthetic reasons, plastic surgery, can be very disruptive to the client's ability to move in general. I have many clients coming in where some kind of surgery has been indicated, and I would say that for a fairly big percentage of them, the work can help, at the least to postpone the surgery, but perhaps even making it unnecessary.

AH: Do you work with the Ten Series?

LFB: No. I use more this palpatory assessment and mostly go with that.

AH: How do you decide how many times you will see somebody, how to progress in the work with each client, and when you're done?

LFB: Normally, the development of the work goes mainly with the palpatory assessment – the blind tailor would like to feel the garments drape well, evenly. Also most clients come with complaints, and so the complaint is one indicator of progress. When determining if the client is getting better in regards to this certain complaint, I want to see him able to resume any physical activity he had to stop because of the complaint. And I want to ensure that he is well enough to go on alone, so in later stages of the work I may spread the sessions out further. When the client is moving, doing exercise, and the complaint is resolved enough, I discharge him.

At any given time, if the complaint comes back, or another complaint arises and doesn't resolve on its own, that's a concern. While it's normal to have pains and aches at times in life, it's a matter of concern if you have one complaint that gets worse or just is always there – this points to the inability of the system to move through it.

AH: I know there's not a set number, but typically how many times might you see a client on average?

LFB: No less than ten sessions. And I have some cases that need continuous attention, especially elderly people with really bad conditions and surgery histories. The adaptability of their systems is degraded so that the system cannot maintain itself.

AH: Your work also points to a type of maintenance that clients need to do themselves – they need to understand pandiculation and the importance of it, and also the importance of recognizing beneception. If they learn to listen to their bodies and allow movement that feels good, they're going to do a lot of their own maintenance.

LFB: Yes. I think this is a big part of it. In this kind of work, we need the support of nature; if the client is not there, things get more difficult. From the very beginning, I actually assign some things. Then clients themselves can feel, "I know it's time to go back and do this and this," because they feel they cannot, for instance, pandiculate as well as they would like to. It's interesting: some people come back not because they are worse off, but because they want to improve more, and they are already in a state better than what they left in. They kept improving.

AH: That makes sense if they're listening to their bodies more! Thank you so much for talking to us.

LFB: You're welcome, and I also thank you for the interest and opportunity!

Luiz Fernando Bertolucci, MD, is a biologist and physician, specialized in physiatry (rehabilitation medicine). A Rolfing practitioner since 1990, he has been teaching anatomy, kinesiology, physiology, and myofascial release to the Rolfing community and other health professionals. Tensegrity Touch has been taught in various countries and within different therapeutic settings.

Anne Hoff is a Certified Advanced Rolfer in Seattle, Washington and the Editor-in-Chief of this journal.

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Iconoclast: An Interview with Michael Maskornick about Rolfing® SI and Craniosacral Work

By Anne Hoff and Michael Maskornick, Certified Advanced Rolfers™

Note from Anne Hoff: This article came about for two reasons. One is that I've been particularly interested in biotensegrity lately, and how to bring that more explicitly into our work. I was intrigued by Michael's article on this topic in our December 2016 issue, his empirical approach and his curiosity with hands-on exploration and model-building. The second reason is that I had a bad fall this past summer, landing on my face, particularly impacting my right eye socket. In the weeks after the fall, my cranium felt mushed, its biotensegrity disrupted. Michael came to mind as someone who could help me resolve that. I had studied his approach to craniosacral work some years before, and in my trips to Bellingham to get some help with my injury, I decided to interview him on this topic.

Anne Hoff: Michael, over the years you've written a few articles for this Journal, and taught your approach to craniosacral work in and near Bellingham, Washington, where you live and practice, but otherwise you've kept a pretty low profile. Why don't we start with you saying a bit about yourself?

Michael Maskornick: Okay. In my mid-twenties, I got really interested in the human potential movement. I came from a really strong science background, the details of which aren't really important, but I got to a point where I no longer wanted to do what I was doing. I thought I was going to go and study as a gestalt therapist,

and around that time I got introduced to Rolfing® Structural Integration (SI).

AH: This was the 60s, 70s?

MM: This was probably in 1974. The first session I had was with somebody who was not a Rolfer but had hung around the Rolf Institute® and actually was training to be a Feldenkrais Method® practitioner. He was up in Amherst (Massachusetts) at the time, and so I had a session with him, and the first session was one of these *aha* moments, like, "My goodness. This is really important stuff." I had it set up for two sessions in two days. The second session wasn't anything special, but I'd already been sucked in. At that time, I was living down in New Orleans, and the nearest Rolfer was in Houston. We arranged to drive over to Houston and get a couple of sessions. We did that a couple of times, and at that point, it felt like, "I'll just keep getting sessions. These are really important for me."

