Rolfing® and The Genesis of Health

By Giselle Genillard

To Tom

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It was midnight in the desert somewhere in New Mexico. I had come, an exile with a small child, to seek counsel from a wise man who I hoped would discourage me from the untimely and illogical compulsion to submit myself to a gruelling midwifery boot camp on the Mexican border. A recent arrival to America and an even more recent single mother my life was in disrepair, my heart broken and my closest friends dead. Dispirited, dispossessed and uncompassed, I sat weaving my sorry tale. The black hawk eyes were not interested, fixed not on my tale but only on my hands. "What do you do with them?" he jerked his head towards the subjects of his fascination. "I am a Rolfer." "Yes, yes, I know that. What do you want to do with them?" "I want to learn how to deliver babies." "Partera?" he said. "Go. You must do this. But let me tell you three things you must remember. Firstly, you will not end up being a midwife. Second, do not come back hating men. And third, the best midwives don't birth the babies. They sit in their doorways and when the pregnant women pass they pull them in and work their bodies and move them about and scold them a little and when the birth comes, well, the real work's been done."

I, of course, did not remember his words.

Until I delivered the babies of scarcely pubescent girls with great big eyes who had been casually raped by neighbourhood policemen and I had to fight not to hate men. Until I recognised the huge and difficult task a home-birth midwife must accept in having the responsibilities of two lives on her hands in a culture that is more interested in litigation than health. And until I saw the difference conscientious prenatal care made to the outcome of the birth, the welfare of the woman, of the family, and therefore of our society. It was not long before I decided to dedicate my time – and my infamously large hands – to that pursuit. The wise old man had clearly been pointing me in a direction.

In the years that followed my training I practiced both as a homebirth midwife and a Rolfer. The pressures of single parenthood and life imprisoned by a pager eventually put paid to my life as a bush midwife, but this time and experience firmly cemented my belief in the importance of wholistic care for families in the childbearing year.

Dr. Michel Odent, the French surgeon and obstetrician to whose mentorship and inspiration I am indebted and whose influence has helped change the face of childbirth in Europe, maintains that there is nothing more important to a nation's health than the time in which the infant is dependent upon his mother. It is during this time, from conception through breastfeeding, that the thermostat for health for the rest of our lives is set. Dr. Odent calls this period the "primal" period. It is then that the immune system, the hormonal system and the primitive brain are formed and reach maturity. This period is the genesis of good health. In Ancient China, they practiced Tai Kyo, or embryonic education, and in India, Caraka Samhita was a tradition that studied the embryo from the third or fourth week of pregnancy and then on a monthly basis up to the seventh month of gestation. The Tibetan r Gyud-b Shi studied the baby on a weekly basis throughout pregnancy. The premise behind each of these traditions was that only a healthy and happy mother could have a healthy and happy baby and that the period of attachment to the mother (here called the primal period) hardwires the parameters for health for the rest of that little person's life.

Dr. Odent's 1980's inquiries into the effects of disruptions during the primal period went far beyond the direct and obvious poisoning of the baby by alcohol, cigarettes, and chemicals crossing the placental barrier. He looked rather at epidemiological evidence on the common afflictions of our society: escalating obesity, heart disease, diabetes, teen suicide, violence, depression, auto-immune diseases and cancer. In each study, there was a direct correlation between the disease and a disturbance in the primal adaptive system, the maternal bond. A few examples:

Teen suicide, violence: we know that in the last thirty years the rate of adolescent suicide has tripled, while the suicide rate for adults has stayed pretty much the same. Suicide in America now rates as the second cause of death after road accidents in 15 to 24 year olds. Among a group of 52 adolescents who committed suicide, a New York team found that the majority had had a difficult delivery, had been resuscitated at birth, and had been separated from the mother during the sensitive period immediately after birth. During this time, the first hour after birth, the hormones secreted by both mother and baby have not yet been excreted. It is what creates that powerful sense of attachment between mother and baby and one of the reasons why men were traditionally excluded from the place of birth: a woman is inclined to form deep bonds with whoever is with her in the first hour after birth. These same hormones are the ones that are produced during the hiatus of sexual intercourse and are designed to create a sense of interdependency. If the baby is removed from the mother at birth, this mutual hormonal exchange is abrupted and the normal physiological process of attachment becomes estranged. Oxytocin is often referred to as the hormone of love, characterised by softness of skin and temperament, nurturing, caretaking, and attachment. It can induce maternal behaviour even in men and virgin females. It is this hormone that is released between mother and baby during the sensitive period. There is nothing more addictive than our own hormones – or their lack. Disturbing this crucial interaction may be the causative factor behind individuals who tend towards suicide or violence in a country that is not reported to be at war yet has 35,000 handgun deaths a year alone.

