

Beyond Pain in Rolfing®

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*All means prove a blunt instrument if they
have not behind them a living spirit.*

Albert Einstein

INTRODUCTION

In 1991 I was part of a Rolfers' delegation to China. I was a new Rolfer and anxious to experience the exchange between Rolfers and Doctors of Traditional Chinese Medicine. We were to learn something about Tuina (TCM Massage) and we were going to demonstrate Rolfing to the Doctors at the Guang An Men Hospital in Beijing. It was a rewarding trip in many ways.

During one of the demonstrations of Tuina, I watched as a patient with frozen shoulder syndrome was treated. I winced as the doctor bent, twisted and manipulated the patient's shoulder. The patient, obviously in a great deal of pain during the treatment, was white faced and rigid everywhere except at his shoulder by the end of the treatment. As the doctors pointed out later when reviewing their steps of treatment with us, the last step was to "de-traumatize" the patient.

Over the years I have gotten new clients who came with some interesting horror stories of their own. There was the client who told me about getting two PT's to work on him for the price of one. How's that? "Oh, one held my body down while the other tried to increase my shoulder range of motion", was the reply. After my internal wince, my question of course was, "Did it work?"

For some, it isn't exactly a story. It becomes an embodied experience. Recently, I got one who told me she had taken a pillow to her Rolfing sessions. In my naiveté, I assumed she had a favorite pillow. Noticing an unusual interest in ascertaining how much the session was going to hurt, it came out that her previous sessions hurt so much that she wanted to muffle her screams so she wouldn't interfere with receiving the work. And yes, she had received work from a Certified Rolfer.

Obviously, the client who related her story to me had some problems that were well beyond structural issues. She also reported the onset of new physical ailments that coincided with her Rolfing sessions.

The more I thought about the topic, the underlying issues that allow the perpetuation of these types of sessions began to reveal themselves. Beyond the surface conversation that addresses pain and the assumptions that we make about it, there exists a broader perspective of Rolfing and skills that allow for safer and more effective ways to work.

PAIN AND ROLFING

Pain and Rolfing have a long history. There are still strong beliefs in our community that support the notion that if it doesn't hurt, it's not Rolfing. Topics worth discussion include our attitude about pain, how pain fits into our understanding of the goals of Rolfing, and most importantly, when does it no longer further the goals of Rolfing.

Painful Rolfing is usually associated with direct techniques. Direct technique is our most basic tool, requiring the least amount of sensitivity and sophistication to learn. When I started Rolfing, I learned using direct techniques. I could leave red marks with the best of them. One thing I noticed during my training was that my instructors didn't. My practicing partner confirmed that no matter how many variations of pressure and speed that I used, I couldn't duplicate my instructor's touch. It was my first glimmer that pain didn't have to be a part of the recipe. Although I couldn't do it, I was consumed with learning how.

IS IT REALLY ABOUT PRESSURE AND TECHNIQUES?

The topic of Painful Rolfing, as generally talked about, is misguided. It is interpreted from the point of view that one's work will not be as good if sufficient pressure is not used to move the tissue. Sometimes that is true, however there is an important and critical distinction between using enough pressure and using pressure that causes pain in your client. Pain from pressure is a physiological warning signal.

Pressure is not the quantifying factor. Pain and pressure have been linked up in a way that doesn't serve our work or the possibility of becoming better Rolfers. Most of what we call conversations on the topic of "pain" are short lived and unproductive. The conversation usually ends quickly with something like "Don't cause pain in your clients beyond what feels OK to them." As you can see from the above example, some folks don't have boundaries that are healthy enough for them to say "Whoa!" There is a large part of our population that was raised on the "no pain, no gain" motto. Your client's permission or lack of vocalization is not always a reliable indicator of whether or not your delivery is appropriate. There can be a huge conflict between your intention, how you deliver your work, and your client's boundaries.

I have also seen the pain topic spiral downward into a debate about whether you are using direct techniques or indirect techniques, or whether you are doing real Rolfing or the new style of Rolfing. Again, unproductive ground and a source of division in our ranks. There is not any "old" style Rolfing vs "new" style Rolfing. There are only interpretations of what we have learned, how we have become more or less skillful with what we have learned, and how we are doing our work.

Shortly after my training I was introduced to indirect work. I wasn't proficient at first and couldn't justify practicing on paying clients. So I got volunteers to come in. Who's to say how long it takes to develop a new skill? For me it was close to a year before I was effective enough with it to make changes that equaled my direct techniques. Eventually they merged and became my new style. Seamless delivery, simultaneously using both direct and indirect tech-

nique, was a new adventure. The red marks became less apparent.

THIRD PARADIGM WORK

The fact that Rolfing produces results can be attributed largely to the work of Dr. Rolf.

She gave us an almost foolproof formula for making huge differences in a person's lived experience. We assume that the work we do is third paradigm work.¹ We assume this because that is the potential of Rolfing and that is what we were taught. We assume this on faith when we start this path. Rolfing, by design, is third paradigm work. Whether or not our individual work is third paradigm work is not a guaranteed event.

