

Containers and Contents – In General and in Relation to Scoliosis

An Interview with Peter Schwind

By Anne Hoff, Certified Advanced Rolfer™ and Peter Schwind, Basic and Advanced Rolfing® Instructor



Anne Hoff



Peter Schwind
(photo © Tachi)

ABSTRACT *In this interview, conducted in September 2018 when he was in the U.S. to present at the Rolf Institute® Membership Conference, Peter Schwind discusses his ongoing work with harmonizing the cavities of the body and their contents. Specific attention is given to a discussion of this in relation to scoliosis.*

Anne Hoff:

Thank you for what you wrote for the “Ask the Faculty” column about scoliosis (see page 7), and I’m glad we have a chance to speak in more detail. It sounds like many factors can be involved when a client comes in and asks for help with scoliosis.

Peter Schwind:

It’s helpful at the beginning to know something, what we know nowadays, about how scoliosis develops and how it manifests. As a beginning Rolfer almost forty years ago, I thought that the rotations and the irregular curvatures of the spine were very important, and that the different development of muscular and fascial layers manifest in the back were very important, and that *they* are the scoliosis. But I was a little bit disappointed with my results when I did practical application of the ten-session Rolfing Structural Integration (SI) series. Then when I got in contact the first time with craniosacral therapy, and then also with authentic cranial osteopathy, I thought *that’s* the key to scoliosis, because like everybody I found very typical motion restrictions

inside the cranial system and also spatial irregularities. But after a while [of working with that], I was disappointed again.

Then I slowly realized that there are different kinds of scoliosis, and the key in the development of those different types of scoliosis, the key for treatment, is how the scoliosis manifests as a very specific three-dimensional arrangement of inner spaces inside the cavities of the body. It’s not just about treating visceral motion restrictions. I think in many, many of the scoliotic manifestations, there’s a spatial dialogue between unilateral motion restriction of organs and the structures inside the craniosacral system, but this develops – the first steps of it – very early in embryological life.

I published my first treatment (technical) book, about fascial membrane techniques, in 2001; that’s seventeen years ago. In the chapter that discusses scoliosis, I described how I speculate that in up to 60% of scoliotic people the stomach has never found its place under the left side of the diaphragm, that it’s still in the middle and totally fixed together with the liver, with the main

space of the liver on the right side of the body. This kind of reality originates very early, in the third month of embryological development, when the embryo is only maybe 6 - 6.5 centimeters tall. At that moment, the esophagus and the stomach and the duodenum are like a straight little pipe in the middle of the body, and the stomach is a thickening in the middle of that pipe. Then during the latter days of the third month, the backside of that little thickening, the stomach, has to rotate anteriorly and move to the left side of the body and grow into the peritoneum. In those people who develop what I call 'stomach scoliosis', this movement of the stomach has not happened. The stomach remains in the middle of the trunk. There is a similar type of scoliosis where the liver is a little bit too much on the left side of the trunk. The ones with the stomach we can treat much more successfully than those with the liver; the liver is much more rigidly fixated by many ligaments, while the stomach is somewhat more mobile.

I had confirmation of my hypothesis about 'organ scoliosis' when I was able to observe the scoliosis of a grandmother, mother, and young daughter who all had the same scoliosis. The mother had to have an abdominal surgery, and the surgeon reported that when he opened the abdomen, the stomach was totally fixed to the midline towards the right side of the body, and to the liver. He cut the lesser omentum and a few other parts of the intraperitoneal structures and the stomach moved to the other side. I checked the client three months later, and the curvatures of the vertebral spine had lessened almost 50% because of this surgical intervention.

However, we have to be careful. It is not just the topography of the intrabdominal organs that comes into play (Figure 1). There is an interaction with certain spatial torques inside the cranium also. The big challenge is not to straighten the trunk too much. The least important is the back and the vertebral spine. That's the area where the scoliosis shows on the outside of the container, at the level of the musculoskeletal system. I am convinced that the deepest manifestation of scoliosis is inside the inner spaces, the inner cavities. It may be inside the thorax, we could call that a 'high scoliosis'. And, of course, a scoliosis has an effect on the whole tensional situation of the dura. Good old John Upledger said – and it's still valid nowadays – you have to open the

upper end and the inferior end. You have to open the transition between the sacrum and the coccyx, and you have to open the transition between the axis, atlas, occiput. The curvatures happen in between. You have to open above and below at the beginning and the end of the treatment. I think that's still very, very good advice.