Auto-immune disease: the equivalent of physiological suicide (see above). Self-destructive tendencies in general relate to disturbances in the primal period.

Diabetes: further studies have shown a direct link between juvenile diabetes and maternal deprivation in nutrition or other distress around the 20th week, when the pancreas first begins to secrete insulin.

Obesity: undernutrition during the first trimester of pregnancy places the fetus at high risk for adult obesity. Most of the studies were done on the survivors of famine in the Netherlands after the Second World War. In our own society, malnutrition is more common than undernutrition, and undernutrition is often a product of oversocialisation: trying to make the burgeoning pregnant body conform to the social model of androgyny.

Stress, hypertension: the release of the stress hormone, cortisol, is neutralised to the fetus by an enzyme in the placenta. However, unless there is proper nutrition this enzyme fails. Cortisol then passes through to the foetal brain, increasing susceptibility to stress and elevated blood pressure in adulthood. A hypertensive person needs to secrete more adrenalin than is normal to face the pressures of everyday life and to enjoy life's pleasures. The action of beta-blockers or drugs like Aldomet that reduce the level of adrenalin decrease in efficiency over some months as the body's set demand for adrenalin pushes production up to compensate for the medication. Sudden cessation of medication frequently leads to sudden and fatal heart attack.

Learning disorders: Bruno d'Udine and Carla van Vlaanderen's glorious article "An Evolutionary Perspective on Brain, Behaviour and Immunity" shares Odent's findings on the effect of elevated maternal testosterone levels on the percentage of strongly left-handed children, who carried twice the incidence of immune disorders and ten times the incidence of developmental learning disorders (such as dyslexia and stuttering) compared with strongly right-handed people. The authors argue that unusually high levels of testosterone (released by the adrenal glands in response to certain stressful situations) *in utero* delay the development of the left cerebral hemisphere, leading to right-side dominance and therefore left-handedness. This also delays the development of the thymus gland, leading to later immunological disorders.

Research into the area of primal health is, however, complicated by several factors. Studies that encourage investigating the genesis of good health are generally spiritual. Whereas our mail boxes and billboards are littered with requests for money that will surely produce a cure for all our malaises, who amongst us is visionary enough to support research into the genesis of good health? Especially as the current scientific paradigm traditionally devalues those things that are specifically female, such as pregnancy, birth and breastfeeding. Distinguishing

between genetic influences and gestational conditions that may take years to manifest is a subtle sport and one that is very hard to market. Odent has promoted the idea of creating a network of primal health centres all over the world to address these ideas, and where couples thinking of having a baby, pregnant women, mothers, babies and grandmothers can all get together. It would be a place to educate teenagers (how many sexually precocious girls understand that bombarding the immature cervix with sperm is a high risk-factor for cervical cancer? Do your own daughters know that they are born with all the eggs in their ovaries of all the children they will ever have?....). Primal health centres are rare, though with the proliferation of alternative medical practices more and more couples are taking responsibility for their birthing environments, both physical and psychic, and seeking education and information on their best choices.

It had seemed until recently, however, that these concerns were primarily for the loud yet impotent feminist fringe element, identified more with banner-waving and Birkenstocks than serious medicine.

I was therefore gratified and surprised to find the cover of Newsweek (27 Sept. 1999) emblazoned with one of the famous *in utero* Nillson photos of a foetus sucking its thumb.

