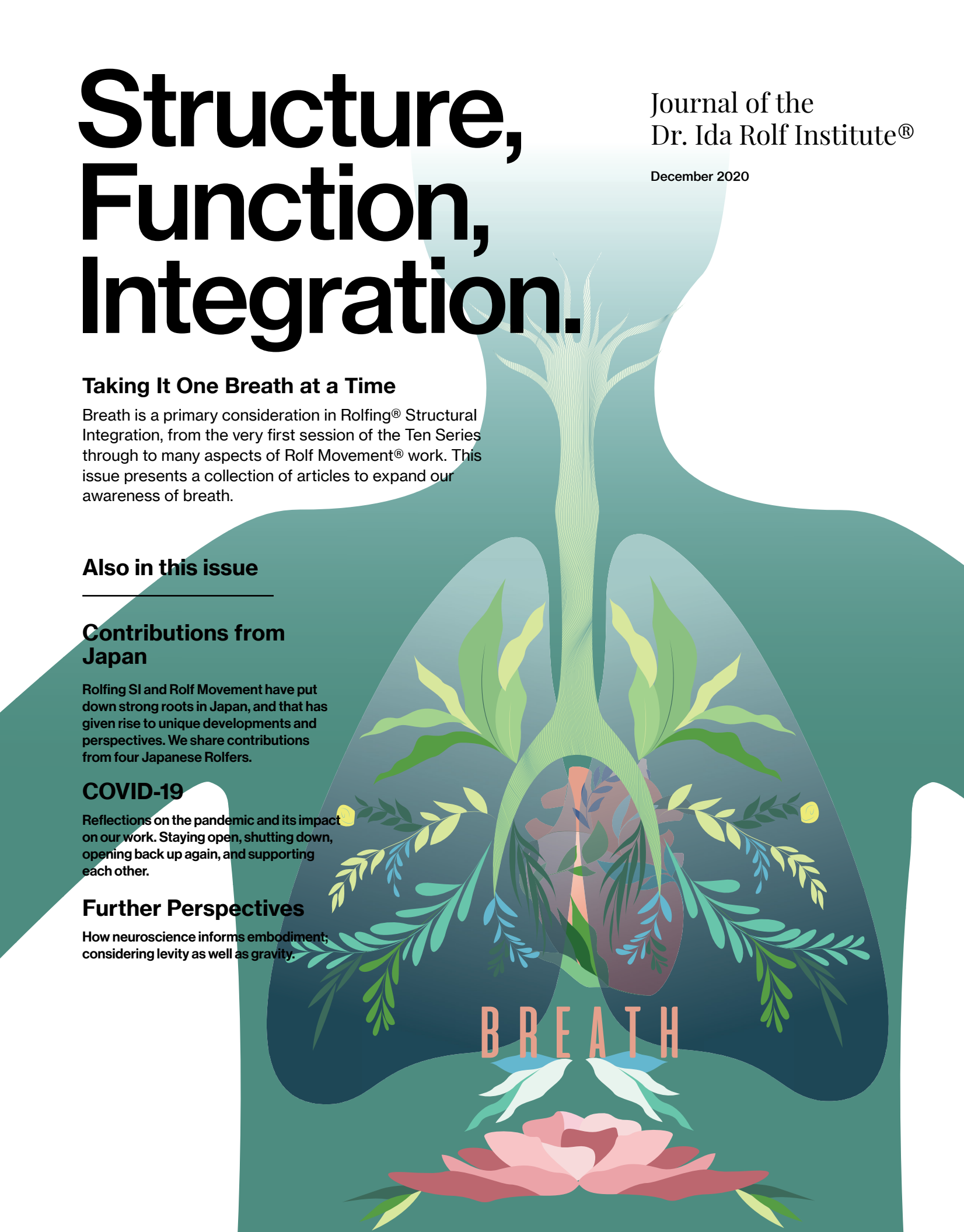
Structure, Function, Integration.

Journal of the
Dr. Ida Rolf Institute®

December 2020

Taking It One Breath at a Time

Breath is a primary consideration in Rolfing® Structural Integration, from the very first session of the Ten Series through to many aspects of Rolf Movement® work. This issue presents a collection of articles to expand our awareness of breath.



Also in this issue

Contributions from Japan

Rolfing SI and Rolf Movement have put down strong roots in Japan, and that has given rise to unique developments and perspectives. We share contributions from four Japanese Rolfers.

COVID-19

Reflections on the pandemic and its impact on our work. Staying open, shutting down, opening back up again, and supporting each other.

Further Perspectives

How neuroscience informs embodiment; considering levity as well as gravity.

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December Cover Art

Taking It One Breath at a Time

Way back in 2019, the 'beforetimes', we decided to do an issue about breath. We lacked prescience then of the coming COVID-19 pandemic, but the new global context was forefront in our thinking this past month as the journal Editors-in-Chief and design team dialogued about a cover image that would illustrate our breath theme. We are living at a time when mere breathing can spread a debilitating and sometimes fatal illness, yet what can we do but continue to go through our lives taking it one breath at a time? Ultimately, we wanted to re-inspire a healthy view of breath, and it was Lina Amy Hack, one of the Co-Editors-in-Chief, who came up with the design concept of the 'breathing tree', which was beautifully executed by the design team at Orange Identity.

Here, Lina articulates the layers of meaning in the cover image:

> *When people think breath, they think of the lungs, the interface where air meets blood. A breath of fresh air, health, and vitality quickly led to the idea of expressing healthy lungs with imagery of lush greenery. From this core concept, ideas flowed. If lungs are represented as green leaves reaching into the body, then the trachea must be the truck and roots of the breathing tree, opening upward. And we must include the heart, the organ that moves oxygen-rich blood through the body and helps remove carbon dioxide, which our exhalation sends out to the trees and greenery of our outer world.*
>
> *When Rolfers™ think about breath, we also think about the diaphragm and its central tendon, a moving midline structure. The central tendon is pulled downward by the diaphragm during inhalation, then there's a letting go of tension that returns the central tendon to its more upward location and facilitates exhalation. This moving midline is stylized in our cover image in the blue bilateral ornamentation, while the terrain below the respiratory diaphragm – including further diaphragms – is symbolized with a lotus. Of course, Rolfers know that the whole mind-body soma is dynamically responsive to breath, so let yourself imagine the 'breathing tree' energetically nourishing our psychobiological totality.*

We hope our cover image inspires you to feel the vitality of your breath as you continue on to read the articles of this issue.

Contents

Letter from the Co-Editors-in-Chief

Anne Hoff and
Lina Amy Hack

Anne Hoff

Lina Amy Hack

Lean into your Rolfing® Structural Integration knowledge, practice what you preach, and when ready, be of service. We are right here with you, cheering you on.

We have two themes in this issue: a collection of articles on breath and another collection of articles written by Japanese Rolfers™.

This December 2020 issue (volume 48, no. 2) of *Structure, Function, Integration: The Journal of the Dr. Ida Rolf Institute®* is being published during a new era for the human family, in the time of COVID-19. We have two themes in this issue: a collection of articles on breath and another collection of articles written by Japanese Rolfers™. We also have some snapshots of this pandemic moment for our Rolfing® Structural Integration (SI) community.

Once we were given the green light to publish this issue, we decided that the Facia Insights column needed to consider COVID-19, Rolfing SI, and fascia, even if the information is still preliminary. Lina Amy Hack spoke with Dr. Wiley Patterson, a Certified Advanced Rolfer and physician in San Antonio, Texas. Next, Lina also interviewed Christina Howe, Executive Director and Chief Academic Officer of the Dr. Ida Rolf Institute® (DIRI), as well as a selection of Rolfers from around the globe for the COVID-19-related article that leads our breath theme. We hear from Howe how she and her DIRI team are guiding the ship through these unprecedented times, both securing funding to survive the COVID-19 shutdown and then managing a safe-restart of trainings. The Rolfer interviews – with Pedro Prado in Brazil, Naomi Wynter-Vincent in the UK, and Jeanne Vadnais in the US – show how various of our colleagues are managing work, shutdowns, and safe reopening.

We all know that breath is primary in Rolfing SI, starting with the focus on three-dimensional breath in the First Hour of the Ten Series. Our Ask the Faculty column addresses breath, and our Letter from the Embryo column looks to the forces that form the lungs and diaphragm. Then, our theme Taking It One Breath at a Time, where we have contributions on breath in relation to pre-movement and orientation, and to anxiety; some breath-centered yoga poses you can bring into your practice; a consideration of the impact of sleep-disordered breathing on the body; and *breathy musings* that evoke the mysterious power of the breath in our work.

