Rolf Movement® Faculty Perspectives

Research: A Tool for Inspiration

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Honestly, there is a lot of 'just figuring it out'. When it comes down to it, being a successful Rolfer and Rolf Movement practitioner involves active curiosity, self-motivation, perseverance, love of learning, and appreciation for the natural world. The tools learned in the Rolf Institute® of Structural Integration (RISI) Basic, Advanced, and Movement trainings are designed to unfold over a lifetime – and they will if they are nurtured by the curiosity that should come from practicing the art. I learned this idea very early in my training and felt both excited and challenged by it. I was thrilled that I had discovered something that seemed so unique – the antithesis of a paint-by-numbers, connect-the-dots approach. In my new professional community, no one was interested in dumbing down something that was profound. My teachers were willing to answer difficult questions by saying, "I don't know, but stay engaged with the question – the answer may come." So, my colleagues and I kept asking, looking, and following. This led us to some wonderful places for study with extraordinary people – it also took us to some uncomfortable places where we were challenged by our edges. Everything was not programmed, codified, or simplified – we had to grapple with the complexity of what it means to practice Rolfing® Structural Integration (SI) and Rolf Movement Integration – to enhance people's structure, coordination, perception, and expression such that they find more ease, efficiency, and grace in living within our earth's gravitational field. "This is the gospel of Rolfing: When the body gets working appropriately, the force of gravity can flow through. Then, spontaneously, the body heals itself" (Rolf 1978, 31). What does that statement really mean? I am still asking the question.

For personal inspiration purposes, it doesn't matter whether you engage with research informally – at the homegrown read, ask, record, and share level – or whether you engage at the gold-standard scientific-method level. What matters is that your engagement fuels you, the practitioner, to become excited every morning – to approach every session as an opportunity for discovery. Thirty years ago, Peter Melchior said to me, "Rebecca, if you wake up one day with the thought that you are going to have to rub someone's smelly feet, then it's time to take a workshop." Similarly, when I heard the majestic Stacy Mills give a presentation, "The Care and Feeding of Rolfers," it wasn't about nutrition – it was about inspiration. Fueling your research efforts will fuel your livelihood and our profession.

How to go about it? For some of us, the first step is to get over feeling intimidated. I live and work ten minutes from the National Institutes of Health (NIH), one of the world's foremost medical research centers. It is made up of twenty-seven different institutes, each with its own specific research agenda, often focusing on particular body systems. It feels like a behemoth ivory tower of top-shelf, scientific-method, gold-standard research that sets the bar of acceptability. I hear myself say, "If one is not doing that level of research, then why bother to engage at all?"

"Why bother?" – Where did this discouraging idea come from?

The answer is that the idea was born during the 1600s, with the advent of modern Western society. Sir Isaac Newton made groundbreaking discoveries that have great relevance to everything in the physical world, especially Rolfing SI: i.e., the Law of Universal Gravitation and the Laws of Motion. Additionally, Newton is credited with developing the scientific method. By 1859, Charles Darwin solidified the scientific method as the established practice in scientific discovery. By 1887, my neighbor, NIH, was established, along with other research institutions worldwide. Before Newton, most Westerners held a worldview called anthropocentrism, in which people were considered to be central to the universe. After Newton's discoveries, the universe was viewed 'as it is', regardless of humanity's existence. This led to the development of the notion that people's opinions and viewpoints – perceptions – were not relevant to scientific exploration. An ironclad bond was created between the scientific method and truth; the goal became to establish truth not through human experience, but through the scientific method. So, that which met the criteria of the scientific method held more value and legitimacy than that which did not. The philosopher, Alexander Koyré explained this sentiment:

> . . . Modern science . . . united and unified the universe . . . But . . . it did this by substituting for our world of quality and sense perception, the world in which we live, and love, and die, another world . . . the world of quantity . . . a world in which though there is a place for everything, there is no place for man. Thus the world of science – the real world – became estranged and utterly divorced from the world of life (Watts 2010/2013, 39-40).

To some extent, these sentiments continue to operate today, and create some strange bedfellows, especially in fields like psychology, sociology, somatics, and SI that overlap medical science but may not be entirely comfortable eliminating the validity of perception. Psychology is one of the fields where the push to make the subjective, objective has led to some quirky developments and difficulties. There is a long list of gadgets designed and applied in the name of generating verifiable universal proof of psychological states through physiological measurement. Debate continues over the findings of the 2015 report of The Reproducibility Project, which reran 100 psychology experiments and found that over 60% of them could not be replicated. Some assert that the issue is only one of statistical methodology. Maybe so. Nonetheless, any field that studies the human experience – which changes depending on individual culture and context, is readily influenced by exposure and awareness, and is heavily affected by perception – is a precarious environment for insistence on universal reproducibility. What if the efficaciousness and individualization of the intervention are interdependent? What does this have to do with Rolfers and research?