The title is: "Where Health Begins. Obesity, Cancer and Heart Attacks: How Your Odds Are Set in the Womb." Inside I found the identical research and statistics that have been expounded since the 1980's by Odent and d'Udine and friends. The Newsweek article reports that a year ago the Society for Epidemiologic Research half-filled a small room at its annual meeting for a session on how conditions in the womb influence adult life, or "fetal programming," as they call it. This spring the subject packed a whole lecture hall: "This whole topic is just now catching fire," says Harvard researcher, Dr. Janet Rich-Edwards. It is the "new paradigm in public health, a revolution in the making."

So the whole topic is catching fire. But what has this to do with Rolfing®? A lot, methinks.

The huge interest in oriental philosophies and the somatic arts might indicate that 100 years of psychoanalysis has done little to soothe the savage beast. As more and more people understand the importance of dealing with past issues, both structural and psychological, before including a child in their lives, it is inevitable that we will move away from educational practices that ignore the body. Maternal and infant massage are now commonplace, but Rolfing? I hear it is dangerous. I am either told it is contradictory to be both a midwife and a Rolfer, or that I must enjoy being in the presence of pain. I receive calls from across the country from colleagues tremulous to work with a pregnant woman's sciatic pain. I know I am neither alone nor naive to realise the great contribution Rolfing has to the field of primal health.

Rolfers establish systems that self-regulate efficiently. We are concerned with relationship, of parts to whole and of the whole to something greater. Pregnancy could be said to be a neuro-hormonal event and also an immune system event, both mediated through the physical structure. We look to the enhancement of good physiology, the development of abilities, intelligence and sensory function. We are skilled in creating movement from immobility and grace where there was disgrace. And we assist in that most vital of human attributes: adaptability. It seems to me that people like ourselves could be in the front line of investigation in this subtle interface of one life so intimately overlapping with another. After all, where more in our human experience do shape, state and ancestry so engagingly entwine as when a pregnant woman enters our Rolfing room?

Most pregnant women come to me because they are in distress. It is not hard to understand why.

During the months from conception until birth, the female body gains roughly 10 to 12 kgs, much of it "centered" around the middle. The endocrine system orchestrates a flow of hormones that provides both for the support of the baby, the relaxing of soft tissue and the emotional lability characteristic of many pregnant women. And whilst the changes are largely around the reproductive system, all systems are affected: the heart increases in size and rate to cope with a 40% increase in blood volume, the respiratory system is charged with an increased demand for oxygen and faced with a decreased space for functioning, the gastrointestinal system is aggravated by hormones and the growing foetus, the urinary system is similarly compromised and the musculosketal system is destabilised by joint laxity and a constant and rapidly changing centre of gravity.

Are we surprised, therefore, to find pregnant women complaining of what are termed the "usual" discomforts of pregnancy? Backpain. Sciatica. Sacro-iliac pain. Morning sickness. Fatigue. Carpal tunnel syndrome. Shortness of breath. Tendinitis and cramps. And following the birth are the attendant upper back pain, perineal lacerations or C-section recovery, incontinence, pubic symphysis and coccyx pain, and good old

exhaustion. These may be "usual" complaints but are they necessary? Are we able to circumvent these discomforts or do we just have to cope? I know I am not the only person who believes that coping is simply not the best option.

On a most simplistic level, the careful application of the principles of Rolfing to the pregnant body have shown that many of the "usual" complaints of pregnancy are relieved when more space and balance is created through the structure. When the pelvis is organised appropriately, the baby is able to settle back against the spine closer to the mother's own centre of gravity rather than tipping the pelvis forward and distressing the lower back and sacral area. Without this constant forward drag, compression of nerves and the tension patterns that have held the baby in space are released resulting in greater ease of movement, less fatigue and definitely less pain.

Ideally, Rolfing sessions would start pre-conception and would continue about once a month through the first year postnatally. This allows for the body's response to the normal adaptations of pregnancy and birth, to help the body open for birth and to come back together afterwards.

I personally never take a woman through the classic Ten Series during pregnancy. Whether or not she has previously been through the ten, she is going through an evolution of her own that has little to do with the evolutionary pattern of the basic series. I aim to see a pregnant woman once a week for three weeks to address the issues of structural pain, and thereafter to see her once a month until about a year after birth. Some women wish to come every week until delivery. In this case much of my work is specific to gestational age, the position of the baby and the maternal history. It may include opening the lower ribs to allow the baby to rise up under the diaphragm so the poor lady can breathe. It may be to prepare for the birth and access the head through the perineal floor. It usually includes work on the interosseous membranes of the lower arms and legs, from where later in pregnancy I can most reliably affect core tension. It will definitely include work on the feet and ankles, through which the implications of the evolving pregnancy must pass at each step.