Our second theme includes four contributions from Japanese Rolfers. Naoki Hattori, a Rolfer and acupuncturist, speaks to the synergies of those modalities. Yoshitaka Koda talks about being the first Japanese Rolfer and his personal trajectory over about thirty years in practice. Masahiko Kushizaki shares the story of the Japanese Rolfing Association and his vision for how Rolfing SI can continue to grow to have a larger presence in Asia. And finally, Tsuguo Hirata takes us into the bone and how to play with tension patterns in order to interact with our perception, movement, and brain.

Then in our Perspectives section, the first article is an insightful and in-depth interview with Rolfing Instructor Michael Polon about how neuroscience plays a key role in the embodiment of SI. In his contribution, Max Leyf Treinen plays with the concept of levity, a philosophical construct brought to the Rolfing context.

We wish all of you, our readership, wellness and security in these times of change. Lean into your knowledge, practice what you preach, and when ready, be of service. We are right here with you, cheering you on.

Lina Amy Hack

Anne Hoff

Co-Editors-in-Chief

Ask the Faculty

Start at the Beginning with Breath

ABSTRACT *Breath has always been integral to our Rolfing® Structural Integration and Rolf Movement® paradigm. In this column, our faculty authors speak to the foundational nature of breathing in our work.*

Q: Most wellness modalities consider breath in their therapeutic interventions. (a) What is unique about how Rolfing SI and Rolf Movement work with the breath? (b) Can you describe one client where the work you did around breath was pivotal to his/her structural recovery and/or the integration of the work? (c) When you are working, how do you consider your own breath?

Editor's Note: The faculty were asked this question before COVID-19 was on all our doorsteps, and they provided these answers mostly in pre-COVID-19 times.

Pierpaola Volpones
Basic Rolfing Instructor and
Rolf Movement Instructor

Everything starts with a breath in. And ends with a breath out.

Breathing is such an expressive movement of our state of being, in terms of wellness and health.

The act of breathing happens at many layers: from the basic chemical and neurological control of providing oxygen and releasing carbon dioxide to assure basic physiological activities, to the capacity to modulate the demand for more air when involved in physical activities. Breathing is not just a neuromuscular activity based in the contraction and release of our diaphragm and other muscles; it is also a chemical activity linked with several other functions – less tangible but not less important, vital unseen functions take place.

Breathing is environmentally dependent: when I imagine being in nature, in front of the ocean, or surrounded by trees and flowers, I feel my breath full and profound. Walking on a busy street full of cars, or in a smelly place, does not invite my breath to be full and deep. Or when the air is too cold, too hot, too humid, most probably my breathing will be reduced.

Breathing expresses emotions; a free breath creates space for expansive emotions like joy, as much as holding and shrinking are perfectly expressing such emotions as frustration or inadequacy. Laughing and crying are expressed by a certain contraction of the diaphragm. Emotions have ways to breathe.

Sometimes a holding in the diaphragm, particularly in its crura, produces back pain as a side effect. A permanent holding prevents our lumbar area responding and adapting to daily-life activities. It might reflect on the mobility and motility of the organs that have intimate relationship to the diaphragm and the spine, for example the duodenum, the liver, the stomach, and the kidneys.

Breathing and mobilization of energy go hand in hand: qi gong and tai chi are disciplines based in breathing practice. And energy balance is a sign of wellness and health well beyond traditional Chinese medicine. Looking back to historical roots in the origins of Mediterranean-basin culture, I found something interesting: *pneuma* is the ancient Greek word that means *air – breathing – souffle – spirit – soul as the beginning of life* – all of these. Similarly, in Hebrew *ruah* stands for *spirit, breath, souffle*. It is interesting to note that in several ancient cultures, the word for breath is the same for life force, creation, and the divine. Breathing is indeed coupled with life.

As we experience every single day, life has a flow, a rhythm, exactly like breathing. Breathing and life have a pulsation, they move in a wave, not as a flat line. A flat line appears when we don't breathe any

Breathing is my compass and my anchor.

- Pierpaola Volpones, Basic Rolfing Instructor and Rolf Movement Instructor

longer, when our heartbeat stops. Nothing stays the same forever: the change of shape, of rhythm, of flow is in the nature of life, is an expression of life. Sometimes, these changes are unexpected and sudden, unpredictable to most of us. My parents and grandparents experienced World War II; I am experiencing the worldwide diffusion of this COVID-19 virus that is changing our lives. Speaking for myself, it has changed my lifestyle, value system, friendships, and my Rolfing SI practice.

In these months, breathing is what helps me to stay present and oriented, to regulate my nervous system when I feel overloaded by the uncertainty of the future – an uncertainty that is not limited to my personal future, but to the future of all of us, worldwide.

Breathing is my compass and my anchor.

Jörg Ahrend-Löns
Basic Rolfing Instructor

I have to confess that in my personal development as Rolfer™ and physiotherapist (PT) it took quite a long time to embody *breathing*! In the beginning of my professional path as PT and even as Rolfer it was *just something* we needed to do in order to stay alive. The entrance to the complexity and different relationships of breathing in my case was provided in a post-advanced workshop with Michael Salveson in Tuscany years back. Michael was looking for a model to demonstrate briefly some structural approaches around the costovertebral joints in the thoracic spine. My intuition let me jump up and before any mindset was preventing me, my body was already on the table. Rather than demonstrating some *costovertebral techniques*, Michael did an entire *breathing session* that lasted for at least one hour. Until today it's difficult for me to find verbal expressions for this *breath-opening* experience. But what I can say with certainty: my understanding of *breathing in gravity* is much deeper since then.

Breathing started to become a discovery, and in the following text I want to describe some of my findings – not written in stone – rather subjective. The frame for my explanations of the different levels of my experiences regarding breathing are the Rolfing Principles of Intervention and Hubert Godard's model of four structures (physical structure, coordinative structure. perceptive structure, and psychobiological structure).

First, breathing is space! If we briefly look at the physiological and anatomical implications of this statement, we can approach breathing from different perspectives. We start with looking at the purpose of breathing: the main physiological function is to provide vital-for-life oxygen and get rid of carbon dioxide. The more space or volume is available in breathing-in and breathing-out, the bigger the difference of pressure between the environment and lungs. The scale of this pressure gradient determines the efficiency of the gas exchange. In order for air to stream into the lungs, the pressure in the thoracic cavity needs to be lower than the atmospheric pressure – in other words, pressure is inversely proportional to volume. The bigger the *inner* volume of the thorax, the lower the pressure within the lungs and the easier it is for air to stream into the alveoli.

Let's have a brief look on how these differences in volumes are provided. From the perspective of Rolfing SI, it's of course most interesting how every single part of the myofascial system is cooperating and how it affects the 'spacers' – the bony parts and their articulations (ribs with the articulations to the spine, the spine itself, the shoulder-girdle clavicles and scapulae, the sternum with its cartilaginous connections to the ribs). Many structures that are related to each other might affect the breathing movement. One clinical example for structural limitations on the joint level is Bekhterev's disease, which often is accompanied by severe respiratory symptoms. The diaphragm and the intercostal muscles are known as the main breathing muscles. All muscles connected to the chest act on the breathing movement. This influence could be accessory but also inhibiting. An example: tension and shortness in the belly muscles – particularly obliques – might limit inhalation by holding the ribs down.

So far, we've looked at *breathing* from a perspective of the *physical structure* – admittedly in a quite roughly summarized way. Now the perspective of the *coordinative structure* needs consideration regarding functional coherences. Core structures play an important functional role, particularly in inspiratory movement and chest breathing. It's embedded in the 'postural triangle' of vestibulum, eyes and feet, the orientation to the substratum, and to space along the line of gravity.

The proprioceptive cooperation of senses provides an activation of the whole core stabilizing system. On the level of the diaphragm this activation – in this case particularly the activation and cooperation of transversus abdominus and multifidi muscles – prevents the central tendon of the diaphragm from lowering (belly breathing) and lifts the ribs instead (chest breathing). In this case active expiration is actually not needed; exhalation happens simply from the elasticity of the thoracic myofascial system and gravity.

Now I'll consider some of our Principles of Intervention that might help with understanding the complexity of breathing. When there's insufficient *support from below* we can see in 'body reading' functional inhibitions to inhalation and/or exhalation. *Adaptability* might be limited not only by a lack of flexibility in superficial myofascial structures and/or articulations, so in regard to creating space we need to look at how superficial and deep structures are in communication – structurally and functionally. Finally, *palintonicity* indicates support, alignment, and orientation in gravity; and in regard to breathing, a respiratory balance.