The 2015 Fourth International Fascia Research Congress (FRC) offered an outstanding journey to the land where scientific research methods meet hot topics in fascia inquiry relevant to SI, such as: sensory aspects of fascia, evidence for myofascial connectivity, embryology and genetics of fascia, to name only a few. The pre-conference workshop, "Understanding Research Fundamentals for the Congress and Beyond," delivered clear guidelines for increasing one's literacy in interpreting and conducting research by laying out levels of evidence in research methods. Certified Advanced Rolfer Eric Jacobson, PhD, MPH, joined with three colleagues to establish viable paths for realistic engagement with research. (This excellent presentation can be viewed at https://frc.conferencevod.com/index.php/pre-conference.) The presentation included an illustration of the 'hierarchy of evidence' as a pyramid with gold-standard randomized controlled double-blind study, systematic review, and meta-analysis at the top and case study, case report, and expert opinion at the bottom. The hierarchy was arranged on the basis of eliminating risk of bias, confounds, and variables by design, resulting in increased reliability in conclusions validated by statistics for the purpose of consistent universal application. Because of the education, expense, personnel, and lab conditions required, the top level of research seems best conducted in affiliation with an academic or research institution. Receiving top-tier scientific validation for how the fascia mobilization aspect of SI works would be a 'dream come true' for our profession, and with several recently published studies, along with the relatively new scientific interest in fascia, this may become a reality.

However, Rolfing SI is not solely based on a series of therapeutic fascia-mobilization techniques. "An effective human being is a whole that is greater than the sum of its parts" (Rolf n.d.). We incorporate ideas such as holism, embodiment, integration, and education – all of which involve perception. "This is an important concept: that practitioners are integrating something; we are not restoring something. This puts us in a different class from all other therapists that I know of. It takes us out of the domain designated by the word 'therapy', and puts us in the domain designated by the word 'education'" (Rolf 1978, 40). Inherent in the concepts of holism, embodiment, integration, and education is perception. Perception is the human process of organizing, identifying, and interpreting sensory information in order to represent and understand our environment. By skillfully addressing our client's perception, we can positively influence the integration of our hands-on techniques including fascia mobilization, such that ease and efficiency in coordinative patterns, including posture, are available and maintained over time. What happens if we consider perception to be of vital importance to successful Rolfing outcomes? What if perception is key in successfully alleviating back pain? What if success is dependent on individualizing the intervention to meet the client's perceptual style and experience? What if the perception of the practitioner influences the effectiveness of the intervention? Does that make our work less valid?

At the Congress, I attended a presentation by Jan Wilke, Department of Sports Medicine, Goethe University, Frankfurt, titled: "Remote effects of lower limb stretching: evidence for myofascial connectivity?" Wilke, along with three colleagues, sought to evaluate the remote effects of lower limb stretching on cervical range of motion (ROM) by investigating the superficial back line (SBL) as designated by Thomas Myers: a myofascial meridian consisting of plantar fascia, gastrocnemius, hamstrings, and erector spinae (Wilke et al. 2014). The intervention group, consisting of thirteen healthy subjects, "performed three consecutive thirty-second bouts of static stretching for the gastrocnemius muscle and hamstrings respectively" (Wilke et al. 2015). ROM in cervical flexion and extension was assessed in this group and in a control group using an ultrasonic 3D movement analysis system. The conclusion based on analysis of variance and post hoc testing revealed improvements of cervical ROM when lower extremity stretching is performed, indicating existence of strain transfer along the course of the myofascial meridian. The purpose of Wilke's (2015) study was to validate the concept of fascia connectivity; it concluded with "further randomized controlled studies on conditions, factors and magnitude of tensile transmission are warranted."

Of course, potential validation of fascia connectivity as shown in this pilot study is exciting. However, I found that I was even more excited by the possibilities inherent in the variables – interventions that would partially rely on perception. What would happen if the subject actively increased proprioception and tonus through the support leg and foot in order to differentiate the function of the stabilization side from the mobilization or stretch side? If the subject feels secure in a sensation of home base (stabilizing side), so that he is free to expand into the world (mobilizing or stretch side), does cervical flexibility increase? Or, what would happen if the subject initiated the stretch from both ends of the muscle chain by imagining that his ischial tuberosity reaches behind while his heel reaches forward – performed with the intention of both ends actively reaching into the surrounding space? Does cueing this sense of bi-directional stretch in the SBL increase cervical ROM? Or what if the subject were given the task of staying present in his peripheral vision, soft focus, seeing and sensing his surroundings throughout the stretch? Would the stretch of the SBL, along with a shift away from a set visual focus, bring increased ROM to the cervical spine? In any of the above scenarios, does increasing sensation in the legs offer ease by reducing habitual cervical guarding or tensional holdings? In an evolutionary or developmental sense, once our legs come underneath our center of gravity to actively support our body, our neck and head are free to float upright, thus allowing a wider visual field to fully scan the environment for signals. When there is insufficient structural or coordinative activation in the legs, there may be a secondary holding in the cervical structures as compensation. We can address it through the fasciae of the SBL, but what happens when we also consider it within a broader context of coordination and perception?