AH: Important in what way?

MM: No clear way to talk about that. It touched me deeply. On some level, I was uptight and tense and sort of corporate and all of that, and I know that was getting worked with, but really, that wasn't it. It was like, somehow, it was allowing me to make some decisions on how to change my life.

AH: How did you become a Rolfer?

MM: When I was living in New Orleans, I became friends with a woman who had been a masseuse at Esalen, and thus started hanging out with a couple of people that would come through from Esalen. Once, it was the end of the workweek for both of us, and after the massage was over, we started talking. I said to the masseuse, "You know, I've been playing around with something. Let me have your hand." And she looked at me like, "What kind of weird shit's this?" but gave me her hand, and I started doing what I was doing, which was a lot closer to the way I work today than to anything I subsequently studied. I had her hand for about two minutes, and she said, "Would you please stop?" And I said, "Okay." She said, "No, no, no, no. I'm not criticizing. How did you do that? I've never had anybody get that deep into me in that quick a time. What did you do?" Anyway, that was the first affirmation I got that maybe there was some part of my mind that was already working in different patterns.

After a couple of years, I decided to quit my job and move to Boulder. I enrolled in the Boulder School of Massage and sent in my application to the Rolf Institute. By that time, I had had sessions with Leland Johnson, Jan Sultan, Peter Melchior. Those were the three primary people that I worked with, and I thought, "Boy, my ideal would be to have one training with Jan and one with Peter" – and it didn't work out that way. But I audited a class with Peter, and that really set the tone for feeling, "This is the place. I'm going to the right place." And I learned from more than formal training. Several conversations and interactions I had with both Jan and Peter (though of little significance at the time) seem to have stayed with me for many years and now appear twenty-five years later as seeds for the directions my thinking and work have taken in the present. So I'd like to add a sincere note of appreciation to both of them.

While I was at the Boulder School of Massage, I continued exploring and asking people, "You want to experience what I'm doing?" Some would come, and almost everybody who came got a little bit addicted to it. I wasn't charging. I was just, "Let me work with it," and all of them were saying, "What are you doing? Who taught you this?" Here are my ten little teachers [wiggles his fingers] – here I'm paraphrasing Peter Melchior, who said, "Your fingers are your teachers." He also said, "You're born a Rolfer: we get together to reinforce that we know what we're doing, in case we've forgotten."

AH: So you studied formally, massage and Rolfing SI, but you also found your own way of working. Tell us about getting into craniosacral work.

MM: I remember Jan Sultan wrote a little article about John Upledger's first book, saying, "You've got to read this." I got the book, and it felt like I already knew that stuff. I took a real basic workshop in the material. My hands already seemed to know what to do. So, I started working with craniosacral, even though this was a little bit arrogant, because the way I learned Upledger's stuff was sort of on the fringes, which certainly fit my iconoclasm. I started talking to people around town. I said, "Why don't you come hang out with me? I'll teach you a little bit of this stuff." I was just using their protocol, ten handholds or whatever, and it didn't feel very satisfying to me. I did that a couple of times, and then I decided that until I figured out what I was doing, I wasn't not going to teach again – which is true, and it took me probably another ten years.

AH: What wasn't satisfying about it?

MM: It was like a mechanical toy. "Do this. Do this. Do this. Do this. Do this." The one thing that I've heard many, many times about craniosacral trainings is that many students say, "I don't feel anything," and are told, "Just do it. It'll come to you." I didn't have that problem. I was feeling all sorts of things that went way beyond what they were talking about. I recognized that I could do this protocol – not that it was bad or wrong, I really have to say that, it's designed so that you can do this, do no harm, maybe do some good – but that's not near the edge, where I like to live.

AH: That makes me want to ask you, what is your relationship to the Ten Series in Rolfing SI? That is maybe a more intelligent protocol, but it still has the elements of a protocol.

MM: Well, I came out of the training realizing I wasn't taught how to be a Rolfer – I was given the tools to learn how to be a Rolfer, and the tools were this protocol. So probably for at least ten years I was a pretty straight arrow, by the numbers. I didn't mix and match, none of that stuff. And somewhere along the line, I started realizing, "There's more to this." I started thinking about, "What's the next step?" I started thinking about, "What's the source of the first session, or the fourth session, or the eight session?" And I started looking at bodies in terms of what's deficient in their structure.