One last point I want to touch on is the *psychobiological*. The two layers of the pleura give stability to the lungs within the chest via adhesive forces, a prerequisite for the lungs being able to follow the chest and diaphragm as they move with the breath.

The pleura is strongly innervated by branches of the vagus nerve – part of the autonomic nervous system (ANS) – and I see this as one of the key relationships to understanding the complexity of breathing. As breathing is thus deeply connected to our brain and ANS, so it is to our *perceptive* and *psychobiological structures*. From my perspective, breathing might be one of the most important pathways to our innermost space or being. This relationship has the potential to determine how human beings

Breathing is one of the most important *doors* for communication between client and Rolfer.

- Jörg Ahrend-Löns, Basic Rolfing Instructor

relate to the world and to themselves. Not for nothing, breathing is in almost all meditation traditions and is an important approach to calm down a 'busy' mind.

In summary, Rolfing SI for me includes the opportunity to look at a very basic and vital-for-life function of our body from different perspectives. The Rolfing Principles of Intervention and the differentiation of structures are important basic 'tools' for Rolfers to get in touch with their clients in a very specific therapeutical relationship. In this regard breathing is one of the most important *doors* for communication between client and Rolfer. This determines opening and closure of an individual process.

Larry Koliha
Basic Rolfing Instructor

Everything starts with the breath. Of all the areas Rolfing SI covers, I feel breath work is the most important because it affects everything in the body. I work to help each client learn to breathe in a balanced way throughout the body, and then build upon that breath education to learn to walk freely. These two things really increase the integration of the body, which reduces a lot of the trouble that people often come in with. I find that Rolfing SI is one of the few modalities that both frees the structure with hands-on work and provides the necessary movement education to keep things free.

The process really starts with the first session of the Rolfing Ten Series. It begins with developing the client's awareness of how s/he is breathing, any restrictions or holdings s/he may notice, and discovering options for improvement. Each session should build on this first session and continue throughout the Series with a deepening understanding of what a breath is, how it affects the entire body, and how one can use breath to enhance other areas of life.

Every client who comes in the door has breathing opportunities. I find that even with people who have practiced yoga, meditation, or other breathing practices, our hands-on approach to breath has a lot to offer. Many have learned patterns of holding or beliefs about how they should breath that often hamper finding ease in their bodies. Breathing shouldn't be hard work or constrain the body. Manual approaches that help the client identify and sense constraints in the breath cycle provide real potential for improvement.

Good breath work requires a practitioner to have solid touch skills, an understanding of fascial relationships, and a good knowledge of anatomy. The practitioner can use these skills to free restrictions and educate the client to explore any newfound space. Two important concepts to keep in mind are to simply teach clients where their lungs are and how the breath cycle works. Just the knowledge that the lungs are mostly in the back of the body and extend from above the first rib to almost the twelfth rib are insights they can use to explore the space. Another seed worth planting early is inside-outside relationship. A key learning is finding freedom not just in the outer layers of muscles and bones, but also in the inside structures from the pelvic floor to the crown of the head.

Working with the breath is a whole-body experience. It is not just about the lungs or the thorax but the influence these areas have on all appendicular and axial sections of the body. Rolfing SI takes this breath awareness into freeing structural work and incorporates it in movement. Continue to work with breath through the session — from table work, to sitting, to standing, and then hopefully into walking.

Here are some areas to work and thoughts:

- Breathing is a balance between inhale and exhale with capabilities to find the full ranges of both. This breath work is very critical in dealing with the ANS patterns associated with some clients and essential to working with structure.
- The inside-outside relationship in breathing is not just moving the tissue on the superficial rib cage. Both practitioner and client need to sense deeply to find freedom in the lungs, heart, and mediastinum in the thorax; the viscera in the abdomen; the structures of the head and neck (including anterior neck, jaw, tongue, palate, brain); and into the appendicular structures. With each breath, everything (muscles, bones, viscera, and soft tissues) should resonate with the sensation of movement transmitting through.
- The ribs are a huge factor in breath freedom. Ribs are a flexible, moveable collection of bones, and not a single unit. As such, the rib cage should respond more like a soft rattan basket than a suit of armor. The rib cage is able to protect our delicate organs not so much because the ribs are strong, but rather because they are adaptable and able to react to outside forces. Many people unconsciously keep the rib cage held. This often creates problems in the shoulder girdle or rotator cuff because these are unable to integrate arm movements into the lumbodorsal hinge. Teaching clients that the rib cage is supposed to move when they do can be a game changer.
- Another important insight for working with breath is that the first and second ribs must be able to move and that the shoulder girdle must have the freedom to drape on top of the rib cage. With the all-too-common forward-head position and respiratory issues, these areas are a gold mine for Rolfing practitioners.
- Of course, don't forget the neck, jaw, and head, and the structures within those areas. Tension in the tongue or clamping a jaw restricts the breath cycle and can restrict movements all the way to the pelvic floor. Even in the first

Working with the breath is a whole-body experience.

- Larry Koliha, Basic Rolfing Instructor

session, check to see if the client can relax in those areas or work with a slightly open mouth to check what the difference is between tension or relaxation in the jaw and tongue. Every breath cycle should allow softening in the anterior neck and head; this can't happen if the tongue or jaw is engaged.

- Use a three-dimensional approach when working with the breath and associated structures. Use two hands when working to help the client experience multidimensional space and movement. Cue the client to sense these spaces both interoceptively and exteroceptively.
- I can't emphasize enough how transformative your work will be if the client can experience integration of breath throughout the body. The body is a series of diaphragmic sections that the breath should transmit through easily. I think of these sections as feet to knees; knees to pelvic floor; pelvic floor to respiratory diaphragm; diaphragm to thoracic inlet; hands to elbows; elbow to thoracic inlet; thoracic inlet to floor of the mouth; and on up through the palate and top of the head. Breath should transmit easily through all of these sections, including through the brain itself. The more moveable, horizontal, and integrated these diaphragms, the more likely your client will feel the subtle sense of whole-body breath.

Breath work affects all types of clients. Three of the most common situations that come to mind are as follows:

- The Type A, stressed-out person, who comes to learn s/he can still be highly productive without paying a high toll in the body.
- The individual where the experience of trauma resulted in shutting off or ghosting sections of perception. People often cope with past issues or present pain by not allowing breath or movement to go into associated areas. For example, I had a client who seemingly disappeared one of his legs because of past trauma: the leg didn't function properly, wasn't part of the body schema, and had pain. All of this contributed to the client holding his breath up and away from that section of the body and trying to work around it with each step. One of the first steps toward healing is getting movement or even the thought of the breath going into those areas.
- Pain is a huge contributor in inhalation-predominant patterns. I've seen several clients come in with acute back pain — barely able to move — who significantly improved with a session of mostly breath work. Helping clients breathe into areas of discomfort is essential to working with pain. A good example of this is working with low-back pain, where encouraging clients to allow breath into the pelvic bowl anterior to the sacrum is often extremely helpful.

As for considerations for the practitioner, the practitioner should be present with his/her breath. If you are not aware of the breath cycle and three-dimensional space in your body, the client will feel it and be impacted. Practitioner breath is a regulator for the client. Know that your client's breath will often mirror your own. This resonance can be used intentionally to facilitate a more functional client breathing pattern, or unintentionally it can alter the nervous system and derail the work. When you are connected with both your breath cycle and the client's, that is the sweet spot that really make structural work shine.

Practitioner breath is a regulator for the client. Know that your client's breath will often mirror your own.

- Larry Koliha, Basic Rolfing Instructor

Hiroyoshi Tahata
Rolf Movement Instructor

The pandemic is undoubtedly having an effect on breathing for many people, even without viral exposure. First, stress about the pandemic is undermining many people's sense of safety, leading to dissociating from their relationship to the world. Second, as the primary vector for viral transmission is through breathing either droplets or aerosols, no doubt fear of catching the virus is inhibiting many people's breathing patterns, with people likely taking less full breaths. As breath underlies life and impacts metabolic activity, the balance of the nervous system, etc., this will have broad consequences.

COVID-19 has done more than affect our breath. It has far-reaching impact on our body relationships. For example, news about the pandemic arouses fear that stimulates a defensive orienting responses and puts us into a state of alert. Many people are also getting much more screen time than usual, and that visual stimulation places a disproportionate emphasis on the head, making grounding more difficult. Finally, and obviously, social distancing inhibits interrelationship with others and reduces contact, including touch.

As Rolfing practitioners, 'touch' is commonly through our hands, and such contact definitely has the potential to function as an interface to reestablish relationship to others. However, if we don't feel comfortable working with clients in person during the pandemic, or if it's not allowed where we live, how can we provide therapeutic interventions without using touch directly on clients, or even meeting them in person?

