

# Radial Decompression: Its Origin and Use

## *An Interview with Jan Sultan*

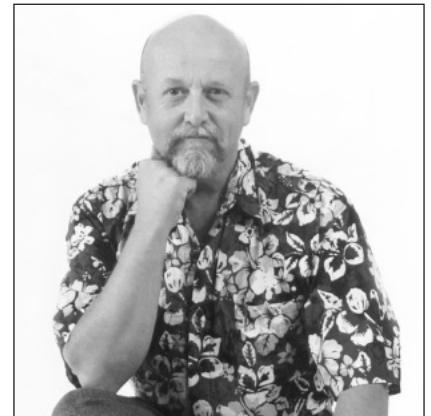
**By Valerie Berg, Certified Advanced Rolfer™**

*In teaching my recent Unit III class, a student asked me to explain radial decompression and axial decompression. I gave my answer and then decided to go the source for the best answer possible. Jan Sultan, in his constant interest and devotion to developing our work, created this session and its name many years ago. The following is my interview with him about radial decompression and its development. I hope you will appreciate, as I did, his ongoing passion to explore and develop the dimension and depth of our work.*

**Valerie Berg:** What is radial decompression and how did you come to create it?

**Jan Sultan:** Radial decompression originally came as an attempt to solve the “pre-Eight” question – is this an upper or lower session? In practice, I’d come to make the simple choice to work the girdle that looked the least organized. Dr Rolf had several criteria that she put forward for this. If you work on the lower girdle, will it transmit to the upper, and conversely, will it transmit to the lower if you work on the upper? We would test this by working on the [iliac] crest awhile and see which way the integration would flow. If it flowed up, you would work down, and if it flowed down, you would work up. At one point she said, “if you pick the wrong one, the person will disintegrate.” We had a good laugh about that, but what she really meant was they would be less integrated.

When I was practicing in my studio, it was fine to pick a girdle and make my call, but when I was teaching, it was a difficult thing to describe. It was the first time in the “Recipe-driven” early sessions that the practitioner had to make a decision based on the pattern of the client. The practitioner had to make a choice, a commitment to a strategy, and then observe what happened. When doing the Recipe, you do the session and hope that [the client shows] the hallmark of that session. When you are confronted with a classic “pre-Eight” client, you have to evaluate what you think will work best, and then have the nerve to self-evaluate and see what the client



got. Years ago, I was preparing to teach a CE workshop with Jeff Maitland on the Eight, Nine, Ten session closure, [and] I was reflecting on how best to go deeper with this moment. What were the possible approaches? I wondered what it would look like to do both girdles in the event that both looked equally disorganized, and therefore I didn’t want to choose between them. Still, to do both girdles thoroughly would be too much information for the person to absorb in a single session.

**VB:** So it came from seeing the need for both girdles to receive work?

**JS:** Yes, a few months before the workshop I was looking at a “pre-Eight” client and I thought that from the knee down they [sic] looked tightly wrapped around the fibula and, simultaneously, the arms couldn’t extend normally. I thought that this was an opportunity to stretch my tactics so I decided to do the extremities – knees

down to the plantar fascia, elbows down to palmar fascia, and a little neck and sacrum work. My thinking was that the client could tolerate working both girdles if I limited the approach to the distal extremities. The person came back next time and [was] highly disorganized, with all kinds of asymmetry showing in the trunk and pelvis. On reflection I realized that the intervention had decompensated the underlying spinal pattern.

So much of the functional patterning of the body is about eye-hand, eye-foot coordination that determines how we move through the world. I theorized that this approach (of working on the extremities) had released some of that “eye-brain” coupling and manifested as allowing the deeper rotations in the spine to surface. I then worked to organize the midline. In those days I had only basic spinal biomechanics, so I freed the spine motion restrictions, and then put the Line in as best I could.

As I practiced this approach with more clients, I came to realize it was a reasonable and reliable approach to certain structural patterns. For this approach, it was imperative to work at the occiput and lumbosacral area first, so that when you did the radial decompression, the release could be accommodated, allowing the reciprocal spinal unwinding to cascade out to the (now open) extremities. It was a profound moment for me to realize that this was a workable strategy.