I was very disappointed by my early belief systems when I thought that [scoliosis related to] one certain dimension of the body, and that the spine and the back, or just the craniosacral system, or just the visceral system, was the most important. Nowadays, after almost forty years of practice, and observation of some of my clients over that period, I have realized that we have to be quite modest, we have to be aware that scoliosis manifests all over the human organism, and it's a deep inscription in how the person orients in space in a tactile way and a visual way. That's why I think Hubert Godard can successfully do his work on the level where he, for example, blindfolds one eye and has the person move. I think it's extremely interesting to look into scoliosis from the perspectives that Hubert has opened for our profession.

AH: It sounds like a practitioner has to understand Roling SI, and visceral, and cranial work, but then that s/he also has to relate to all of those in a very different way, relating to the spaces.

PS: Exactly. I think that's most important, and also we have to be aware that scoliosis is inscribed in the whole system very early, before you see it from the outside. I always thought that it's a genetic disposition, and actually this has found some confirmation in the latest research. It was – if I remember right - in 2016 that some research groups found a specific chromosome that is very active in certain phases of growth and is responsible for the scoliotic development. There are genetic orders for growth and some important ones manifest on the level of the endocrine system. Scientists have documented how the injection of certain hormones into the body of fish will make them develop a scoliotic pattern.

But there is a much more global reality to be looked at: even considering just the outside of the body, the shape of the 'sleeves', we find spinal curvatures from the sagittal perspective, that are different in African cultures or Brazilian cultures compared to Asian cultures like Chinese or Japanese where you have less pronounced

curvatures. That's a simple example. Also there has been some new research about the role of the organ anatomy, that the genetic orders that happen during growth for the organs to find their right position, that plays a very, very, very dominant role. In 2016, besides the genetic research, there were some interesting publications from a group in Utrecht in the Netherlands about the role of the development of the anatomy, motion restrictions, the position of the organs inside the body, and how those relate to scoliosis.

AH: Even if it's genetically driven, affecting embryological development, can you later in life get a change in the pattern, get the anatomy towards more optimal positioning?

PS: Yes and no. You have to really evaluate all the inner spaces, all the horizontal subdivisions from the thoracic inlet down to the diaphragm and the pelvic floor. You have to really be aware that even the vertical and diagonal 'pipes', the arteries, the veins, all those things, they are in a very specific condition in a scoliotic person. I learned from some sad experiences that an overcorrection of scoliosis – trying to make a scoliotic person too 'straight' – is not beneficial. We have to aim for quite modest goals. However, if we start very early, with a newborn infant, and if we do minimal corrections, maybe three times a year only, ten- to seventeen-minute sessions, then longer sessions after puberty, then we have a chance that the scoliosis will not fully develop and may even disappear almost 90%.

AH: You described a family where you worked with three generations.

PS: Yes. I treated the grandmother, then I treated the mother, and then her baby. When the baby arrived, an orthopedic doctor did an x-ray and said there is no scoliosis, the spine is totally straight. A pediatrician who is also a Rolfer – my colleague Anne Koller – and I found that's not true. One of us would hold the pelvis and the other would hold the cranium of the few-weeks-old baby, and as we relaxed the baby there would be the whole shape of the scoliosis in the whole organism. I have observed this particular case of the girl for more than twenty years. We had to walk through dramatic challenges around her third year of life. There were times when we almost lost the courage to continue with our work. However, I just recently talked to her



Figure 1: A keystone of the treatment for scoliosis in adults requires sensitive treatment of the visceral structures and their relationship to the respiratory diaphragm. However, this is only a part of the treatment. (Photo from Peter Schwind's *Praxishandbuch Faszienbehandlung: Muskelfasziien, Membranen, Organhüllen*, 4. Auflage. München: Elsevier, 2018, page 85.)