AH: Give an example of what might be deficient.

MM: Somebody who is not very well grounded, looks like they're lifting off the ground, and thinking about that in terms of [sessions] two or four. Or people who are having problems, their breathing wasn't organized, and I thought about that in terms of how that might relate to [sessions] one, five, or six. I wrote that tensegrity article where I was talking about my journey around that time when I started thinking that the Rolfing Ten Series is really only one session that's broken down into these components. If you think of it this way, that opens up how you do the work. There are all these stories about Ida Rolf. Somebody would come in, and she was talking about the first session, and then she'd start working and do something completely

different. Everybody said, "Why did you do that?" And her answer was, "That's what he needed." That sort of triggered my thinking about all of that.

Talking about my development of cranial work, probably the most significant person I studied with was Alain Gehin, [a doctor of etiopathy in France], he did a 100-hour training in Seattle. He was introducing some of the anatomy and physiology, but when it came to doing the work, I wasn't learning much, even though Gehin was doing really complex manipulations. I'd see other students who at the end of the day weren't looking too good – remember as students we were using each other as models – and some of them would come over and say, "Can you help me?" I'd put my hands on them, do whatever I did, and they'd go away and they'd feel better. For me, it was easy, though the thought always was "Where do I get the hubris to be doing this kind of stuff?" It just came out of me.

AH: It sounds like there was a recognition that you knew something, even if you maybe couldn't articulate how you knew it, how you learned it.

MM: Well, my hands were talking to me all the time about how close I was to the edge, and was I going in the right direction. Even following a protocol, it was like, "Oh, yeah, don't push it that way."

AH: So you were able to read something very precisely.

MM: If you pay attention to how the body is talking to you, the chances of you getting in trouble are reduced by orders of magnitude. I had already gotten to a point where I trusted, and I still do: I trust my hands. I read a lot of stuff about different forms of cranial work, and there's a chiropractor who has an incredibly complex protocol, each finger doing something to the head with five levels of differentiation – that guarantees that you're going to be totally confused, because it's all intellectual, coming from ideas of here's how the bone is, here's how the bevels are, here's how the sutures are . . . So if you're working around the mastoid suture, you got to press this way and turn this way and hold this way.

Reading ideas like that, I get into an internal turmoil about, "There's got to be another way to teach this stuff." I was still teaching protocol, but I started saying, "Okay, we're in class now. Suspend your disbelief. I'm going to tell you that there's a subtle thing that you can feel there, but I'm *not* going to tell you *what* it is." That's the first rule. I'm not going to tell you what to feel. That developed into, "I want you to tell me what you feel," and students usually would come back and say, "What do you want me to feel?" I thought it would be an easy way to teach – what a mistake that was – but over the time that I was teaching, I got a catalog of language about what people felt through their hands. They never felt sutures moving or the bones moving. It would feel like, "Oh, there's a pulsation going on there or a fluttering going on there."

I broke down the different things that people were talking about into categories like rhythmic movements (tides, waves); smooth movements; abrupt movements (like a snap or a jump or a pulsation, a single pulse); strong movements (like where your hands are being pushed away, or the bottom would fall out of something) . . . And again, this started me on the path of, "Notice the language people use when they're challenged." And people would say, "I can feel something, but I don't know how to talk about it." I said, "Okay. This is your challenge: find some words that you can reproducibly say, 'That's pretty much what I felt.'" And you start gaining a repertoire of language.

I had people reading Upledger's book, so they knew sort of what was 'supposed' to be going on, this idea of a smooth wave this way and a smooth wave that way, but nobody was feeling that and it was a great relief to them to know that they weren't wrong. So they would describe movements like chattering or saw-like movements, and then things like whooshes . . . And by the time people had run out of things to say, they would say, "You know, every once in a while, I didn't realize I was feeling something until it stopped, and the cessation was almost immediate, and it was like silence." And they realized that was important too. This is where I started realizing, "Okay, we're developing a language which is really pretty different than is in Upledger's book or in Magoun's book, but that sounds a lot like a still point."

AH: You were teaching people to listen and to develop trust in what they were feeling.

