The "Journal" is a regular feature in which Rolf Institute members may explore topics on Rolfing and Rolfing Movement Integration philosophy and technique; share creative writing of interest to our readers; and discuss practice-building and management. The ideas and concepts here are an exchange among colleagues who are not being spokespersons for the Rolf Institute or its teaching faculty when they contribute to this part of Rolf Lines.

CRIOR AND COLLAPSE
Part One: How We React to Trauma

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FOREWORD... *The following article is the first in a series of two which were published in October issues of Physical Therapy Forum, a weekly magazine with a circulation of over 50,000 physical therapists throughout the United States. Reprinted with permission of the author and publisher.*

Some asides from the author before you read: *While my clients often see me because of physical or emotional trauma, after working for two and one half years in a large orthopedic group, I am very clear (with myself and with my clients) that Rolfing is not physical therapy. On the other hand, it is also very clear to me that physical therapists can and should be our allies and that communication between our groups does everyone a lot of good. Lastly I refer to clients in this article as "patients". That is only because of the context.*

All sentient beings that I have observed react to trauma in specific, predictable patterns: to the extent they are able, they withdraw; to the extent they are unable to withdraw, they collapse. Poke an amoeba, an elephant or a human and it will immediately pull away; poke it hard enough and it will break down.

Withdrawal and collapse usually happen together. At the epicenter of the injury, collapse - a loss of structural integrity - may occur. Radiating outward from this center we see the stabilizing effect of the withdrawal pattern. In a traumatic back injury, for instance, collapse of disc fiber with the herniation of the nucleus may result. The familiar "list" of back patients is a full body attempt at stabilization and protection against further injury.

Another example of this pattern occurs with knee or ankle trauma. A limp is our structural attempt at withdrawal, at keeping the wounded part from more damage. If we were to examine the traumatized tissue carefully, we would often find fibers - ligamentous, muscular, capsular, periosteal - which have torn.

Interestingly, we react in these predictable patterns not only in the presence of physical trauma; withdrawal and collapse also describe our emotional reactions. We use the same patterns in the anticipation of trauma as we do in the actual event. F.S. Perls, a well known theoretical and clinical psychiatrist, has said that "neurosis is characterized by many forms of avoidance, mainly the avoidance of conflict." Common expressions like "shrunken with fear" or "You look petrified" describe components of the withdrawal response. Patients who tell us that they "just can't get out of bed", that they are "all done in", are manifesting the psychological equivalent of collapse.

Trauma is most often associated with injury: a car accident, a broken leg, a bad fall. It may be more slow in occurring: a disease process, emotional deprivation or nutritional insufficiency. A way of looking at trauma may be to describe it as anything which causes a persisting withdrawal or collapse response.

All things being equal, tissue will collapse if the injury is sufficient. But, of course, all things are not equal and therefore collapse will not be solely dependent upon the amount of force involved in creating the damage. A person who is fit, who exercises, eats well, is in the physical "prime of life", will usually respond with a lesser collapse reaction than a person who is in poor condition and who is either very young or very old. Likewise, a person who is culturally timid or psychologically tense may show more of a withdrawal response than one who is more confident and relaxed. The degree to which we withdraw and collapse will be a reflection of many variables. As we have experienced in our practices, patients' reactions to trauma are extraordinarily different. They are always, however, a combination of the two general themes.

The withdrawal response has four components, and I use the mnemonic CRIOR as a way of remembering them. The four elements - which usually happen all at the same time and may be looked at as parts of the larger reaction - are Contraction, Retraction, Immobilization, and Often Rotation. (The "O" in CRIOR is for "often")

Orthopedically, we can again use the limp to illustrate the common pattern of contraction. Our body may be seen as curling over the injured part: the leg is lifted off the ground, the shoulder often drops, flexion may occur in the spine and hip. Anyone who has worked with thoracic pain will be familiar with the contracted pattern that the scapulae often exhibit, winging backward in an attempt to cover the traumatized area.

Retraction describes the expression "getting out of harm's way". It is most familiar in the immediate aftermath of an injury such as when we pull our hand out of a fire, but certainly it can be

recognized with chronic pain patients. They sometimes hold themselves as if they were trying to escape a demon. Eyes slightly closed, moving slowly and carefully---tentatively---they try to pull away and manage their pain.

Contraction and retraction are similar, but not the same, responses. In one we make ourselves smaller, in the other we pull away. If something gets in our eye, we quickly tighten and shut it---contraction. Simultaneously, we yank our head back---retraction.

Immobilization is our third approach to minimizing trauma. We simply stop moving. People with cervical pain are the most common examples of this component in my practice, but I see it with low back injuries, with post- operative complaints, with headaches; in fact, I see it all the time.

Rotation is usually involved because mechanically it is impossible to get axial bending without rotation and axial bending is often a part of contraction and retraction. A limp without some rotation is hard to imagine; low back pain often has a rotational component in the structural response.

The withdrawal or CRIOR response is intended as protective. It will last as long as the person feels that he or she is in danger of re-injury. In time it can be come "institutionalized" into the habits of posture. Those anomalies of structure we see daily--the shortened gait, the chronically contracted cervical and thoracic musculature, the low back list--come from somewhere. If they are not congenital, they are usually the result of our reaction to trauma or to the anticipation of trauma. (It could also be argued that CRIOR and collapse occur within the womb and what we sometimes describe as nature--as opposed to nurture--is, in reality, nurture before birth.)

The value in appreciating the way our bodies respond to trauma is in the perspective it allows us in understanding healing. Seeing the patterns a person uses while reacting and going in to pain can give us clues for helping to lead him or her out of it.

The next article in this series will concern creating a strategy for dealing with the body's musculo-skeletal response to trauma.

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