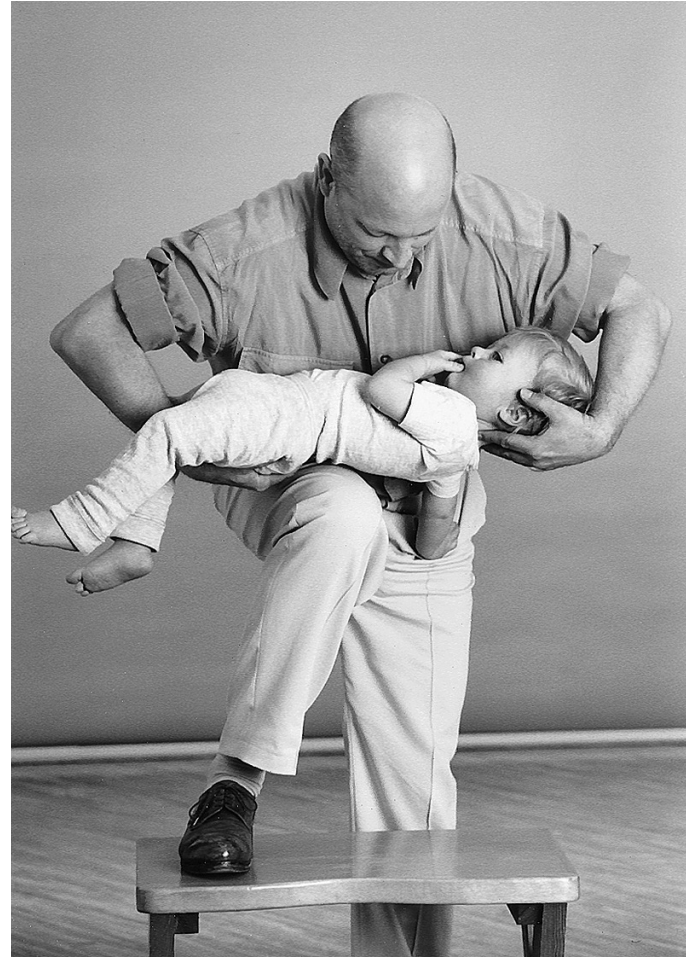


Figure 2: The treatment of scoliosis in infants requires specific understanding of the membranes inside the cranium and inside the spinal channel. (Photo from Peter Schwind's *Praxishandbuch Faszienbehandlung: Muskelfasziien, Membranen, Organhüllen*, 4. Auflage. München: Elsevier, 2018, page 84.)

mother again, who also has scoliosis, and she says that nowadays you see nothing in the daughter, even from the back. We checked, and tried to be as modest as we could in looking at the result. Even on x-ray, all you see is a little bit of soft side curvature. However, this can only happen if you start treatment very early with the baby, and apply only a small dose of treatment once in a while. If we correct too much towards the so-called 'normal', it will be risky. What was tragic, but taught us something good for our insight, is that her brother, who also has a scoliosis, was never treated young. I didn't get to work with him until he was seventeen. Comparing him and his sister it's really amazing. If the scoliosis manifests more clearly after puberty, it will change the shape of bones, especially in the rib cage. Once there's this unique individual

manifestation in the bones, we have to be very very modest in our work and our goals and it will take a long time to see a really positive shift of the whole spatial arrangement and the curvatures.

AH: It would seem like change has to be very gradual because the entire body has to adapt if it's grown that way from embryology.

PS: I agree.

AH: You don't want to change something and then have other parts of the body not able to catch up.

PS: What you say is really essential. I remember . . . once, during a workshop in the United States – way back – I did a demonstration session. I really tried to show a very drastic structural shift on all levels of the body during only one

treatment. I wanted to show what is possible. I used techniques that some of us – including myself – might call 'Stone Age Rolfing' work . . . I made the person too straight, and while I was able to impress my colleagues, the person I treated was in misery for a very, very long time. Sometimes we learn more from our mistakes than from our successes . . .

Unfortunately, there are also problems – once in a while – with the outcome of brilliant surgery. In the old days, they would take part of the tibia and put it alongside the spine, or they put in a rod. Nowadays surgeons intervene – and sometimes there is no other choice, they have to do that – in a much more smart way; they put titanium elements on two vertebrae, two vertebrae, all the way on both sides from the first thoracic vertebra down to the fifth

I think it's very, very interesting to look at scoliosis, to think about scoliosis, and evaluate in the most critical way possible what we are able to accomplish and what we are not able to accomplish. I think that we really have to look at what researchers say, we have to look at surgeons' experience, we have to look at what different bodyworkers do.

lumbar and the sacrum. The people are more aligned and do not collapse anymore onto the heart and/or one of the lungs. It's sometimes necessary to do that because the person gets high blood pressure, which is life-threatening, and cannot get enough air in the left side of the lung anymore. However, I have checked some people, they have tremendous problems, tensional problems, inside the cranium after that surgery. Also, the nerves that are related to organs are really in trouble. I have not found solutions for that. It's possible to get these people out of trouble for three weeks or four weeks, but then very serious problems come back. I talk to colleagues who have more experience than I, and they struggle with the same problems in these cases. It shows that the 'essence' of scoliosis is not in the spine, in the back; if that would be true, we could do surgery and things would be fine.

There is another surgical intervention done by two surgeons in Italy that is very interesting. Dr. Lorenzo Genitori works with children at the Meyer Children Hospital in Florence. And Dr. Marco Ruini works with adult patients somewhere in the region of Reggio Emilia. I have to get more information about this work. If I understand what they do, they are aware of the pulling forces of the dura inside the spine, so they will cut some fibers of the dura at the filum terminale just at the place where the dura comes out of the sacrum

and connects towards the periosteum of the coccyx. I have not checked it yet, but they seem to have interesting results.