MM: And I wasn't telling them which were important. They're all important. By the time I had done this a lot, I started using the language of, "Okay, go in and feel what's there. Once you can reliably say, 'I know what I just felt,' give yourself permission to put that aside and ask the question, 'And what else is there?' And turn that into a mantra. 'And what else is there? And what else is there?'" Then it gets to the point where I basically would say, "Among the thousands of things that are there to feel, what's the one that's most in the foreground?" That gives a totally different perspective on what you're looking for. It's like there's this congregation of information that's there, and you're making a choice, which is really different than saying, "You're going to feel a restriction."

AH: I first got interested in your approach to cranial work years ago from the way your class descriptions talked about feeling the whole of the cranium. So I want to bring in tensegrity, biotensegrity, which is the last topic you wrote about for this journal (Maskornick 2016).

MM: If you think you're working with bones, you're limiting yourself to the surface of a sphere. For a while, I used those big long sausage balloons, a student with closed eyes feeling one end and another student on the other end making very minute movements. I thought that would really sensitize people, but what we're feeling in the cranium is so much more subtle than that. But at least it gave the idea that you can feel things that relate to the volume changes and perhaps tissue changes.

AH: But it sounds like you were figuring out something about how you worked and how to get people to the same place.

MM: Right. That's what I introduced at the beginning of any teaching, that what I was teaching was intended to save them five to ten years of learning in their practice. Part of the training was to have students notice when their 'practitioner' was really present and when he faded away, when he was active and when just present. By mentioning it and giving them that direction, they could feel the difference. I remember one person said, "I only work with my hands out in the aura," but when other students gave her feedback, they said, "It doesn't feel like there's anyone there." She was freaking out, concerned she was going to disrupt her model's energy field. I told her that saying that when the person was asking her to do more was diminishing them, taking away the person's authority over his body. She really got that, so she was willing to try, to go way beyond her

previous boundaries, and people were saying, "You know, that feels good when you do that." Likewise, when people would try to work on her, she was initially afraid it would be overwhelming, but before the workshop was over, she let people work on her a little more, and she wasn't freaking out.

One of the things I got from Gehin, which was really great, he said that in the world of physical manipulation, there's a range. On one end, you've got the hard bone-crunchers and people who bruise everything, and it's easy to say they're bad, but they're not. If they're really good at what they do, that's the way they do it. On the other end, there are people who are energetic healers that can work across the country and across the room, and if they're good, they affect things. The trick is to find where you sit on that continuum and get really good at it. That was another part of my development, learning the boundaries. A lot of people say I work in an energetic realm. I don't perceive myself as doing that, but I know I don't want to work on the other end either. I'm somewhere in there, but not on either extreme, and that's what I wanted to start teaching, providing a safe environment to explore that range.

In my teaching, the first level of contact is what I call *listening* – you're touching, but you're not trying to influence the system. You're trying to just get what's there. That's an easy one, but it's hard to feel what's going on, because your contact is lessened. Next is *interaction* as you start making more contact – when you feel something coming to you, you don't try to influence it, but you allow yourself to go with it. It's a little bit like surfing; you're not affecting the waves, but you're not resisting them either, and that's more contact. The third is *directive* – where at some point, you're saying, "I think I want to explore a little bit more about something that just happened, so I'm either going to re-target or advance it by using my hands." My hands are always moving a little bit, so I'm always in what I call it 'the dance'. It's like 'push hands' in tai chi. I'm always in the dance, and occasionally, the dance means that I'm going to lead. There's a lot of levels of direction: if you continue to push where the system says no, it's going to feel bad; good directive influence is when the system gets that you're not letting it just flap around. You're holding it a little bit. You're directing it a little bit, and it still feels good. This allows you to avoid red herrings – where it feels like something really is happening, but if you wait for twenty minutes, you find you're right back where you started. When you start directing things, maybe you go through a couple of red herrings or cycles, but then you say, "We've been here. I don't want to go there again. Is there a place where I can begin some direction that will get this more into a healing phase?"

The next level, which I never really teach anybody, is what I call *the challenge*, and that is where you come to the end of the direction and you say, "Everything inside me says we have to go beyond this boundary," and you start really making tissue move, and all sorts of things move. That again has lots of different levels all the way up to what I call *the far end of the spectrum*, and I never go there, but I do go into that challenging phase occasionally.

AH: It sounds like when you do that, there's a very clear knowing of the appropriateness of doing it – you recognize something.