I'll offer here a case study, from a session I conducted online recently for a sixty-three year-old female client who was suffering from COVID-19 infection and could not breathe easily. She also had chronic tension in her shoulders and back. From what I could observe online, she showed signs of distress. My intention for the session was to reestablish the client's relationship to space and her sense of safety by working with *ma* (a Japanese concept of how you somatically relate to space and time; see Tahata, 2018).

Prior to the start of the session, I worked with ma for myself by finding an appropriate sitting position to settle in with to feel comfortable in my room. Then, I asked her to find the position where she could feel most comfortable. This is a conditioning process, and is the key to start because this procedure for positioning helps us to find resonance with each other with ease and a connection to resources, even when we are in different spaces. After the conditioning, she noticed a sensation of being wrapped with something when she oriented to a specific direction. She noticed a different quality of olfaction, the sense

COVID-19 has done more than affect our breath. It has far-reaching impact on our body relationships.

- Hiroyoshi Tahata, Rolf Movement Instructor

of smelling a flower like a lily. From these awarenesses, her perception shifted to feel more space multidimensionally, which could be interpreted to mean that she recovered an affinity to space. As another step, resourcing specific positioning sometimes gives a cue to open the client's perception. With this client, she could have a sense of a 'seating face'; that is to say she could contact the area around the sit bones and hamstrings of her body with the chair. She felt more sense of weight, felt more contact to the chair, she *yielded* into the chair (see Agneesens & Tahata, 2012). Her pelvis yielded into the chair and her legs in turn yielded to the floor, all this while she was in her seated position.

Her system then allowed her body to settle. I observed her eyes were more open and she commented that she could see more clearly. Finally, she felt less tension in her shoulders and back and also comfortable breathing arose spontaneously. She later told me the remote session was so helpful for her return to daily life ten days later. This client had completed a Ten Series eight years ago, so her body likely had basic support and adaptability that facilitated her self-organizing with the cues given in this remote intervention.

From this perceptual intervention without touch, I realized that simply helping the client to find a sense of safety, as well as a sense of appropriate positioning to feel better, are great foundations for better breathing. Even if connecting to resources and safety does not come easily, my sense is that the positioning strategy to find a sense of good ma could facilitate resourcing and staying out of a trauma vortex. Being conscious about positioning should be of benefit to both the client and the practitioner.

It is not easy to explain work with ma, or yielding, in this brief context, so I refer you to earlier articles for more complete descriptions and exercises (see Tahata, 2018 and Agneessens and Tahata, 2012). Although these ways of working with yielding and ma are recent developments, I find strong support for the methodology in this quote from Dr. Rolf, which shows that psychological anxiety can be reduced when gravitational support becomes adequate:

> No situation exists in a human which a psychologist would diagnose as a feeling of insecurity or inadequacy unless it is accompanied by a physical situation which bears witness to the fact that the gravitational support is inadequate.
>
> *Ida P. Rolf (1963)*

No matter how we approach our clients, our practice has great potential to help people to restore well-being and gain resilient adaptability to counteract pandemic stress.

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Fascia Insights

Adapting to COVID-19 Conditions: An Interview with Wiley Patterson, MD

By Lina Amy Hack, BSc, BA, Certified Advanced Rolfer™ and Wiley Patterson, MD, Certified Advanced Rolfer

Lina Amy Hack

Wiley Patterson

ABSTRACT *In this interview, conducted in early October 2020, Dr. Patterson offers what this COVID-19 moment looks like to him as a Rolfer and as a physician. Patterson outlines how he is working safely with integrated public health practices and also how he is caring for his own health. The conversation touches on recent literature with regards to the value of vitamin D and melatonin when individuals are facing COVID-19 infection.*

Lina Amy Hack: Thank you for meeting online with me to talk about this COVID-19 moment we all find ourselves in. I'm curious about what your practice looks like these days and how has it been this year?

Wiley Patterson: When COVID-19 hit, it slowed down to about 25% of volume. Now it's probably up to about 60% to 70% of previous volume. You know, I learned a long time ago at medical school, during hospital training, illness is like the Amazon river, the river of illness never stops.

I have a medical practice and I have a manipulation Rolfing® Structural Integration (SI) practice, the manipulation part of my work is half people who say, "I want you to do Rolfing [SI]," and the other half say, "Fix my shoulder." So, I decided to stay open, not because I'm that noble necessarily, because I just wasn't as scared of it. We took on precautions way before it became out there. I ordered masks way back when. I started taking supplements that support the immune system. And of course, we wipe down, we changed the way we scheduled. I have fifteen minutes between each client now. We send questionnaires to people the day before their appointment, and we have a policy that's up on the wall about how to take care of your COVID-19 hygiene before you come, what to do. There is never more than one person at a time. But also, people that are sick in that way don't come to see me.

I have a friend [who is a medical doctor] here in town who has a clinic, he's treated over 500 people with COVID-19 so far, and I don't think I've had any. Each of those 500 people that he's treated, he's used melatonin in a really large dose of milligrams per kilogram per day (Castillo, 2020; Mercola, 2020).

What I'll say first is that all viruses run their course. They come and they go.

LAH: Wow. I hadn't heard about that treatment avenue with COVID-19.

WP: So, say we have a 220-pound guy, according to the Castillo protocol, the doctor prescribes 100 milligrams of melatonin every day. My friend says they all state they begin to feel better the first day, most of them are well in a week. The people that have refused to take the melatonin have an unusual fear in that they say, "I hear when you've got COVID-19, you die in your sleep. I don't want melatonin to put me to sleep so I die in my sleep." Otherwise, everyone else takes it and they've done really well in his clinic. Zero deaths.

LAH: What is your sense of the tissue damage that COVID-19 is doing in the body?

WP: COVID-19 affects some people with rampant, out-of-control inflammation in a given tissue that can lead to local organ dysfunction and, if even worse in magnitude, to death. Elderly and comorbidities are the best predictors of the seriousness of the illness. I'll send you a reference so your readers can review the main histopathological findings in COVID-19 (Vasquez-Bonilla et al., 2020).

LAH: What is the most important thing you'd like to communicate to our colleagues who are Rolfers in this COVID-19 era?

WP: What I'll say first is that all viruses run their course. There hasn't been a single virus that just persists and persists and creates this much havoc forever. They come and they go. So, it's inevitable it's going to slow down.

Spanish flu [the 1918 flu pandemic] lasted three years. It was way worse than this thing is probably going to be. This thing's going to run its course. It's going to kill the susceptible. It's morbid sounding, but it is. And you can social distance and wear a mask and all it's going to do is slow things down and spread [it] over time. The best thing to do is just make sure your immune system is right.

LAH: It is nice to think about a post-COVID-19 era.

WP: It's inevitable this will end. You know, you've heard about vitamin D's effectiveness, right? There's a pretty good study from Germany talking about vitamin D's effectiveness, 780 patients, all COVID-19 positive, have you heard of that study (Borsche & Glauner, 2020)?

LAH: No, what draws your attention to it?

WP: They correlated how sick patients were to their vitamin D levels. The researchers investigated 780 definite COVID-19 positive people, and they measured their vitamin D levels to correlate with how sick they were. They found that if the patient's vitamin D was above 80ng/ml, all of them had zero symptoms. If the vitamin D level of the patient was above 60ng/ml they had symptoms of flu. Between 34ng/ml and 60ng/ml, people were in hospital; if their vitamin D level was below 17ng/ml, there was 100% mortality. That was the standout thing, below 17ng/ml. So, taking vitamin D, smart.

Also, getting sun. You can see I'm a little bit tan. I swam a lot this summer on purpose. Everybody wanted me to tell them how many minutes they should be in the sun. The rule is never burn. As a rule of thumb, you can create 1000 units of vitamin D in your body with four minutes of sunshine, something like that. Higher latitudes, you have to take supplementation, you can't get enough sun.

LAH: For the clients that you're seeing, of course you engage with COVID-19 procedures, is the work in the treatment room changing?

WP: I know my Rolfing SI doesn't change. I'm definitely wearing a mask and I ask them to or not, depending. If it's a head session they take their mask off. I wear a mask and face shield at times – this virus is small airborne stuff. The science is already there, we just have to learn it and pay attention to it. It floats through the air. Like a person I know who plays the piano at a church choir, and that church pastor insisted that their choir keep going. So, they all sang together, now half of them are COVID-19 positive. That's just the rules of airborne viruses.

LAH: Do you find that working with a mask changes the social engagement? Any change in therapeutic relationship?

WP: Some people really object to them. Other people tell me that they can't understand me with my mask on. But there's a lot of people who leave their mask on, who want it on, and would be offended if I asked them to take it off. So, I'm pretty open. But yeah, it changes things.