We know that in working with the joints we affect the Golgi apparatus which has a direct line to the hypothalamus, the gland that deals with stress, body temperature, the appetites, endocrine function, emotional behaviour and the activity of the visceral nervous system. The hypothalamus is the master gland in terms of its authority over the body's adjustments to the external and internal environment. Though it has not been possible to show the effect on the fetus of activating this line of command, we may assume that any enhancement of the mother's ability to adjust to the internal and external environment must allow her to more appropriately negotiate terms with her demanding guest. (Morning sickness seems to be one of those points of negotiation.)

As the intention of this article is merely to draw with a yellow pencil all over this influential field of our practice, I will only give a stick-man outline of what we may be looking at structurally trimester by trimester. It is, after all, an article all to itself:

Pre-conception, Rolfing prepares the "soil" by improving posture, enhancing physiology, mobility and motility, and allowing for greater tissue hydration. Rolfing has been known to help in cases of infertility and though I am claimed to have sired babies in three continents the evidence is unfortunately so far only anecdotal. It does make logical sense, however, in that the reproductive organs are suspended in an intricate fascial complex that is sensitive to stressors both structural and emotional.

In the first trimester, the lumbar spine is less compromised than the thoracic spine which needs to adapt to the rapid growth and sensitivity of the breasts. Nausea and vomiting are other common problems at this time. Emotionally, this is often the time of the greatest volatility as the mother adapts to the sudden flood of hormones and to the implications of the life unfolding in front of her. Sessions during this time might address creating foundations of support and adaptability within the body and without.

In the second trimester, many of the problems are caused by structural shifts as the uterus expands out of the pelvic cavity. Unless the posture is well-adapted, the lumbo-sacral and thoraco-lumbar areas are likely to be stressed. At this stage also, the effects of relaxin are beginning to bear on the soft tissue and the residue of accidents or poor posture pre-pregnancy may now be adding their weight to the growing load. Sessions now are more likely to be directly related to previous structural stressors that are now compounded by the growth of the baby.

In the last trimester, the baby is rising up under the diaphragm leaving little room for the stomach or the lungs, and the general increase in weight can make everyday tasks difficult. Our work now is to provide appropriate accommodation for the baby in the mother's body, and to help the mother carry her baby comfortably through the passage into parenthood.

Post-natally, and up to the end of the primal period, the main issues are

resolution of any birth traumata, integration, and adaptation to the rapid shift in weightbearing from the midsection to the upper thoracics where baby and lactating breasts both meet for considerable and extended periods. The main problem, however, is "the primary maternal preoccupation," otherwise known as "the baby." Unless there has been a traumatic delivery, a new mother is inclined to focus on the needs of her family rather than on herself. How kind of the airlines to have given us an international dictum, one I repeat ad nauseam to my birthing ladies: "In case of emergency, when travelling with a small child, put the oxygen mask on yourself first"....

But Rolfing is a wholistic system and how can we justify calling it this if we only talk about structure? Clearly we can't. Outer forces do indeed influence the formation of the embryo. Our personal philosophies do indeed affect our shape. Yes, our shape in turn is formed by internal stressors and external influences. And by the weight of 400,000 ancestors "leaning on us from behind" (thanks, Jan, that's very cool). Our profession is now well versed in the languages of integrons and information molecules and psychoneuroimmunology and most of us have erudite specialities of our own. But whilst our taxonomies, derived themselves from embryological development, have been well described (structure, function, geometric, energetic and worldview), there is an important additional taxonomy that underlies and includes all the others but which applies specifically to a pregnant woman. It is called "Shit Scared." No more shit scared, probably, than any of us are of death but unconsciously – and maybe this is inculcated deliberately and consciously by the medical profession – for most pregnant women birth is a curtain to be passed through, much like death. This is reinforced societally by our medical profession and our media. Any visit to your OB's office is likely to be a microscopic search for pathology and if you look hard enough you are sure to find it. The emphasis is on what may go wrong, not in the assurance that a healthy, happy body knows exactly what to do (and has 400,000 team mates egging it on from the sidelines).