AH: It would be great if you could get your hands on the cranium of someone where they've done that and see if you find the shift that you don't find with the surgical titanium.

PS: That would be interesting. I will try and get in contact with the surgeon who does this kind of work. There is also one researcher who claims that scoliotic people have unilateral attachments, extra attachments, of the dura inside the spinal channel. I do not know whether that's true or not, but it may be true because I'm absolutely sure that some of the very, very dramatic forces that act in the scoliotic organism manifest inside the spinal channel. I'm quite sure about that.

AH: You felt that with your hands on the clients?

PS: Yes. I feel that with my hands. I think it's very, very interesting to look at scoliosis, to think about scoliosis, and evaluate in the most critical way possible what we are able to accomplish and what we are not able to accomplish. I think that we really have to look at what researchers say, we have to look at surgeons' experience, we have to look at what different bodyworkers do. We have a good chance, I would say, within the next three to five years to make some very relevant conclusions

that will make our efforts as Rolfers and as instructors of our method much more beneficial for everybody.

AH: Can you say a bit to help readers in thinking about how to at least palpate some of these patterns you're talking about? What are some ways people might relate more to cavities than structures?

PS: For traditional Rolfing work, it is helpful to use our traditional visual analysis, but forget about the outside contours of the body and think about the inner spaces – like the intraperitoneal space, the retroperitoneal space (which contains mainly the psoas, the kidneys, and the supporting fat of the kidneys), and the subperitoneal space. These three spaces in the center of the trunk, in everyday activity like breathing, should function like the inner space of a vertically oriented accordion. The inner space on both sides should be in balance when people move around, when they breathe. It doesn't matter on which layer we work, so long as we support better expansion of the spaces that are compressed. We should respect some of the motion restrictions on the level of the vertebral spine. In a more regular physical structure we may eliminate motion restrictions, especially those that manifest bilaterally, they are unnecessary. But in the case of a scoliosis, some motion restrictions are necessary for stability so we have to be very careful in adjusting vertebrae in

relationship to each other. We have to sort out how much irregularity in joint mobility and restriction is helpful for the person, and how much of it is actually reducing a person's vitality.

AH: It seems like the inner cavities have to change first, then that need for stability might be less. Eliminating the joint restrictions without the inner cavities changing, you'd be messing with how that person knows how to hold himself together and function.

PS: Exactly. Looking at the 'column of organs' – as I call it, and as Jean-Pierre Barral calls it – if the column of organs supports the lumbar spine quite well, we can remove strain on an articular level of the vertebral spine – but only as far as this is supported from the front in the three-dimensional space. If you remove the restrictions between vertebral bodies, or between ribs and vertebral bodies, without having better support from the front, it won't help the person that much. When we work on one level of the organism from an anatomical point of view, you have to watch whether the other anatomical – 'spatial' – units say yes to that or say no to that. I think that's probably the best strategy. People say that Ida Rolf once stated, "Man is something build around a line!" – But what is the *something* around the line? The something is cavities relating to each other in the field of gravity. In my opinion, man is certainly not made by lines around a line. Well, we may speculate that cavities and pipes do relate to each other in curved planes. I do not say that we have no linear force transmission inside our organism. But the nonlinear force transmission inside the fascial spaces should never be neglected. When Jan Sultan introduced the notion of *lines of transmission* in the old days, this made sense, because he was smart enough to give his internal-external model a spatial dimension.

AH: Now you spoke about the percent of scoliotic cases that you think relate to this embryological pattern affecting the cavities.

PS: Of the stomach, 60%. Then there may be 12%-20% related to the liver's development. Then there are others which are more related to especially the heart inside the thorax, and others – not so many as I originally thought – to a sort of a torque inside the spaces of the cranium. While thirty-six years ago I would have thought there were problems on the sutural or membranous level of the cranium, now I would say it's on the level of spaces,

because the scoliosis is manifesting even within the different units of the brain itself. If we correct only the container of the brain and we do not have elegant direct access to the brain and its nerves and arteries, we have a certain effect on the 'contents' – the brain – via the container but it's not profound enough. That leads to my favorite inspiration from the work of Jean-Pierre Barral about direct manual treatment of the brain and its nerves and arteries and all this kind of thing, which is different from the traditional cranial osteopathic approach. I'm not saying that's bad; cranial osteopathy, what Sutherland developed, is a very big step forward, but it's probably not the most important part of the game. Treating the container, the cranium and the subdivisions with membranes, in an intelligent way, as Sutherland did, you automatically do something good to the blood supply of the brain and also to the nerve connections, but – sometimes – it's not enough.