Just as doctors can take the Hippocratic oath, it is not guaranteed that their work is always delivered for their patient's highest potential health. They may believe they are doing something positive, but in actuality they may be causing harm.

Rolfers can deliver work that would not qualify as third paradigm work. Instead of being integrative, it can lessen a person's lived experience. Our usual measurement for effective work is based on positive structural changes, with no negative side effects. What if a side effect of our work doesn't show up in physical form? What if it appears only in the person's lived experience, with the physical symptom appearing down the road a bit?

TRANSFORMATION IS A TWO WAY STREET

Rolfing is often referred to as transformational work. It can fundamentally change the nature of a person's being. We generally assume that if transformation happens, it is for the highest good of the individual. It alters the nature, function or condition of the person so that their lived experience is more present and authentic. This can translate into relationships and experiences in that person's life. Paralleling the Principles of Rolfing², these relationships and experiences would have qualities of adaptability, support, holism and balance embodied in them.

Any experience can be transformational. A beautiful sunset, a birth, a kind word at the right time, even a death. There are no limitations on which experiences can bring about a fundamental change in the nature of a person's being. But, not all experiences

make a person more whole. Typically, the ones that make us less so are the ones that are the most painful.

MODELS FOR INTERVENTION

Depending on our perspective(s), models represent our experiences when relating to others and are for our own understanding. In the health arena, there are numerous models that help us explain how we think something works. Anywhere from how the latest drug affects our health to how we can change structure. All models have inherent possibilities and limitations. For instance, the blocks and cylinders models show alignment issues and can be used to reference physical changes. Other things may happen, energy patterns may change for instance, but these models cannot reference that because they are outside the scope of the model.

A MODEL FOR CONSIDERATION – WORKING WITH THE ANS

In 1997 I participated in a workshop entitled "Identifying and Tracking Neuromuscular Response to Trauma" presented by Bill Smythe. During an elaborate context-building lecture series, Bill laid out aspects of trauma, how the autonomic nervous system (ANS) deals with traumatic events, and the long-term effects of unresolved trauma. For me, it helped explain many of the sessions where I had to work too hard, where my clients had recurring symptoms, and where my clients couldn't feel any changes.

There are other models that could explain the somatic sensations that occur when working with the ANS. What I liked about this one was that it was presented in a way that integrated structural work with the physiology. Imagine being able to access the control room for hyper- and hypotonicity in your clients. In theory, it was an opening to an absolute gold mine of potential.

TRAUMATIC RESPONSE – OUR OVERWHELM SAFETY NET

Traumatic response is how we cope with conditions that overwhelm our current physical and psychological capabilities. It happens when we can't deal with a situation or experience that is beyond our resources. It is not an intellectual decision, rather it is a survival response that comes out of our physiological makeup.

Traumatic response manifests itself structurally in two ways. Through immobility or freezing type responses, and through resignation type responses. These responses are transformational. They alter the nature, function or condition of the person so that their lived experience is less present and authentic.

Unresolved trauma induces a sympathetically tuned nervous system. Somatically, this combination would appear as hypertoned or hypotoned tissues. It also allocates some of a person's resources to holding on to these experiences. In other words, it takes directly from the chi bank, leaving less energy available to handle other functions.

As a corollary, there are connections between a sympathetically tuned nervous system and symptoms and syndromes as diverse as fibromyalgia, cerebral palsy, depression, and poor vision. Sometimes trauma resolves and sometimes trauma becomes part of our makeup. It permeates our structure with inconsistent, non-integrated areas of hyper and hypotense tissue.

CALIBRATING YOUR TOUCH

Working with the ANS is a bilingual conversation. I interact with my client's system through my touch. This language of touch was introduced to me as "QQDDD." It represents the aspects of physical contact that can be put together for every intervention: Quality, Quantity, Direction, Duration and Depth³. I regulate the quality of my touch (including which tool I use, knuckle, elbow, forearm, etc.), the quantity of my touch (how much pressure), the depth I am working (my intention), the direction of my movement, and the duration of my intervention. My client communicates back to me through their physiology.

Calibration is necessary with every intervention. I calibrate my touch to neuromuscular responses that I track in my client. I intervene and track, over and over. There are not any rules for how to apply QQDDD since every client's physiology is wired differently, and during a session, it is constantly changing.

For me, working with my client's physiology also required some skill building time outside of my normal Rolfing sessions. My biggest obstacle was learning how to work in the moment, without any preconceived notions about how the session was going

to unfold. I certainly had intentions, but they slowly transformed from goals to possibilities. The possibilities grew exponentially as I gained more skill. The results of my sessions dramatically improved with far less strain on my ambitions and my structure.