**VB:** Did this come from cumulative observations in your work from the past?

**JS:** I had been observing for years that when you work on the interosseous membrane in the forearm, there would be a corresponding volumetric change in the thorax. Lower-leg work would correspondingly affect the intra-pelvic volume. When both distal arm and leg were done together, the rib cage and pelvis would shift accordingly.

**VB:** Just working on the interosseous membrane?

**JS:** Yes – working flexors and extensors and hands, not purely but including the interosseous membrane. This would reliably create volume in the thorax. I am always looking for predictable technology: if you do this, the body will do that. It’s how the self-teaching cycle is applied, and I watched to see if that was true. If I worked on lower legs,

I would watch what happened to intra-pelvic volume. It is not as easy to see inside pelvic volume as it is thoracic, but with empirical observation, I came to see that you could effect volume changes in the core by working on the extremities.

**VB:** So do you always open the spine first, meaning the occiput and the lumbosacral area?

**JS:** The radial idea is the six distal points – extremities, the sacrum, and the crown – as represented in Leonardo Da Vinci’s Vitruvian Man in the circle. If you open extremities and don’t prep the occiput and upper cervicals, sacrum and environs for new information, you risk releasing part of the perimeter and leaving the spinal rotations with little or no adaptive capacity on the vertical axis. A curvature has stored energy. It’s not static. It behaves as if it is compressed and coiled. To get the radial decompression to work, one has to prepare through the occiput and sacrum. You have to go through the occiput because this is where the vestibular system is consolidated, and where hand-eye and foot-eye coordination is organized. Imagine you’re walking down a trail and fifty feet out you see a root protruding. You change your pace without thinking, and when you get to the root, your gait is just right to step over it. Backcountry runners know this well. Hubert Godard has worked with this for years, and developed a comprehensive approach to include this functional patterning in the work. If you want integration, change the coupling where hand-eye and foot-eye link. That is the hypothalamus, vestibular function, and brain stem coupling directly to the extremities.

**VB:** So every time we work on hands and arms we have to open up the axial system?

**JS:** Almost without exception, to the extent that I don’t do any interventions, Recipe work, radial decompression or otherwise without starting with the neck. Often, I do both sacrum and pelvic work before I start a session. People integrate and come into the present much better. That, however, is palliative, not technical. For deeper effects, you intend to destabilize patterns in the neck and sacrum before adding new information, so that new information isn’t going up against stable patterning.

**VB:** What about scoliosis? How did you see radial decompression relate to that?

**JS:** As Rolfers, we see a lot of adults and young adults who have curvatures or

scoliosis. I have a class handout for training on curvature patterns in the extremities. You might wonder how, in a structured Recipe approach, do you go after this? One needs to establish deeper mobility first, to have something to work with. There is no specific Recipe place to get that. Typically, the more profound access to the spinal pattern happens in the last three sessions of the series, because of the availability of adaptation at the sacrum and occiput from sessions six and seven.

As these ideas developed, it became apparent that it must be a prerequisite, or rule, to create space in the periphery before going after spinal curves, because the limbs are adapted to the spinal pattern. It doesn’t sound like rocket science but it took me fifteen years to figure it out. If it is appropriate to put in a radial decompression session earlier in the series, do the One to Four or Five sessions, then do radial decompression, and then do Six, Seven, and so on. Using this approach I found more predictable releases in spinal patterns and that people were integrating better.

**VB:** When do you use radial decompression?

**JS:** Let me say when you *don’t* use it. Underline this. Don’t use it as a closure strategy *ever!* This should be obvious, because you are destabilizing deep hardwired brain-stem linkage. Once a Rolfing® colleague did a series on my daughter and used radial decompression as a closure to the series. The kid was “disintegrated” and generally disorganized. I talked with the practitioner, and as it turned out, she had used radial decompression as closure. This event first illustrated strongly to me that it was not the place to use it.

**VB:** When don’t you use it?

**JS:** Typically not as an opening strategy [on a person who has never received Rolfing]. You need to prepare before this level is available.

**VB:** What do you mean by *this* level?

**JS:** This is a high-impact intervention. You might do this on someone who has had a lot of Rolfing, or someone who is very sophisticated in his or her body awareness, or someone whom you think can accommodate it. Radial decompression is a way to open the system, and you can do this with a lot of vigor or in a restrained way. It’s not a case of either go full on or don’t do it at all. Say someone is coming in with spinal, postural problems, exhalation-

fixed rib cage, shoulders up to the ears, or legs jammed up. How can I get room in this person? I can't go straight to the rib cage with nowhere to discharge. This would be a good preliminary session for someone quite restricted. It would also be better with an ecto-meso than an endo or endo-meso [type of structure].