For me, it was always interesting to speculate that there is permanent interaction between the cavities of the body. So the craniosacral system and the inside of the cranium are not separate from the inside of the thorax and the abdomen. What most of us do not know is that when Sutherland, the founder of cranial osteopathy, taught his first course, many years before Jean-Pierre Barral, he taught visceral manipulation as part of the cranial work. There are photographs of that, of

deep liberation inside the spinal channel. I'm not sure if Ida Rolf was aware of that because she talked so much about mobilizing L5 and S1 and many other aspects of the pelvic lift. But when Lloyd worked on me more than forty-five years ago with the basic Rolfing series, when he performed ten times a pelvic lift, six times I was deeply moved and four times thought it was a pelvic flop where nothing happened. But those other six times I felt this incredible positive impact on the autonomic nervous system and I had the feeling that something inside my whole organism, very deep inside, went in flexion and extension. I didn't have the anatomical and physiological knowledge in those days. – some forty-five years ago. I had no idea what was happening. Nevertheless I was quite desperate for a long time in the years after, because I couldn't find anybody who could do this kind of pelvic lift for me. In my personal experience, most of us were only able to release compression between the lower part of the lumbar spine and the sacrum but were not able to affect the dura and the spinal cord. For that reason, prevertebral and postvertebral balance was accomplished quite rarely.

AH: Again you're talking about the importance of multiple layers being affected.

PS: Multiple layers and cavities. Putting the inside of the cranium aside for a

The containers and the contents are in a permanent dialogue, a spatial dialogue, a tensional dialogue.

the first class that show how Sutherland actually treated the liver, treated the kidney, and also treated the psoas. He even did a pelvic lift – he called it pelvic lift – in a different way than the pelvic lift that Ida Rolf taught. But Ida Rolf was in the class and actually I think that she took the notion of the pelvic lift from Sutherland. Sutherland did the pelvic lift while he had the client resting in a side position. He took the occiput and the sacrum and carried the whole system in flexion and extension and released the dura.

My first Rolfer, Lloyd Kaechle, did a pelvic lift in a profound way that I felt it as a

moment, the most interesting cavity is this very long cavity, the channel inside the spine, the spinal canal. Not only the dura but also the spinal cord live inside that space. We may call the contents of the two spaces, the contents of the cranium and the contents of the spinal channel, the most important core structures. Compared with these core elements, the psoas is a quite superficial muscular structure. This muscle is so important to move the leg, but it has almost no power to move our back. The anatomist Frank Willard had something quite relevant to say about this when he discussed the