Added to which, all the way from classical literature to modern TV soaps, the preferred way of getting rid of any inconvenient heroine is to kill her off in childbirth. The better "educated" and more highly "civilised" or upwardly socially mobile the woman the greater the fear. The mark of a successful, powerful woman is a flat stomach, zero body fat and an empty womb. Pregnancy defies all our cultural models. It has an inevitable conclusion. It is unpredictable. It is mysterious. And it is something only women can do (well, guys, you do get to pee standing up). It may not be literal death. It may be death of personal freedom, death of an identity, death of a tight pussy (know the Californian billboard that said "Keep your passages honeymoon sweet: have a C-Section"?), or death of pert breasts. But it is deathly and few people I meet simply glory in their state, their shape and their impending proximity to the ancestors. (The recognition of having this many ancestors leaning from behind is actually hugely empowering to a pregnant woman, because it is certain that all of them, illiterate, wartorn, privileged or peasants, were part of an unbroken line of successful breeders.) Pregnancy is a cultural bind, literally. Our first job may be no more than to begin to let the natural shape emerge and dumbfound the cultural associations. That in itself is a major contribution to the health of the family, and well within the everyday scope of our practice.

Whilst I firmly believe that judicious Rolfing is not a risk factor to a normal pregnancy, all practitioners of any modality must be well-trained to recognise symptoms of pathology that require referral for medical consultation. These will be discussed in detail in future articles, or as requested. Non-medical risk factors that may be mentioned in passing are associated with clients who are: medical professionals, work-out fanatics, people who have read every book that has been written on pregnancy, and people who invite their acupuncturist, astrologist and Rolfer to their birth. It has been shown that the neo-cortex is the greatest inhibitor of the birthing process and that the number of people present at a birth increase the risks of obstructed labour exponentially. Birth, like beautiful sex, is in essence an intimate and animal event, and I use the word "animal" in its most celebratory sense.

I have been asked whether only midwives should Rolf pregnant women. Do I need to be an Olympic athlete to work with Olympians? Or a violin virtuoso to work with musicians? No, clearly not. The advantage of my midwifery training is that it gives me licence (literally and figuratively) to explore a subject that is often shied away from because it is held in a vice grip between awe and litigation. There are always and only two sets of limits in working with a pregnant woman. Hers. And yours.

When I work as a midwife, I am privileged to be unencumbered by technology that needs interpreting according to its own dictates. The honing of my sensory skills allows me to watch and wait and listen through every pore for the signs that

may call for action. But my main role is passive. As a Rolfer, it just looks different. My Rolfing sessions are mini primal health centres, in the co-presence of three, with the ancestors always welcome. Whether the third person is me or the baby or the Holy Ghost matters not, but three is surely a mystical number. I do invoke the baby's aid, as I did mine in the last moments before she crowned, to help the mother move towards freedom. I do 'influence' the baby's position ("It is a precarious undertaking to say anything reliable about intention" says Einstein). I educate with my hands. I educate with my voice. Probably by morphogenesis rather than education the work of Peter Levine, the motions in the hollow organs and the analyses of Oschman precede me at every move. They, too, are the voices of the living ancestors. Whether I see a pregnant woman once or if I see her every week forever, my role is to engage every cell in my body into communicating to hers her own sense of inherent possibility. The risks are low.

And the rewards may be monumental. ❑

LIST OF REFERENCES

Odent, Dr. Michel, *Primal Health*, (Century Hutchinson 1986).

The Developing Human, by Keith Moore (Saunders 1977)

Readings on the Scientific Basis of Bodywork, by James L. Oschman, PhD

Physiotherapy in Obstetrics and Gynaecology, by Polen and Mantle (Butterworth Heinemann 1990)

"Shaped by Life in the Womb" by Sharon Begley (*Newsweek*, 27 September 1999)

"An Evolutionary Perspective on Brain, Behaviour and Immunity" by Bruno d'Udine and Carla van Vlaanderen (Paper for Rolfers' Meeting in Wurmannsquick, 18 September 1988)