**VB:** Why?

**JS:** I am not always sure why. When clients are wound tight and posturally disorganized, the opening of the perimeter can be profound because the tension is in the neuromuscular, neurofascial system. The endomorph constitution has deep tension in the visceral/core space, so this approach might not work for someone with a softer body in general. It works great for a hard body, mountain climbers and rock jocks, or for people who actually work for a living. It's a strategy for them to get room and be able to reach farther. Obsessive runners who carry their arms bent, and pump with their legs also benefit from this. It opens their stride and creates space for the spine to move with less inhibition. Fundamentally, it is not about the extremities, but they are "handles" to get into the volumetric space of the core or for creating adaptability for the derotation of spinal patterns. Precautionary notes? Don't do it as closure, be cautious in opening with radial decompression, and definitely don't open with radial decompression in a soft body.

### The Interosseous Membrane

**VB:** So what is the magic of the interosseous membrane in radial decompression?

**JS:** The interosseous membrane is loaded with receptors that tell us how the limb is oriented in space and also informs the brain stem from where the limb is organized. You can do a radial decompression and a little superficial work to test the water with a client, but to make it really work you have to go along the bony edges. That's where the periosteum and the interosseous membrane are sharing fibers. Doing radial decompression would look like a lot of deep, very slow-moving scraping and cleaning along the bony edges of the medial tibia, lateral tibia, and the front and back of the fibula – all being "gates" to the interosseous membrane of the lower leg. It is not doing all the muscles and fascial tissue. It's meticulous, specific, and not general. It is not radial decompression if the forearm or lower leg is all red and you have not

gotten the interosseous membrane. Simply, if you skip the interosseous membrane, it's a different story. Robert Schleip's work highlights the distribution of receptor fibers in the deep fascia and septa, and this is partly why radial decompression works.

**VB:** Hands and feet are left out?

**JS:** No, they are not. I include palmar and plantar fascia.

**VB:** What are the common responses to radial decompression?

**JS:** Expect less visible order afterwards and a felt sense of being somewhat undone. The developing order during the series, with its hierarchical, systematic approach, will be temporarily lost for the client, but radial decompression provides the opportunity to go further and you have to expect the chaos response along the way.

**VB:** Is this a transitory state?

**JS:** If you do radial decompression and decompensate the stable pattern of hand-eye and foot-eye, you have to do integrative work to put a pattern in that a person can use. Obviously, if you did radial decompression and never saw the client again, [he] would eventually stabilize. One of the rationales for doing extremity work exclusively lies in the way it reveals how the limbs are placed into space in relation to the spine. This relationship is one of the ways we know where we are proprioceptively. This describes a very intricate feedback system that is neural, fascial, and musculoskeletal. Its effect may also be (perhaps) related to the meridian theory. One time I was teaching this in an advanced class in the '90s. Michael Reams took me aside and told me that acupuncture meridians are at the surface on the extremities and it is at the elbow and knee that they dive and go to the organs. I checked this out with a doctor of oriental medicine and it's accurate. This is a very interesting idea. In order to get to the interosseous membrane in the extremities, you have to go through the surface, so it occurred to me that maybe what was happening was an information barrage that was released by doing extremity work that informed the whole energetic system in the traditional Chinese medicine paradigm. This is exemplified in the microcosmic orbit. The apparent opening of vitality in people might have something to do with the set of reflexes set along the meridian lines.

**VB:** How many times might you do this in one series? How often do you do this with one client?

**JS:** Here is one example: This is *the* strategy for working on pregnant women because they are experiencing this giant change in their center and the extremities are reflecting the non-pregnant pattern. You stay off endangered sites and do systematic reserved radial decompression and then they can accommodate better. I do it many times in the course of the pregnancy, like monthly, and clients feel they can contain the child better. It's great for them. Again, you do the occiput, sacrum, and extremities.