Since the conference, I have experimented with each of these ideas (and a few more) with my clients who have cervical ROM issues. I made treatment notes documenting the kind of suggested intervention and how they embodied it over time: did the client continue to perform the stretch? Did s/he incorporate the suggested perception? Did s/he develop or alter it? Did it spill over into other activities? Was there a lasting effect on cervical ROM? Were other aspects of his/her alignment and coordination affected? How did I determine which intervention suited each client? This line of inquiry, mainly relying on subjects' perception of task, self-reporting, multiple variables, and my interpretation, may not be the stuff of gold-standard scientific method, but it has kept me vitally engaged in exploration and learning for several months.

For me, what was wonderful about Wilke's research presentation was the fact that I was flooded with curiosity and inspiration. How could the subject 'live' in the exercise, becoming more present. How could it ignite new patterns of coordination in his/her whole body? What would inspire my client to add the exercise to his/her resources for well-being? This active engagement with the topic led me to relevant PubMed searches, interaction with mentors and colleagues, inquiry with related somatic disciplines, and client interactions supporting ongoing engagement, education, and embodiment. Perhaps with the addition of standardized tools for measurement and reporting, this documentation could form the basis of a case report or case series.

The value of case reports was evident in the presentation given by Ruth Werner BCTMB at the FRC pre-conference workshop on research literacy (available for viewing at https://frc.conferencevod.com/index.php/pre-conference). A case report is defined as an article that describes and interprets an individual case, often written in the form of a detailed story. While they are considered as occupying a low level in the hierarchy-of-evidence pyramid, they often are where new issues and ideas emerge. A good case report is clear about the importance of the observation reported. If multiple case reports show similar findings, the next step might be a case study to determine if there is a relationship between the relevant variables. In the grand scheme of things, our entire field is a new and emerging idea, often incorporating novel concepts and interventions that are not mainstream to address mainstream problems, such as low back pain. In the *Journal of Medical Case Reports*, the world's first international PubMed-listed medical journal devoted to publishing case reports from all clinical disciplines, Richard Rison MD (2013) wrote:

> Case reports are a time-honored tradition in the medical profession. From Hippocrates (460 B.C. to 370 B.C.), and even arguably further back since the papyrus records of ancient Egyptian medicine (c. 1600 B.C.) to modern day, physicians of all specialties have described interesting cases involving all specialties. Published case reports provide essential information for optimal patient care because they can describe important scientific observations that are missed or undetected in clinical trials, and provide individual clinical insights thus expanding our knowledge base. The publication of case reports has indeed become a standard lexicon of the medical literature. Examples abound.

A well-designed and well-written case report may provide an avenue for the wider field of health professionals to learn about our work. Werner encourages all of us to write case reports and enter them into the MTF Case Report Contest! Writing a case report can streamline and refine treatment strategies and protocols. Reading case reports often inspires new ideas and connections; those written specifically by and for Rolfers are especially beneficial to us. Information on the specifics of writing case reports by Werner and others can be found in a free five-part webinar series at http://tinyurl.com/case-report-webinars.

By all means, if you have the professional credentials, institutional connections, and funding sources to participate in gold-standard scientific-method research, please do. Fascia is a hot topic – jump in! If not, jump in anyway; there are many other valid and productive ways to participate. Join the Fascia Research Society – its website (https://fasciaresearchsociety.org) includes presentations from past conferences and announcements about future events. Visit the Research section of the RISI website (www.rolf.org) to find information about project development, grants and funding, lists of peer-reviewed references, and summaries of the most current clinical studies. Peruse the Ida P. Rolf Research Foundation website (http://rolfresearchfoundation.org) for resources and a series of articles about clinical research design by Dr. Thomas Findley.

Visit websites such as PubMed, ScienceDirect, Medline, Elsevier, and Google Scholar to access large databases referencing international abstracts and articles. Subscribe or gain access to publications from Elsevier such as the *Journal of Bodywork and Movement Therapies*, *Human Movement Science*, or *Manual Therapy*. The *International Journal of Therapeutic Massage & Bodywork* and the *International Body Psychotherapy Journal* are available online. Some organizations, such as the American Physical Therapy Association, allow a non-member to create an account providing access to abstracts.

Design a case study, leading to a case report. Share your report in this Journal, the *IASI Yearbook*, and other journals. Create a group with colleagues for the purpose of sharing case reports. Start a Rolfing book club! Create an ongoing digital or paper journal with articles, quotes, ideas, images, and drawings – your personal research collection. Become familiar with local academic and research institution libraries, laboratories, departments, and public lectures for rich opportunities to interact with research topics and form alliances. Take a course for non-credit. One of my favorites was a college course that combined anatomy, drawing, movement, and Irene Dowd's "Spirals"™. Why not?

These suggestions are just a beginning – choose one of your interests, start, and the process will unfold. The important thing is to start with a question and follow your enthusiasm. Whether it leads to the *Eureka!* moment or deeper conversations with colleagues, it will feed your practice and soul.

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