LAH: Do you monitor for COVID-19 population rates in your area? Do you have any advice around local infection rates and should that change anything for our colleagues? For example, if the infection rate in a Rolfer's city is greater than 250 people per 100,000? At what rate should it affect how many clients a Rolfer sees?

WP: Right, should that practitioner behave differently than the practitioner who's facing 10 infections per 100,000? I think they should. Look at my choir example, I'm sure not one of those people who went thought they had COVID-19, and now half of them do, right? So, somebody there was asymptomatic.

Clearly, if it's a really dense population area, like how bad it was in New York initially, how could you assume anything other than the next guy has got it? But also now, different from before, rural America, places like Wyoming, are getting hit. It just took a while for the virus to get there. Again, it's going to spread its joy all over, so to speak, and it's going to get the susceptible. If you're living in a higher COVID-19 density area versus a low-density area, of course that should affect your thinking. I couldn't pick a number to decide from, there's no way to know that. I thought of such things early on, and I realized that's just numbers, that may or may not represent the actual chance I'm looking at of getting sick.

It'll come in waves. The Spanish flu did, there were three different waves of it over three years, each at a different level of severity. The second one was worse. The

Once structural integration takes hold, it gets better and more deeply installed in clients' structure, they're healthier, they don't get sick as much, and they all know it.

last one was geographically isolated and not as severe.

LAH: What do you think our greatest challenge is right now as Rolfers, to execute our work?

WP: I don't think anybody's lost one bit of Rolfing acumen or skill. Even if you haven't been as busy. So that's not changed, right? So, I think as people's confidence comes back, people are going to want to come in. Rolfing SI certainly isn't going to cure any COVID-19. But people who come to get Rolfing SI work are generally, not always but generally, healthier. They realized it's doing something for them that's good and they live at a higher level of health once that happens. Once structural integration takes hold, it gets better and more deeply installed in clients' structure, they're healthier, they don't get sick as much, and they all know it.

LAH: That's great. Thank you so much for your thoughts at this time.

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Lina Amy Hack is an Advanced Rolfer practicing in Saskatoon, Saskatchewan, Canada. She is also Co-Editor-in-Chief of this journal.

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Letter from the Embryo

A Sigh

By Konrad Obermeier, Basic Rolfing® Instructor

Konrad Obermeier

ABSTRACT *In this installment of the "Letter from the Embryo" column, Konrad Obermeier discusses the development of the respiratory diaphragm.*

The respiratory diaphragm is not made for breathing.

A fertilized ovum, blastocyst, or embryo lives in the here and now. It isn't projecting into the future. It doesn't plan for times to come, nor does it prepare, while still floating in fluids, for the respiration that it will depend on later in life. The developing organism is living in presence and, for this reason, answers metabolic questions according to its momentary disposition and potential. These question-answer exchanges manifest in an environment that we can call the epigenetic field.

There is no cell, no tissue, no structure that does not already function during its development. The fundamental functions are growth functions and growth functions precede all later functions. Deliberative planning, for instance, comes much later and is not even biological *per se* but rather is a cognitive function and is completely subject to culture in a way that biology by definition is not.

When we ask: "*Why* is the respiratory diaphragm developing?" many of us will likely answer without a second thought: "For breathing." But the better and more pertinent morphological question would be: "*How* is the respiratory diaphragm developing?" Any "why" question will at once depart from observable morphological facts and end up somewhere else – most likely in the department of speculative philosophy.

I invite the reader to contemplate the wolf's answer to Little Red Riding Hood's query:

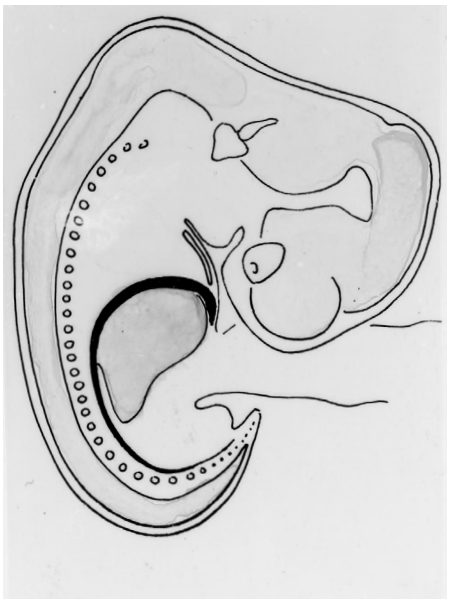
> "But Grandmother! What big eyes you have," says Little Red Riding Hood.
>
> "The better to see you with, my dear," replies the wolf.

The exchange between the girl and the wolf admonishes us to beware of the conjectures of speculative teleology. So, let us leave the speculations of the *Why* and consider the *How*.

The central tendon of the respiratory diaphragm initially forms in the cervical region as a compressed tensional field between the heart and liver (see Figure 1). In this early period the phrenic nerve (C3-C5) starts to relate to the diaphragm and will follow all later developmental movements. The tissues between the two fluidic high-pressure areas of heart and liver are compressed and flattened. The compressive forces manifest the central tendon of the diaphragm, relating the heart-pericardium to the liver-peritoneum.

The same tensional field also relates to the developing spine and attaches to the front of the thoracic, lumbar, and sacral vertebrae. This structure contributes to the differentiation of the anterior longitudinal ligament.

While the growing viscera manifest volume and increasing fluid pressure, the vertebral column manifests expansive bone growth – primarily in a longitudinal direction. The anteriorly relating tissue field is stretched by the increasing length of the spine and thereby generates a tensional response — the posterior sheet of the diaphragm. This tissue sheet anchors to the spine (depicted as the black line around and posterior to the liver and anterior to the inferior spine in the graphic 'representations; see Figure 2).



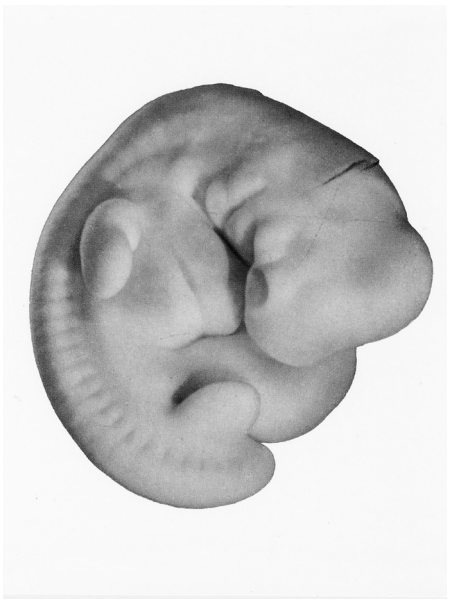


Figure 1: Beginning of week six; approximately 8 mm length; massive heart-liver complex; limbs budding. All illustrations are originals from different publications by Dr. Erich Blechschmidt, used with permission. Specifically see *Studies in Biodynamic Embryology* (Kiener Verlag, Munich).

With the increasing length of the spine, the whole arrangement of the diaphragm – anchored to the sacrum – is pulled in an inferior direction. It draws with it the entire visceral cavity. Thus, the space containing the visceral organs descends with the development of the diaphragm.

The nervous system is posterior to the bodies of the vertebrae and (relative to the viscera) is ascending, as it is anchored to the inside of the glabella area via the falx cerebri. In this way the glabella is the reference point (relative fulcrum) for all the anterior-posterior, accordion-like folds of the brain and, at the other end, the cauda equina, as the inferior part of the nervous system, is pulled up and into the spine. While the viscera descend, the nervous system ascends.

This elegant and beautiful developmental origami engages the whole organism and manifests (among many other things) an interesting space. This space, located anterior to the spine, cranially to the diaphragm and posterior to the heart-liver will become the area of lung development (see Figure 3).

As the increasingly stable spine is lengthening the developing ribs begin to stabilize the posterior-lateral organism. The heart and liver are expansive, fluidic high-pressure areas. The descending diaphragm creates a substantial tensional force-field.

The above described space of lung development is situated between all these forces and increases in size as well.