**VB:** Has there been further development from this work?

**JS:** After playing with this for awhile (years), I looked at someone who was not really a radial decompression presentation and instead looked at the shoulder and hip joints. What if I made the circle smaller? What if I did the occiput, sacrum, and big joints. What if I did that? Oh boy! Another area to explore. It was the elements of Ida's third hour, but not really, in that you don't drive for the lateral line.

**VB:** Why did you see this? What made you ambiguous about using radial decompression to get adaptive mobility in the spine?

**JS:** Well, ambiguous is not quite it; I was cautious, and systematic. I confined my intervention to the rotator-cuff structure in the shoulder and the gluteus minimus/medius/TFL and rotator attachments on the greater trochanter. I was not following the muscles but stayed right where the tendonous insertions were coupled with the bone. One sees a delightful opening, though not as strong as the radial extremities decompensation. It can be a really powerful opening in proprioception, in how the person handles [his] body in space.

**VB:** So the changes were not as profound?

**JS:** I saw more integrative and manageable changes. As this was big-joint decompression, this would be useful in someone who actually works for a living – such as laborers, not athletes. Laborers are the people carrying the loads, and are working using their big joints and spine. Big-joint decompression is a great single session for people who have never had Rolfing, and who you may never see again. It's a good strategy, framed like a third hour

with respect to the lateral line, and clients will more likely not have a crisis response.

**VB:** So is big-joint decompression a deviation of the radial decompression approach?

**JS:** I would say it's an octave of radial decompression. I don't like the word deviation, as radial decompression is not orthodoxy.

**VB:** Can you modify it? Are there any other octaves?

**JS:** It might happen that as you are developing order, you get to a point and you have done radial decompression and gotten a response in the spine, but you need more room to derotate group fixations and you're up against deeper layers of immobility. It is imperative to then mobilize the motion restrictions in the axial complex to help achieve deeper integration.

## Other Options

**JS:** Another great option is a costo-transverse decompression. With it, you go systematically to the costo-transverse joints, opening the articular function, and organizing individual ribs, and in the next session you do a radial decompression again.

**VB:** Does this give the rib cage and the spine a whole lot of the variant, big joint decompression?

**JS:** It's not as profound, but it's still a very integrated feel-good session. Clients end up lighter and easier in the shoulders, and

their hips can wiggle a bit more. The results aren't the same as in radial decompression, but it is the same in the concept. The rules are still there: occiput/sacrum/big joints. One could carry that to the extremities as palmar and plantar fascia work, but if you go wide and broad, you get a nice arm and leg session but you don't activate the radial decompression effect.

**VB:** Are there any limitations on the variant with any different results?

**JS:** If you decide to do shoulder and include the palmar fascia, and then hip to plantar fascia, it is not radial decompression. It would be more like an upper or lower Eight/Nine session and does not produce the radial decompression results. It doesn't tend to produce unwinding, or predictable changes in the core volume of the infra-/supra- diaphragm spaces. Still broader work is a nice intervention, but you won't produce the same kind of volume changes that are intrinsic in radial decompression.

## Volumetrics and Radial Decompression

**VB:** Volumetrics is a term you have been using and been interested in for a long time. Where does that fit in here?

**JS:** The idea of looking at core volume has been going on for many years. Peter Schwind gave a talk at an annual meeting about the "core" that was inspirational to my thinking about volume displacement. Imagine looking at core from the side and

identifying displaced internal volume. Then consider the girdles, axial, and sleeve against your perception of the core. This exercise will deepen your seeing, and give you new ideas for application.

The seed for this inquiry comes from Joe Goldthwaite's book, written in the '30s as I recall. Jim Oschman found it during his original search of the literature, looking for work that had been done that would validate Ida's thinking. Goldthwaite stated that the displacement of the volume of internal space was a predictor of potential pathology in later life. This idea simply disappeared without much notice.

In pondering these ideas over the years, I wondered if you could use the shape of the core as a measure of whether we get the job done. Can a person get maximum core volume without sacrificing other geometric and functional qualities? Maximum core availability throughout the whole internal space is one measure of integration and adaptability.

**VB:** How does all this relate to core/sleeve?

**JS:** If you look at a vessel, the wall of the vessel defines the shape of the inside. That vessel absolutely and profoundly defines the core shape. If you are changing the volumetrics of the core, you are automatically changing the core/sleeve relationship.

**VB:** Thank you, Jan. We look forward to further developments!