WORKING WITH AN INTELLIGENT SYSTEM

We often use dialogue to facilitate our sessions. We ask for a breath here or a “let go” there to help engage the client’s consciousness and their physiology. Coaching the individual facilitates getting inside, helps to loosen restrictions, and leaves us with less work to do from the outside.

Working with the ANS is another way to engage in a dialogue with your client. As such, all bodywork can be considered as a conversation between two intelligent systems – yours and your client’s. This is not a conversation of the intellect. It is an experiential dialogue that is enriched only through presence. If I am tracking my client’s response to my touch, I can be precise in providing exactly the right combination of QQDDD that will engage their ANS.

The ANS is an intelligent system with responsibilities that govern much of the tonus of the body. Combining knowledge of spatial organization while engaging your client’s physiology allows the possibility to bring almost any area of holding or resignation back into normal range. And it requires much less effort, since your client’s natural ability to self-regulate (i.e. modifying tonus to normal ranges) is doing the work.

Structural patterns manifest from areas of holding and withdrawing. Holding and resignation patterns are different for every individual. Our initial Rolfing training opens possibilities to access them by working directly with the structure. The combination of working with the structure and working with the physiology provides a possibility of seeing the whole from two perspectives. If your skills also include working with energy, belief systems, dreams, the psyche, etc, you can expand your perspectives to get a more complete picture of who and what you are interacting with.

Communicating with a client’s physiology requires a range of touch. Too much pressure can overwhelm a client’s ability to

adapt. If their physiology reacts to my interventions as an overwhelm, it causes resistance. More pressure, more resistance. Eventually, my client’s physiology could express the overwhelm as a resignation and abandon the area, leaving it soft and malleable, but without life. I can in effect have a structure that looks aligned and upright, but in doing so I have lessened other aspects of their being. Likewise, if my touch is too light, I can fail to contact layers of structural holding that need stronger feedback to engage the ANS.

A QUESTION OF INTEGRATION

Working with the physiology of my clients has upset some of my previously held assumptions about structural integration. After my basic training the best concept I could put together was that we were integrating the human structure in gravity. I was armed with models of blocks and cylinders and a strong sense of up and down.

I didn’t change my views much after I developed my indirect skills. It never connected for me that I was working two different aspects of my clients at the same time. It wasn’t until I started becoming proficient with tracking the physiology that I got a clear picture that direct work and indirect work sometimes overlap and sometimes they don’t. Since I have added working with physiology, I have the experience that sometimes the speed of the unwinding movement must be slowed down to allow the ANS to engage, as if the two aspects of my client were out of sync.

It has brought the question of integration to the forefront for me. What exactly are we integrating when we say structural integration? I’m getting more comfortable not having an answer for this.

CONCLUSION

My Rolfing training has been blessed with many gifted and generous teachers at the Institute, as well as many gifted and generous colleagues in my life. My observation is that none of them work the same. Only very rarely do they see the same things or have the same strategies for any given model/student. The most valuable thing that I have learned is to see how high they have raised the bar for themselves. I don’t always know how they do some of the things they do, but I have been extremely grateful to them for their perseverance in presenting their concepts and demonstrating their experiences.

I had an awakening during my advanced training that really changed my perceptions of how I work. My instructors were Jeffrey Maitland and Bill Smythe. Jeff related that he considered one of the differences between basic and advanced training to be that after advanced training, Rolfers should own the work. I thought that equated to being able to do formulistic work, as well as to create strategies for non-formulistic sessions. I felt capable of doing that. After one particularly great session that was rich in somatic dialogue and profound change, I was telling Bill Smythe how I was doing some of his work (the ANS stuff). He looked at me and said, “no, you are doing your work”. Some dominoes tumbled on that one. It translated directly into what I had heard often, and somewhat believed, that we are doing Ida’s work. We aren’t. Although it had given me comfort thinking that I was. The reality is that it is our hands that are working on our clients. Fueled by our own interpretations of Rolfing and delivered with the skill sets we have chosen to develop, or not.

Our clients don’t come to us to receive pain, although sometimes they have accepted that it is part of the process. They come for a myriad of other reasons. Representing pain as a part of Rolfing is a misnomer. From the beginning, pain has been enmeshed in our own interpretation of what we think Rolfing is. It sounds very different if you change the statement “Rolfing causes pain” to the statement, “I cause pain.”

The issue of how we deliver our work is of course up to each of us. When clients ask me about pain and Rolfing, I have to say they are not dependent occurrences. I offer my perspective on pain and demonstrate what is available if the autonomic nervous system is engaged in the session. Educating my clients about another perspective is a part of my sessions when it is appropriate. I do add that if they really want a painful experience... well, I charge extra for that.

REFERENCES

- ¹ *Developed by Jeffrey Maitland.*
- ² *Taxons as developed by Jeffrey Maitland and presented to the Rolfing community over the last decade.*
- ³ *Language of touch information developed by Bill Smythe and Peter Levine. “Identifying and Tracking Neuromuscular Response to Trauma” workshop (1997) and Advanced Rolfing Training (1998).*