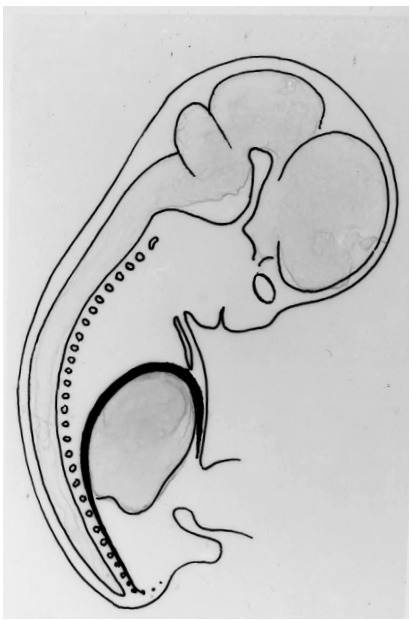


Figure 2: Middle of week six, about 11.5 mm length, massive heart liver complex, limbs starting to differentiate. All illustrations are originals from different publications by Dr. Erich Blechschmidt, used with permission. Specifically see *Studies in Biodynamic Embryology* (Kiener Verlag, Munich).

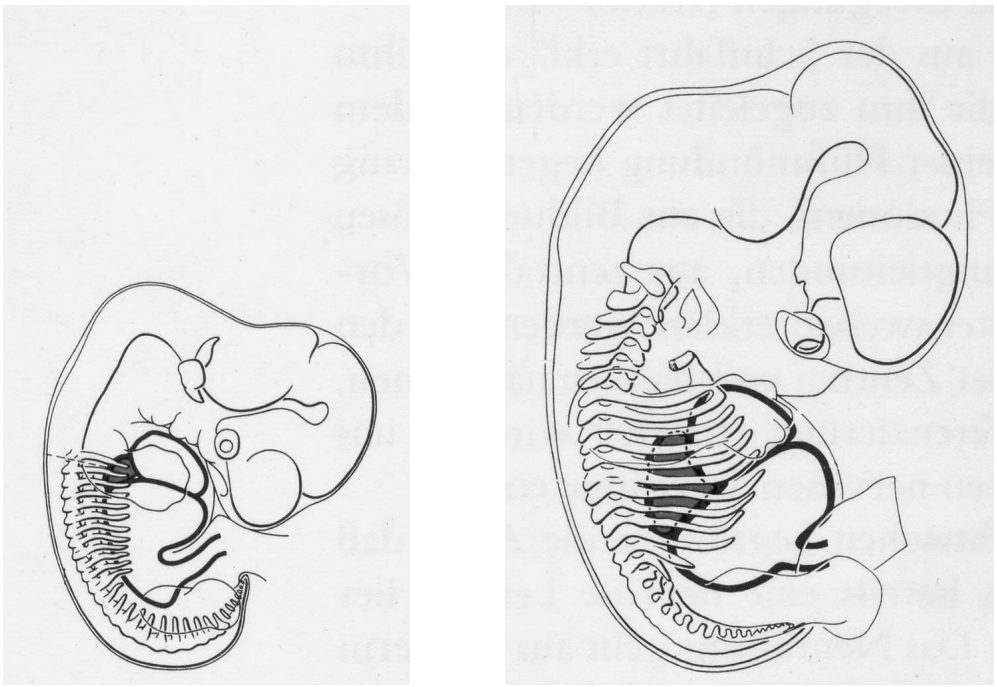


Figure 3: While spine, ribs, heart and liver expand, limiting tissues are sucked into this also expanding (shaded grey) area by negative pressure: the lungs develop in a suction-field. All illustrations are originals from different publications by Dr. Erich Blechschmidt, used with permission. Specifically see *Studies in Biodynamic Embryology* (Kiener Verlag, Munich).

When we ask: "Why is the respiratory diaphragm developing?" many of us will likely answer without a second thought: "For breathing." But the better and more pertinent morphological question would be: "How is the respiratory diaphragm developing?"

This space between masses of expansive high-pressure and high-tension areas consequently manifests negative pressure during growth in this location.

The limiting tissues of what become lungs are sucked into this area. Lung development manifests in a 3D-space, where negative-pressure-forces are a formative precondition for all later differentiation. The structural pre-movement for breathing is the development of a suction field. Any being 'intending' to breath air later in life needs to morph through a developmental movement manifesting a suction field first (see Figure 4).

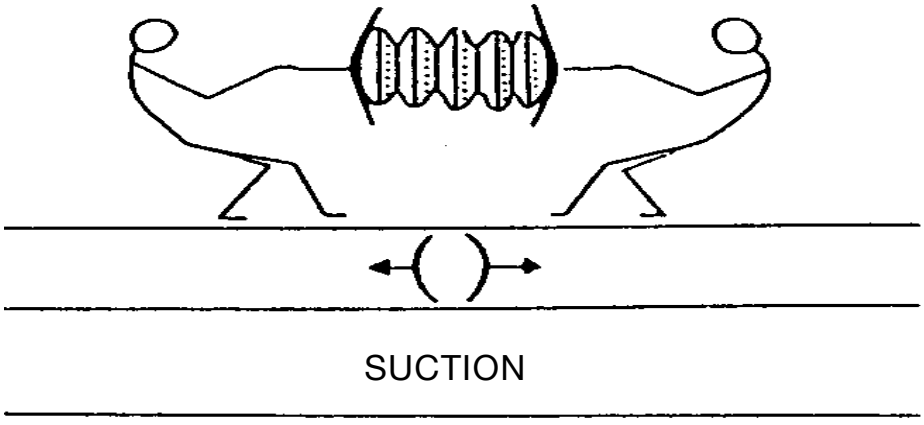


Figure 4: The structural pre-movement for breathing is the development of a suction field. All illustrations are originals from different publications by Dr. Erich Blechschmidt, used with permission. Specifically see *Studies in Biodynamic Embryology* (Kiener Verlag, Munich).

Ahhhh . . .

This is the secret and silent sigh of the embryo,

the developmental movement is the function.

Konrad Obermeier holds a degree in communications from the University of Munich and has been a Rolfer since 1991. Currently, he serves as chair of the Anatomy faculty for the European Rolfing® Association. His is the editor of a series of books on the biodynamic embryology of Erich Blechschmidt.

Lina Amy Hack

Christina Howe

Pedro Prado

Naomi Wynter-Vincent

Jeanne Vadnais

COVID-19 Adjustments in the Rolfing® SI Community

A Collection of Interviews

By Lina Amy Hack, BSc, BA, Certified Advanced Rolfer™

ABSTRACT *The COVID-19 pandemic is affecting the Rolfing Structural Integration (SI) community in different ways. In this article we interview a number of people for their perspectives: (1) Christina Howe, the Executive Director and Chief Academic Officer of the Dr. Ida Rolf Institute® (DIRI); (2) Pedro Prado, a founding member of Brazilian Rolfing Association and faculty member; (3) Naomi Wynter-Vincent, the European Editor for this journal, who has a Rolfing practice based in London, UK; and (4) Jeanne Vadnais, an Advanced Rolfer based in Seattle, which faced one of the first U.S. COVID-19 outbreaks.*

Interview with Christina Howe, DIRI Executive Director/Chief Academic Officer

Lina Amy Hack: How is the fall season going for you and the team at DIRI, now that we all operate in this new COVID-19 era?

Christina Howe: I think there is a strange tension around many things at this time. And ironically, COVID-19 has become a container that, while very scary for all of us, particularly older folks who, like myself, are susceptible; it is also a strange container for mindful reflection and repositioning of our values, deepening of relationships, and reimagining ourselves. I hear from the people around me we are giving ourselves renewed permission to do things like meditation, exercise, cook great meals, play with our kids, watch a movie we wish we had had time for before. So COVID-19 has been a container – despite the fear it brings – that actually brings many blessings as well.

From the Institute's perspective, during this difficult time, there is a similar tension mixed with hidden blessings. There is a financial piece, where COVID-19 has forced us to be more resourceful and adaptive as an organization. We have had to meet real challenges. We were closed for two months; we laid off the staff and canceled classes.

It has been challenging setting up safety protocols, and for our students to wear masks, maintain social distance, and navigate more online course materials, and in general navigate going to school in a COVID-19 environment. On the other hand, as an organization, we have become more resourceful. For example, we were able to safely and with consistency run three classes during the fall months.

We also made great financial strides, despite the closures and canceled classes. The board leadership successfully renegotiating our lease, cutting it by almost a third. We applied for and received both

From the Institute's perspective, during this difficult time, there is a tension mixed with hidden blessings.

a $215,000 PPP loan and a $500,000 US Department of Education, HEERF-Cares grant. Because DIRI is recognized by the US Department of Education and is accredited and licensed as a school by the state of Colorado, we were eligible for a Cares grant. We learned how to work through the challenging grant.gov site, where there are other grants we can apply for in future.

So, despite the many real challenges of COVID-19, we have grown as an organization and pushed ourselves in ways we have not before.

LAH: That is incredible maneuvering that you and your team have done, well done.