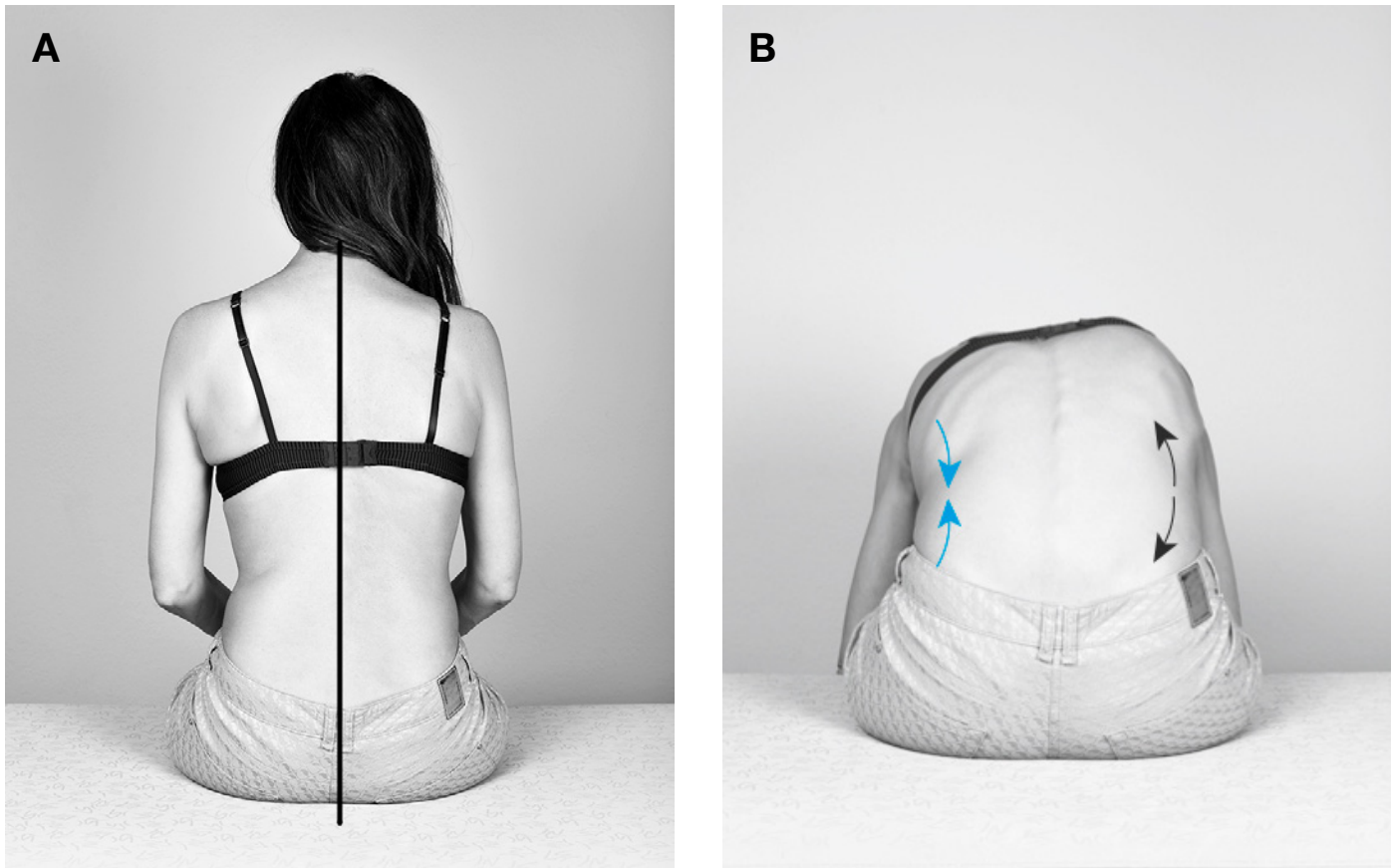


Figure 3: With the client in an upright seated position (A), we may not see that there is a spatial collapse underneath the left side of the diaphragm. As the client bends forward (B), however, the spatial collapse on the left side between the twelfth rib and the crest of the ilium becomes evident. (Photos from Peter Schwind's *Praxishandbuch Faszienbehandlung: Muskelfaszien, Membranen, Organhüllen*, 4. Auflage. München: Elsevier, 2018, page 87.)

outcomes of his inspiring anatomical research at the Osteopathie Kongress Berlin 2018 in November.

AH: So it's the containers, their shapes, their qualities, and also their relationships to each other and their contents?

PS: That's what I want to say. The containers and the contents are in a permanent dialogue, a spatial dialogue, a tensional dialogue. On the container level, we have flexion and extension of the muscular units. But part of it is transmitted in a nonlinear way inside the fascia, as Huijing has demonstrated so clearly with his research. On the level of the contents inside, we find an exchange of differences of hydrostatic pressures between the different cavities – and you can speculate that that is true all the way down to the cells. You may look at the joints inside the capsules and realize that most joint problems are not only too much tension or a lack of tension in the layers that cross the joint; it is also the hydrostatic pressure inside the joint capsule which is the problem. One of the

really important goals in treating joints is to reduce the pressure inside the joint capsule. If the pressure is natural and not too high, through movement of the sliding surfaces (which are covered by cartilage) we have better flow of the synovial fluid inside the joint, and that's the nutrition for the cartilage which has no arterial blood supply. It can only stay alive by the support of the synovial fluid. Also, when we have problems in the vertebral spine, we have to become aware that it's not a problem that the disk is too thin or too small or that it bulges out. The problem is that the pressure inside the disk is too high, and we have to treat the structures related to that to diminish that pressure.

AH: It seems like a lot of this, to generalize, is talking about tensegrity.

PS: Yes and no, because the tensegrity model that originally came from architecture is a model that is only useful to a certain degree. We have to be aware that if we have the traditional tensegrity model with struts and cables, it is a very dry model. In the human organism, the

bones and the teeth are the most solid parts; they are the 'struts'; however, they are floating, their ends sit in liquids inside joint capsules. In the traditional tensegrity architectural model, you don't have that; it's very dry; it's much more simplistic. We have to be aware that, actually, we have to understand it better. If we want to go on to use a tensegrity model to explain what we are aiming for, we have to expand this model respecting the realities of fluids and cavities and we have to forget struts and cables. We have to add to the model the hydrostatic component at the endpoints of the struts. We also have to be aware that we will not find 'struts' inside our bodies. There are no straight struts in the body, no straight lines. There are curvatures in the body that change also in relationship to the longitudinal and diagonal 'pipes', like arteries, veins, lymphatic vessels, and so on.