MM: The metaphor that I used teaching was being in a ballroom. In the interactive phase, you're dancing, one of you is leading, but it's basically you're having a good time, nothing particular is going on. The directive phase is you want to talk to somebody over on the other end of the room, and you start directing the dance, and in two or three minutes, you're over there, where you wouldn't have been otherwise. In other words, your intention gets drawn, and you go there. The challenge phase would be telling your partner, "We're going over there," and you start going over there. The really strong challenge phase would be you pick your partner up and walk them to the other side of the room, but you don't hurt them. You're still respecting them, and you're trying to get them somewhere.

AH: This is quite a learning curve for students.

MM: All of this gets really far away from a protocol. It's about a process. So I had to start teaching a different way of thinking about the skull, the bones, the tissues. Being an iconoclast, I never believed that the cerebrospinal fluid is the driver in the craniosacral system. Chaitow has a description of how little fluid is involved; I never bought the idea of the closed hydraulic system of the skull. I'm more intrigued by Traube-Hering-Mayer waves. It's not the cerebrospinal fluid – it's the cardiovascular system that we're paying attention to. Compared to the small amount of change in cerebrospinal fluid, this tidal wave of blood is going through the brain, the brain is not a closed system. It's got this river going through it called the cardiovascular system, and any changes that are going on with that are magnified. It also helps explain why you can feel the cranial rhythmic impulse in other parts of the body. I never got to a place where cerebrospinal fluid made any sense about that. Cardiovascular made more sense. This guy Botte used very sophisticated math on heart-rate variability called Fourier transforms, Fourier analysis. When he did that, looking at heart-rate variability, you can pull out all of the cranial rhythms, the long tide, the mid tide, the normal one. This expansion and contraction of the cardiovascular system is happening in the skull, putting pressure on the ventricles that cause the cerebrospinal fluid to flow out of the skull and down the dura and back again. It's a better driver.

Since I'm already in iconoclast mode, let's talk about lesions, because a lot of cranial work is about lesions and it's always said lesions are a limitation of the sutures. I realized, yes, the sutures are vital, as is their movement, but the bones are softer than we are taught. Spinal models make you think that's what a bone's like, hard, but it's not. If you put your hands on something and you feel hardness, it means the whole system is compressed.

There's the idea of *vectors*, that something goes through the skull, but it doesn't involve a suture necessarily. It goes wherever it goes. The lesion may be in a part of the bone, and because of the movement of the skull the stuckness migrates to the nearest suture. You can go after the sutures, or you can try and find where the entry point was of the injury and work there. When I feel softening, I know I've released the system and started getting some space in there. So my preference these days is to find the primary source of it and notice how the sutures then start *responding*. Our language informs how our hands work. If we talk about 'vectors', our hands start thinking about arrows. If we start talking about entry areas and how impact migrates, that's a different story altogether.

So this was the third big iconoclastic thing for me, and from it I allowed my hands to go where they're comfortable. Placement has a function, but you can start teaching your fingers to be intelligent and to pay

attention to small movements. You start by just putting your hands where they're comfortable and noticing what you feel. So rather than a preconceived idea of what is supposed to be going on, one of the metaphors I use is to imagine you're in a roomful of friends – they're all your friends, but you recognize different personalities. Now, here you've got eight major bones and imagine that they have personalities. How would you describe them? Which ones move easier? Which ones feel more friendly in your hands? Which ones seem to be resistant?" After a while, you start understanding, "Oh, I've touched enough frontal bones. That's what frontal bones feel like." The elements that you're feeling are shape, density, fluidity, resilience, and responsiveness, and those are going to be different for each of the bones.

AH: Yeah. How much are you on individual bones, and how much are you taking in the cranium as a whole?

MM: I think I'm always taking in the cranium as a whole, but you've got to get to know what these bones feel like and how they talk to you, so that when something feels really stuck when you're dealing with the skull as a whole, you can place your hands on a particular bone knowing you might get a little more reaction or a little more movement or a little more change. You'll know what they feel like, how they react.

AH: You said to me earlier, before we were recording, that there's a wave response. Even if an injury comes as a vector, when it meets the cranium – or any part of the body – the response is not going to be like an arrow, but more like an ocean wave.