CH: Thank you. The staff really is amazing and has worked hard. We continue to network and look for different resources that will support our membership and new students. For example, we are exploring Veterans Administration funding that would help our members who are veterans pay for the Advanced Training and for Rolf Movement® training. We are exploring grants that would support minority students who want to study Rolfing SI. So, we're having conversations that I don't think we would have had otherwise because of this odd container we are finding ourselves in.

LAH: There must be a big learning curve for all these new procedures for the whole school?

CH: There has been a big learning curve. One of the biggest ones for our faculty and staff has been how to utilize technology to stay connected and continue learning. Quite naturally, there was a lot of resistance to technology in the past. And I get it, because a computer will never be a replacement for human touch and face-to-face interaction. But technology, while not a replacement, absolutely is a supplement to connection and communication, especially when face-to-face interaction is limited.

Even without COVID-19, [lack of] proximity has been a problem in our organization for many years. Our faculty, members, board members live all over the world. We rarely see each other face to face. It can feel very isolating and lonely to be a Rolfer in some areas. So, the technology must be leveraged to stay connected, to learn from each other. We all have been overcoming our resistance to learning the new technologies [and] the timing has been good. Over the past three years the Institute built and installed a lot of infrastructure like the Canvas Learning Management platform, where we can design and offer interactive online classes. And our MemberLeap membership database system – on which our website sits, and which allows us to launch webinars, offer things like ConnectMembership, etc.

As a community, we are becoming much more tech savvy. And our faculty rose to the challenge in a beautiful way. Members rose to the challenge in a beautiful way. We finally launched the much overdue audios of Ida Teaches. We now have free webinars up. In a way, COVID-19 was the nudge we needed. These new adaptations are bringing a lot of imagination, excitement, and agility with it.

LAH: What is the response like from students, what is this moment like for them and their Rolfing education?

CH: We had certain students who were already planning on coming and they have for the most part been willing to show up. There is also an interesting new group of students who are enrolling as a result of rethinking their life goals; people have had time at home to readjust their values, to step back from where they are and dream of something else. Many have lost their jobs and been forced on unemployment. And over time they develop a fresh perspective on who they want to be and are saying, "I don't think I want to do that old job anymore." Most of us really want to do meaningful work, transformative work. I don't think most people want to work remotely all the time. They want to have a career that is rewarding, while also being of service to others. Rolfing SI offers a very meaningful career. So ironically, while COVID-19 is ostensibly driving us apart, it is also highlighting how important touch, closeness, and relationships really are to all of us.

We often talk about fear-based things and these are very real. We have real anxiety about COVID-19. But there are these transformative moments where things are changing all around us, when "the center cannot hold," as Yeats wrote. And then we readjust where that center is. That seems to be happening for this organization and for individuals who are enrolling. So, out of a bad thing, there is good.

LAH: It must be different around the building.

CH: Thankfully, we are all well. Everyone is following the protocols. We are all being careful. The building is functioning in silos, so the students from one class are not mingling with other classes in the building. Our building design lends itself to that. Everyone is wearing their mask. We are checking temperature every morning. Students are filling out daily health forms and staff is checking them with the help of technology notifications. Overall things feel productive and learning is continuing at a rich level. I'm proud that we have been able to reopen safely at the same time that other institutes of higher education in Colorado have reopened. We are showing up as a professional school and association. And that's important for us because it gives us immense credibility with students, regulatory agencies, and the marketplace in general.

LAH: Tell us more about the kind of technology DIRI is using.

CH: So, we have become a lot savvier with technology, as I was discussing earlier. We have installed a new membership database, a new accounting system which is accessible to all board members, a

I'm proud that we have been able to reopen safely at the same time that other institutes of higher education in Colorado have reopened.

new website platform with a section for members only, an online catalogue, and the Canvas Learning Management system. All of these systems have been linked with APIs and work seamlessly together. When I started at the Institute in 2015, there were nine staff members. We have been able to reduce that number to five, because the technology has allowed us to become so much more efficient. The current staff is highly qualified and experienced in working with developed and customized systems. We are better able to manage things like admissions, registering for classes, processing online payments, keeping track of certifications, etc. The technology has made us more efficient and able to focus more on what matters, like better connecting with members and improving our educational offerings. With the technological efficiencies, we have had more time to work on important projects like ConnectMembership, membership retreats, etc. Next year we hope to support the development of regional membership networks, a video resource library, and other projects that will support membership.

LAH: What do you think the membership is focused on during the pandemic?

CH: I think the membership wants to be reassured that the Institute is going to continue to protect and increase the value of the trademarks – that we won't risk the value of those marks in any way. When we talk about the value of the trademark, fundamentally we are talking about the meaning the brand evokes when anyone encounters it. Meaning-making for anything is a confluence of many things. For us, it is our history, the quality of our practitioners and our educational program. It is our public presence, which includes our marketing, our journal, and how we show up in the professional world of fascia. The Dr. Ida Rolf Institute is the longest-standing SI organization. We have a long history, which is a narrative that has meaning. Dr. Ida Rolf founded the institute and we bear her name. Our faculty is large, highly qualified, and in the direct lineage of Dr. Rolf. We are one of the few SI schools in the country licensed and accredited; our program is 730 hours – much longer than many other schools – and our graduates are held to high standards of continuing education (CE). We have a membership organization, with standards of practice and a code of ethics. We have a large directory of professional practitioners with strong credentials and experience. The public learns about who we are and what Rolfing SI is as a brand by discovering us through a well-maintained, beautiful website, or our compelling ads in well-known magazines. They might come across our beautiful, quality journal. Or see one of our members presenting at a conference. So, when we talk about the value of the trademark, we are talking about all those different quality pieces fitting together like a puzzle to develops a meaningful picture of DIRI as an original, dynamic, thought leader in the field of structural integration.

LAH: Tell me about the ConnectMembership online platform.

CH: ConnectMembership has been one of the exciting things we have done this year, and we plan on continuing the program next year. The goal has been to connect with membership around topics that might interest them about the Institute. Some of these are organizational and some are about the work. We recently had a ConnectMembership meeting where we met with about forty-five of our members and our legacy faculty, Michael Salveson, Jan Sultan, and Tessy Brungardt. It was amazing listening to the stories about where we started and how we developed into what we are today. But what really stood out to me was how much of a community we are – there is deep connection, shared history – it felt like a family who all know and share the inside stories. It was also beautiful to see our new graduates soaking it all in. We plan on continuing the ConnectMembership series and will be inviting members to submit topics of interest. One of our goals is to offer substantive content that will support our membership in their work, in addition to meetings where we can all simply show up and connect through meaningful dialogue as a community.

I want to add how helpful it is for me as the Director to hear from members directly about how they feel and think about different topics. This includes both the positives and negative concerns of members. From our side, it is helpful to address any rumors or misinformation that might be floating out there. As we listen and learn more about each other's perspectives, the hope is to build trust and relationship. Ultimately, together we are creating the culture that defines us as a community. I think ConnectMembership is an important, albeit small part of this process.

LAH: How are CE offerings looking for the coming year?

CH: Because of COVID-19, we are discussing how to leverage the technologies wherever appropriate. We hope to offer new webinars developed by faculty like those offered for free to members. There are also new areas we are discussing. For example, we may offer courses required for licensing such as ethics and diversity training. We will of course ensure that Advanced Training and Intermediate CE is available – both are in the planning stages for next year. We anticipate offering good options for face-to-face classes at the Institute during the year. We are also very excited to be offering an intensive format in Rolf Movement Certification. We are also in discussions about adding a practice-building externship to provide supervision and support for new graduates from the Basic Training.

LAH: Thank you Christina, connecting has never been more important. Thank you for all your funding efforts and your vision for this moment. It's really helpful to hear.

CH: Thank you Lina for inviting me.

Christina Howe has been the Executive Director of DIRI since 2015.

Lina Amy Hack is an Advanced Rolfer practicing in Saskatoon, Saskatchewan, Canada. She is also Co-Editor-in-Chief of this journal.

Interview with Pedro Prado, PhD, Basic and Advanced Rolfing® Instructor, Rolf Movement® Instructor

Lina Amy Hack: Hello, where am I finding you for this online interview?

Pedro Prado: We are doing quarantine a couple hours away from São Paolo in our country house and we've been here for seven months. It's a lovely place, green gardens and horses.

LAH: And what does your Rolfing work look like these days?

PP: A billion emails everyday . . . It's been excruciating screen time to adapt to COVID-19, adapt the trainings to online formats, adapt to changing things, and lots of meetings with everybody . . . It's been a lot of work, at the same time it's been creative. Asking questions: What is the work now? What is it now in such complicated times?

LAH: How are DIRI faculty and the Brazilian Rolfing community doing in this pandemic?