Nowadays people forget that we Rolfers were the first ones – aside from some creative architects – to talk about tensegrity; it was in the '70s that Frei Otto

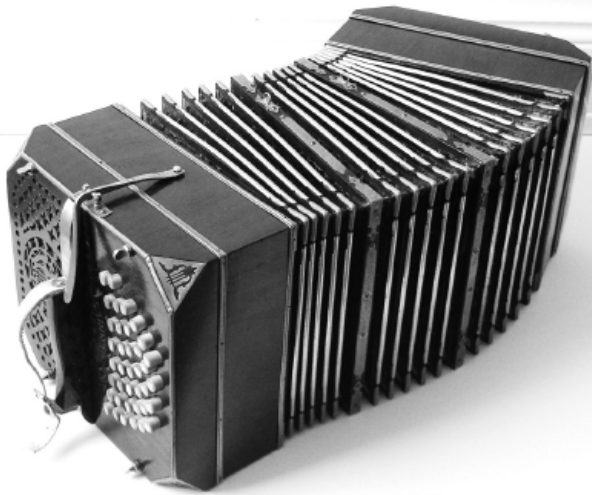


Figure 4: The bandoneon was invented in Argentina. When we look at this instrument, we may understand what inner motion of a cavity means for the human organism. (Photo: CC BY-SA 2.5, <https://commons.wikimedia.org/w/index.php?curid=395715>.)

published an article in the old journal, the *Bulletin of Structural Integration*. Nowadays, everybody talks about tensegrity, sometimes only from the perspective of marketing – which is not a bad thing. We all may benefit, those who are mainly interested in marketing and those who are interested in new insight, we all may benefit if we try to expand the models we use in a more intelligent way.

AH: Right. I wasn't thinking so much of a simple idea of the struts; I was thinking that really even a joint capsule or a joint itself is like a tensegrity structure; and that these tensegrity structures exist within larger tensegrity structures like the cavities. It seems like there would be an optimal shape and elasticity for the cavities, an appropriate arrangement of their environment.

PS: That may be true. And please let us not forget about gravity. Gravity is not only interesting from a perspective of alignment of that what we see on the surface of the body, like on the back curvature or front curvature. Gravity is very important to see in relationship to how the different cavities can slide on each other while gravity acts.

To give an example, let's look at the peritoneum as a whole; I don't think so much about individual organs and their movement only. The peritoneum as a whole should be able to slide not only downward with its posterior wall in relationship to the psoas fascia and the renal fascia, which in turn would all also slide upward; it should also have the capacity as a large unit in space to rotate and sidebend, up to a certain degree, to the left and right – just like, for example, the sacrum on the level of bony segments.

Similar to the micro-adaptability we see in the different segments of the sacrum. Osteopaths know that the individual segments of the sacrum should have the capacity to micro-rotate on each other and even micro-sidebend on each other. It's equally true for a bone and for large units like the cavities of the body. They should show the same behavior if they are free in space. The simple vertebral movements that avert pressures in relationship to other vertebrae inferior or superior, movements of rotation and sidebending for example, should show also as movement potential in larger units of a whole cavity.

The large intraperitoneal space supports the lumbar spine from the front. If there's a collapse inside the peritoneum, a spatial collapse, it means that one side of the vertebral spine is not supported in an efficient way from the front. You can treat the fascia of the back as much as you want; it won't work. Of course, it may be helpful to train the transversus abdominis muscle.

AH: This goes back to the accordion that you described.

PS: Exactly.

AH: The accordion can't expand and contract within certain spaces.

PS: Yeah. Think of the torso of the human body as being like several small accordions stacked on each other. While breathing, a certain accordion may expand well on both sides, and the next small accordion under it may only move on one side while on the other side it's stuck. I don't know if you know the bandoneon, the instrument of the unforgettable artist Piazzolla. The bandoneon is much smaller than the accordion. It's almost like a cube, and it

explains this in a much, much better way. If you imagine a bandoneon in a vertical position, that's the best image of what happens inside a person's whole trunk when a person breathes and moves around.

AH: This seems like it would very much relate with the whole idea of lift.

PS: Yes. There should be enough lift, but there should also, in a similar way, be a certain capacity to collapse in space, to fall into space, to bring the space under compression deep inside and let it expand by self-regulating pressure. Hans Flury has described that for *normal function* – if I remember right – as sinking into the fascial net.

AH: What do you think about the different things that people wear for scoliosis, braces and corsets?

PS: I don't want to struggle too much with the orthopedic profession. Some leading orthopedic doctors around Germany send their own family members to a Rolfer rather than using these kinds of devices. I have many times had discussions with them. I know that actually there is a very problematic side to teenagers wearing those corsets, because there are underlying emotional patterns related to individual organs. If you squeeze the organs in a particular direction where they cannot comfortably stay, you run the risk of developing tremendous psychoemotional problems. As a result, many times besides the corsets, they have to prescribe heavy psychopharmaceuticals. That's something I see from a critical perspective: if you compress an organ, you cannot exclude psychological reactions. The corset squeezes the container more towards an ideal average position, but the contents can only follow up to a certain degree, so you create a struggle between a more ideal container and the contents. Sometimes in these cases, the contents don't fit the forced container shape.