MM: If we think about the skull as a three-dimensional, semi-spherical thing, you've got shape; you've got density as you go through the bone, different densities depending on whether it's a thin bone or air-pocketed bones; then further inside the cranium you can start to feel how there are again different densities, or more to the point, different resilience and responsiveness in the dura and other surfaces. Then you've got the brain itself, medulla, cerebrum, cerebellum, brain stem, and you've got the ventricles wherein cerebrospinal fluid is generated. The density changes as you go to these different things. If you think about the skull as the earth, with a fluid core that the crust lives on, you can get a sense of what we're talking about here. Because people get locked into what the sutures look like, I started talking about 'domains'. Each of the bones has a domain. In the middle of the bone, it doesn't move very much, because it's all locked into the bony matrix, but as you get toward a neighbor, you have a relationship between two different domains. Notice how your hands think of that differently than if I say, "There are the sutures" and you pull up a mental picture. It allows you to be far more expansive. You can put your hands almost anywhere on the head and start feeling how it moves or doesn't move, this three-dimensional sphere that is full of different densities and different fluidities. Your hands go toward more fluidity, more space, they never want to make it tighter or more dense. Just the nature of that exploration often creates more expansiveness.

AH: What I'm hearing is that your hands have to encompass these different domains, internal environments, and the relating between the domains. You've got different densities at each layer and multiple layers, and you're forming a relationship to the whole of it.

MM: Absolutely.

AH: And feeling the shape of the whole of it, the resiliency, the mobility, and where there's things that are not consistent with what you feel would be the integrity of it.

MM: And the language you use really affects your hands. I keep emphasizing that, and letting the somatic experience of your fingers teach you what's going on. To get an idea what things look like, have good anatomy books and a skull (both complete and disarticulated). You need that. Textbooks, references, and models are valuable for consulting, but always ask your hands what their perception of the tissue tells you. The work depends on really getting sensitive with your palpation.

AH: It seems like you had that from the get-go. Were there things that helped you develop that?

MM: One of the things that really interested me was neurolinguistic programming, which Bandler and Grinder modeled on Ericksonian hypnosis, or indirect hypnosis. He wrote a foreword to one of the books, said they were good modelers, but then at the end of it he said something like, "But don't confuse what they're saying with what I'm doing." Ernest Rossi, who was a student of Erickson and wrote a book about him, noted that Erickson had polio as a kid and was disabled by it. He thought that Erickson's experience recovering from this disease taught him how to bypass the intellect and talk to the unconscious parts of our being. In my work, I talk to the client's body. I talk to the client too, and use her ears as a translator so that her body can cooperate, but I pay attention primarily to how her body answers. I've had that right from the get-go.

AH: So that's typical in the session – that you're talking – but you're really talking to see how the body responds to what you're saying, more than the person answering.

MM: Right. A lot of sessions have sort of a stream-of-consciousness element. I notice that when something important starts coming up, the person shuts up, I shut up, we go into it. Something happens. Then we come back, and we sort of continue our conversation. So it's not that we're chattering away and just wasting time. It's like we're keeping our conscious minds out of the picture so that this unconscious stuff happens, and when it gets important enough it sounds a klaxon and says, "Okay, idiots. Now pay attention for a while."

AH: I think it's probably good to bring in what you framed at the beginning of the first session you did for me. You are working with a direct trust of your palpatory skills, but you've set a framework in the beginning for the client to tell you if anything doesn't feel right.

MM: Rule number one for the client is, "You're in charge. The only reason you're here is your well-being. You know more about that than I ever will, no matter how good my intentions or intuitions are." And then, the rest of it goes with what you say. If it ever starts feeling like we're going off-track or too fast or anything, say, "Let's hold it. Time out." The other thing I often say is, "If you ever say 'Stop', I will not say, 'Let me finish what I'm doing.' We will stop." That's about edges. Work like this is really creative the closer we get to the edge, but if we go beyond the edge, you're not going to let me go near an edge again.

AH: Also during the session you were continuing that trust-building. You said things like, "Okay, I feel it. We're almost there. Here it is." So besides my body sense that things were going well, I could note, "He's tracking what he's doing, because he's telling me what he's tracking, and therefore . . ."

MM: And that's like biofeedback. You're feeling something, maybe feeling a multitude of things, and you're saying, "Oh, of all the things I'm feeling, he's tracking this piece." I've had people say, "How do you know that? You can feel that?" Because they didn't think anybody could feel stuff like that.

AH: I think that's quite interesting, because often with cranial work, we expect silence. That probably works really well for some people, but I see that your way brings a different element into the process.

MM: It's the collaboration of our nervous systems.

AH: I wonder if that was part of what allowed such a phenomenal amount of change to happen during that session.

MM: Well, part of it is that I'm always testing to see what your system is doing. The client's system is going to put a couple of tests for me. I don't always pass the tests, but if I'm pretty good at it, your system says, "Well, yeah, that's worth another try." And after a couple more, it's like, "Oh, we are working together." And after people have come for a couple of sessions, they start trusting me more than I ask them to, and I sometimes will challenge them. "Remember, you're in charge. Don't give up your authority. I want us to meet as equals."

AH: Thank you, Michael, for sharing some of your story with us.

Michael Maskornick is a Certified Advanced Rolfer who lives and works in Bellingham, Washington. He spent eight years studying chemistry, and eight more years in the chemical industry, before realizing it wasn't right for him. He trained in Rolfing SI during the last year of Ida Rolf's life and never had the opportunity to meet her. Since then he has been living in this wet corner of the US using his skills to help his clients cope with this grey, depressing climate.

Anne Hoff is a Certified Advanced Rolfer in Seattle, Washington and the Editor-in-Chief of this journal.

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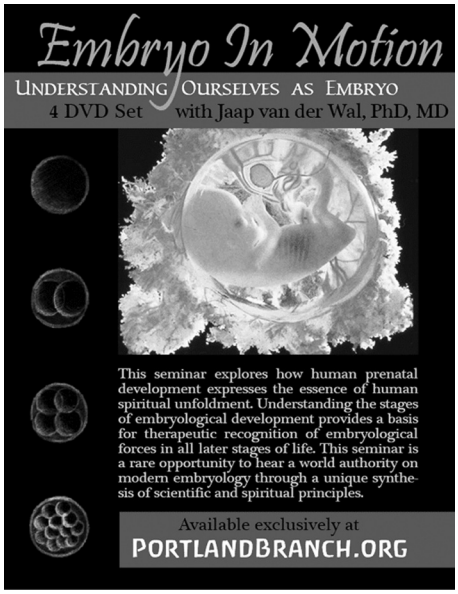
Maskornick, M. 2016 Dec. "Musings on Tensegrity and Biotensegrity." *Structural Integration: The Journal of the Rolf Institute®* 44(2);16-18.

Review

Embryo in Motion: Understanding Ourselves as Embryo (DVD seminar) by Jaap van der Wal MD (The Portland Branch of the Anthroposophical Society of America, 2010)

Reviewed by Lina Hack, BSc, BA, Certified Advanced Rolfer™, Somatic Experiencing® Practitioner

If you are like me, you have bought an embryology textbook or two in order to inform your Rolfing® Structural Integration (SI) practice. What I found in such books was pathology, images of distorted development accentuating the grotesque. Finally, my questions about embryology and the early development human form have been answered by Dr. Van der Wal in his four-DVD presentation *Embryo in Motion: Understanding Ourselves As Embryo*. This recording of a 2010 seminar is sold by the Portland Branch of the Anthroposophical Society of America (www.portlandanthroposophy.org/shop/embryo-in-motion). In it, Van der Wal gives a rich phenomenological description of human development, focusing on the structures of form. The embryological organization patterns described by Van der Wal complement the Rolfing model of seeing adult human form, and I highly recommend adding this DVD set to your library, allowing his embryological view to inform your Rolfing practice.



In the DVDs, Van der Wal describes embryology from the phenomenological perspective, a philosophical mode of study where the researcher imagines himself as the concept under investigation. Imagine life from the perspective of the embryo. His whole narrative is a profound first-person description of what an embryo experiences from being a single cell to being a human taking in air for the first time. This perspective is a distinct complement to our Rolfing seeing model: we too work to experience the form of our clients by 'trying on' their structure. This informs us about restrictions, tension patterns, and lines of gravitational forces that are unique to each of those individuals. Van der Wal speaks to this perspective; imagine being the single spherical ovum cell doing a mating dance with many sperm suitors, this is how all of us started.

Van der Wal starts his lecture with orienting the participants to their own bias of experience, the duality of experience that human consciousness affords us. This duality of consciousness is that we live in a body to experience the world, yet we set our awareness of body aside to attend to the world. Our consciousness brings the world into awareness, and when it does this our awareness of our own body fades into the background. He is describing how most people put more attention to what is happening to them externally; the body becomes absent from their awareness in order to notice the world. To challenge this he asks each person to feel his or her brain inside the head while doing all this outward observation. This is where he wants the participants to be: trust sensation, be aware of personal form, and let this place give information about humanity.