AH: There needs to be a harmonization between the contents and the container.

PS: Exactly.

AH: There's also the psychological impact of being the only kid in school wearing a brace, especially at the vulnerable time of puberty and teenage years. I think it can create a self-image of, "There's something wrong with me."

PS: You are right. If we push the container too much towards an ideal shape and the contents cannot really follow, there is a big conflict not only in the anatomy of the

If you know what to look for, you will see something. If you don't know what to look for, we will see just our fantasies – which sometimes touch into reality, but unfortunately, only sometimes.

physical body but in the whole person. Also, I would say if we push the contents, without the preparation of opening the container so that the contents have space to go to, you also create a conflict. It's really important that we are aware, generally – not only in the treatment of scoliosis – that the contents and the container fit well together.

AH: You're working on a new edition of your book, right?

PS: Yes. Books are always good, they stimulate thinking. The new edition of my book is unfortunately only in German so far. We have an English version from way back, and we have a Polish edition skillfully done by our colleague Adam Polanski from Warsaw. Now – for the fourth German edition I wrote a new chapter about scoliosis, and I wrote a new chapter about a completely different approach to the psoas (compared with the old approach that we use). I tested the new approach to the psoas and I'm a little bit more optimistic about this approach than the approach I used thirty-eight years ago.

AH: How can people learn from you?

PS: I may offer some workshops in South America next year, maybe in Colombia together with our colleague Juan David Vélez, and North Americans could travel there. It's not as far away as Europe, where I teach sometimes for the European Rolfing® Association and for our Munich Group – by the way, also in English. There are also people around me who understand these things and can teach. It's less important to study with a particular practitioner than to understand the concepts.

AH: Okay. I've not heard other people articulating this in quite the same way as you.

PS: Sometimes it is helpful to look back and to look forward at the same time. I just had a great talk with one of my

really important teachers – Jan Sultan. I remember the workshops he organized for me together with Bill Smythe. That was twenty-four years ago. And I am happy to look to the future when I listen to the questions of the young American colleagues I met at the membership retreat on Whidbey Island.

AH: I remember the class I took with you in Santa Fe in the 1990s.

PS: I taught two workshops in Santa Fe. It was the beginning of this thinking.

AH: You were talking about the spaces and how the spaces interacted. I can see the thread through this, but you've taken it so much farther now.

PS: I'm pretty sure that in those days, in the '90s, we were aiming in the right direction. The techniques I taught then nowadays look a little bit clumsy to me. They were headed in the right direction, however it took a long time to remove the clumsiness from my approach.

All the people around me who have spent the last years coming to workshops, especially in the last five years or so, I see that they all make progress and become creative themselves. I think these new techniques, based on both tradition and new concepts, have some value. But whenever we introduce something new, at the same time we lose something. I got some feedback just now – after two weeks of advanced teaching. The feedback tells me that the most efficient things are not that difficult to do. If you know what to look for, you will see something. If you don't know what to look for, we will see just our fantasies – which sometimes touch into reality, but unfortunately, only sometimes. Maybe my colleague Hans Flury would like that statement . . . Whether we like it or not, concepts are – in my view – more helpful than endless lists of techniques.

AH: Is there anything else you want to say?

PS: I'm really curious what other colleagues have to say about scoliosis. I hope for a dialogue. I hope to learn something more from other people. I have been invited several times, as I stated in the other interview [see "Navigating Between Technical Refinement and the Vast Dimensions of the Soul: An Interview with Peter Schwind" in the March 2018 issue of *Structural Integration: The Journal of the Rolf Institute*®], to present our view to international societies about scoliosis. I've always said no, so far, because I feel that I don't have things quite together yet. Let's see what the dialogue with other approaches will bring to us in the future.

AH: Thank you, Peter. I think this is a beautiful big discussion of the whole topic.

PS: You have supported my contribution to our approach for so many years, thank you very much.

Peter Schwind Ph.D. was certified as a Rolfer in 1980, as a Rolfing Instructor in 1985, and as an Advanced Rolfing Instructor in 1999. He practices in Munich (Germany). Peter regularly publishes articles about the treatment of fascia in various European journals of osteopathy. He has written a series of books that were translated into several languages. The English version of his latest book, The Croissant Inside the Brain, will be published in the U.S. at the end of this year; it deals with the new approach that Jean-Pierre Barral has developed for the manual treatment of the brain. Peter has worked with the practical application of this approach for ten years.

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