Phenomenology, according to Van der Wal, is asking questions about the world and carrying the questions with us, every day, for years. (Sounds like the Rolfing model, we carry Rolfing philosophy within ourselves as Rolfers and it informs

all our days.) This is what he has done with embryology; he has lived the story of the embryo as a physician, as researcher, and now can tell us first-hand the most important knowledge: development is behavior. Growth is movement. Cellular differentiation is a dance. And we are all embryos in motion.

There are so many profound moments in these lectures, I couldn't name them all, but let me give a few highlights. Van der Wal draws from Rumi to describe how the phenomenon of the embryo contains all forms of life: minerality, vegetativeness, and all forms of animality on our journey to humanity. He is not shy to relate the death and birth cycles to processes within the life of the embryo, that gestation holds these changes that the adult experiences throughout the life cycle. He correlates throughout the seminar the soul's journey from conception to the journey we are all on now, that it is all the same and we can better understand our current experience when we live the knowledge of the embryo. Van der Wal paints a picture that our human form is clothing for the soul that started in the womb.

The best part of the DVD seminar is his narrative about the embryological organization of the human form. First property of human existence: we develop a center and a periphery. After dozens of cell divisions post-fertilization, the human organism has a spherical shape where there is a center separated from the world and held away by its periphery. Sound familiar? Seeing the whole person in Rolfing SI starts here too, foundationally we are observing where the client organizes around as center and how his or her periphery is informed by the center. This is the first embryological spatial arrangement of human beings.

The next differentiation of form according to Van der Wal is ventral and dorsal. The ball of embryonic cells implants into the womb, the ball is fluid filled with one yolk sac and one amniotic sac, and diving the two is the embryonic disk: the center. The embryonic disk comprises the omnipotent stem cells that will become the body of the person. This early in development there are only two layers of embryonic cells, the ectoderm and the endoderm. "We have no middle!" Jaap passionately proclaims on disk three. We experience a front and a back, the endoderm and ectoderm respectively, before we develop middle. Lateral-line SI work happens before core work – did Dr. Rolf intuitively feel this early front/back differentiation?

Van der Wal gives another beautiful description of how the embryo nestles into the uterine wall dorsally: we back into our mothers. Nutrient exchange, the connection between mother and child, migrates from a dorsal position and pauses at the tail of the little animal. Otherwise called caudal, root, base, the pelvis. He lingers on this point, taking the time to give the audience the phenomenological point of view of experiencing nutrition, warmth, and mother from below. Base of support, as Dr. Rolf described.

By definition, once the human embryo has a bottom, it now has a top, the ectoderm/endoderm sandwich develops a cranial territory and a caudal territory. From here comes the midline. Like a zipper up the ectoderm, an involution of cells migrates caudal to cranial, transforming into the cells of the spine and central nervous system. This differentiating nervous-system line becomes our vertical line, delineating left body from right body. When we compare the Rolfing model and Van der Wal's Embryo in Motion model, it is like two line drawings being put one on top of the other, and them lining up to show unique details of the same complex picture.

Van der Wal has many moments throughout the seminar where he speaks about the mesoderm development, fascial development, and the impulse of human to upright orientation. The mesoderm cells early in gestation will give rise to the middle tissues of the embryo: the blood, the skeleton, the vascular system, the muscles, and the fascia. The fascia, he says, is so much more than tissue that connects. He focuses on how embryologically fascia shapes space. Fascia makes pockets of distinct tissue early in life. He describes how the sheets and fabric of fascia construct the shapes essential for the functions of life. These fluid-filled tensegrity structures that make organized microscopic spaces hold spherical shapes, tube shapes, and vortex shapes, and follow fluid dynamics. Of course as Rolfers we already have a sense of that, he is speaking our language.

These notes are only the tip of the iceberg for what Van der Wal describes in his eleven hours of embryological training in the phenomenological point of view. The embryo is in motion, cellular development is growth and it is also behavior. Cellular growth as a movement is a profound notion that we feel in our hands every day. Before listening to these DVDs, my concept of movement was an arm making a gesture, where the cells are static and simply moving through space. Now I see that every part of the human form is making a gesture by pulsing, breathing, and being, that life is a gesture of the soul. Van der Wal offers a refinement to our Rolfing model where the adult experience is informed by the phenomenon of the embryo. Add this DVD seminar to your core knowledge and your seeing of Rolfing patterns will forever be informed by the motion of the embryo.

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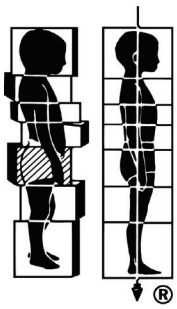

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