PP: We were all surprised with COVID-19, how all of a sudden the whole community

got threatened. We especially were considering what we would do because Rolfers touch people, we are in close one-to-one relationship in our offices, and at the same time we all have to survive. So, there was this alarm happening in the community, and immediately a kind of communitarian sense woke up in me. The Associação Brasileria de Rolfing (ABR) board and faculty organized group meetings immediately. We had the common question of what to do now, and considered the online possibility. We realized we've got enough knowledge and tools – touching, physical touch, is not the only possibility. You can touch with words. You can touch with your resonance. You can touch with your input."

First came the movement approach, of course. This is one of the taxonomies in Rolfing SI that could best serve in this moment. [Editor's note: All trainings in Brazil are cross-training in structural and movement work, resulting in dual certification.] Also, the psychobiological perspective could be an entryway because people were all afraid – defending themselves from contact, from relating, and, most of all, afraid of being infected, infecting others, or ultimately dying. So, we recognized a lot of meaning layers that could be addressed by Rolfers, that we could get people feeling more safe in their bodies while working with clients online.

We had faculty and membership together in those online meetings, and the faculty would also meet on their own to reflect on how can we connect and unite the membership and bring forth their abilities to meet this moment, how we could make online work a reality for them. We first made sure that Rolfers could perceive that they had enough tools to work online, that this could be a possibility for work, and that it would be also relevant to clients who were still wanting care. I wanted our community of Rolfers to know that their job was assisting people.

What was great in these online encounters was that we could meet as a professional community, and we had massive attendance. We had meetings three times a week with over half of our Brazilian Rolfing community attending. We addressed holding and containing the anxiety, beginning to bridge to adaptability to these new times . . . And we ended up saying: "Well, this can happen."

Once we decided that online work was a possibility, we talked about how to do that. We had members bringing in their experience, and we organized a kind of supervision in which we could collect information from members about working with clients online, their cases and their doubts. We asked important questions about online sessions: How do we establish the relationship? How do we build safety online? How is this evolving for the client in a process? We found as themes: (1) relationship between practitioner and client; (2) movement and psychobiological skills that we need to address the needs of the client; (3) enhancing movement with psychobiological perspectives and bridging these themes to structure and gravity. In the supervision online people could bring their cases and their doubts to the group, and their achievements! And, one of the things we perceived there, Lina, was that people started enjoying being together. They valued that there was a community thinking together and we found out that we could nourish that. Nourish the fact that we were one, that we were together, that we had common challenges, but also that we had a common knowledge.

LAH: Beautiful, so proactive of all of you to come together.

PP: So, then we started to deepen that reflection. The Zoom meetings would have small group discussions, and we would orchestrate reports to the big group. The faculty would design the encounter. No one had a crystal ball to pass to anyone else, despite the fact that some of us were faculty; the more important fact was that we were all colleagues. We had to acknowledge that we were all living through the same challenges.

LAH: Did you record any of these?

PP: We were very loose . . . We didn't know what we were doing actually. But now, with the sense that we were collectively creating something or organizing something, we have started to record the encounters. And many more people have started to come. And then more and more Rolfers started doing sessions online, and also started to charge for their online sessions as well as reaching out to their client lists so that more could become connected. And many clients came in to the sessions, they valued the connection.

Common reflections opened up ideas for instructors, so we built small continuing education workshops. There was a workshop on movement, another one on body reading, a discussion for revising the 'Recipe' for online work, another one on the psychobiological perspective, a reflection on "How is it that we're dealing with connection and safety?" Then there was also a workshop on marketing. But all this knowledge was coming from the members, it was not something that we brought from top down, it was from bottom up.

We first made sure that Rolfers could perceive that they had enough tools to work online, that this could be a possibility for work, and that it would be also relevant to clients who were still wanting care. I wanted our community of Rolfers to know that their job was assisting people.

LAH: So through the creativity of the moment of crisis, and through the support of your professional community, Brazilian Rolfers have transitioned to doing their practices online with a portion of their clients?

PP: Yes, and validating that it's not something less. What we do as Rolfers, it's a language. Rolfing SI is knowledge that can take many forms. Even if we end up being an online culture, we still have value to transmit, something unique to share. That understanding started to come into the consciousness of the membership, that this is very valuable. So, it's interesting,

What we do as Rolfers, it's a language. Rolfing SI is knowledge that can take many forms. Even if we end up being an online culture, we still have value to transmit, something unique to share.

rather than being cut off [by the pandemic], we perceived that we could be on the edge of something that is contemporary, that is new, and, although uncertain, yet can be part of the future. It bonded us as a group, at a deep level, for the first time. It was different than going to a biannual or annual meeting and listening to a couple of scholars talk and feeling inspired. It went into the core reality of who we are. It was a healthy discussion. Ultimately, we are benefiting from the crisis, to be honest.

LAH: To my surprise, while I connect with our colleagues around the world as well, I see that in all this difficult stress we also have our Rolfing foundations; Rolfers are saying that we have adaptability, resilience to meet this moment. It's like the model is serving us personally right now.

PP: So, this is a common experience. This is even better.

LAH: Normally I feel like I operate as a single business in my city, and I have the experience of being the only Rolfer in my city. Now we have this connecting technology, I too feel much more connected with Rolfing colleagues, more than ever before.

PP: Yes! The challenge now is how can we incorporate values that we are experiencing into the future, so we can benefit from that. Not just go back to our old style when this nightmare is over. Because, with the crisis, there has been an evolution also of the way of working, of understanding the work.

LAH: How do you prioritize the time you have in your day? What's the most important thing for you to put your energy towards?

PP: Here, in the country, this is a place I've always spent vacations, I thought I would have time, I would study, I would read. But this has not happened at all. I've even been working more than before. It's a different environment, there has been a lot of demand from all the kind of jobs that I do in terms of the community, in terms of teaching, that has required a lot of adaptation. And this takes a lot of energy. There were many classes that were scheduled before this all started, and they all needed to be transferred to being online. There have been many webinars, many workshops that I have organized and done. So honestly, I've not been laid back, I've been into a lot of production.

LAH: How do you do self-care then?

PP: I continue to do yoga, ride horseback, walk . . . Fortunately, there's a very refined yoga instructor right here in the neighborhood. Another element, I've been eating and resting very well. This has changed my habits. Before, in the city, I would be standing and eating whatever between clients. Now, I've been eating very well with food produced locally here. And I'm in the middle of nature, deep nature. It's beautiful, mountains and waterfalls.

LAH: You look happy. You're just a glow actually.

PP: Yes, but not happy for society, with what's happening in the world, the politics . . . There is much reflection needed on what role we have as individuals and as a community these days.

LAH: How is our Rolfing community in Brazil specifically?

PP: Well, we're going through challenges., we're fighting for survival. But as I told you, we are also growing in a sense of identity and we've deepened our bonding. The ABR itself had challenges about what to do with the classes that were planned, so again, a lot of meetings. We're asking ourselves how we grow, how we can cope, how we can nourish students, and how we postpone into unknown deadlines. This has not been simple but we're supporting each other.

LAH: From your position of leadership as faculty, what do all us Rolfers need to focus on in this moment?

PP: Presence. Live the Principles of Intervention, our Rolfing principles. Honor that the body is the house. That it is the safe place that one can live. Honor the 'Line'. Honor gravity. That principle is with us. And even though we are going so virtual, bridge the polarity between virtual connection and the connection of physical reality. And get ready because as soon as COVID-19 is over, people are going to really benefit from what we know. I want Rolfers to know that our profession might have a leap into service; real service. If we can move through these times, centering ourselves, dealing with our emotions, going into the physical body according to the principles, we won't get lost or go crazy. And we will have more sturdiness to wait and to move through this. Get ready, there's lots of work to come!

LAH: Beautiful. I wanted to take a moment to thank you for teaching me so well, the way to embody this work, this wisdom. Thank you and all our Rolfing instructors for what you've given us all. We stand in that knowledge now more than ever.

PP: Yes, this is true, thanks to you too.

Pedro Prado Ph.D. was the first Certified Rolfer in Brazil in 1981 and was a founding member of ABR. He is a clinical psychologist, Somatic Experiencing® instructor, and Advanced Rolfing and Rolf Movement Instructor.

Lina Amy Hack is an Advanced Rolfer practicing in Saskatoon, Saskatchewan, Canada. She is also Co-Editor-in-Chief of this journal.

Honor that the body is the house. That it is the safe place that one can live. Honor the 'Line'. Honor gravity.

Interview with Naomi Wynter-Vincent, PhD, Certified Advanced Rolfer, Rolf Movement® Practitioner, Certified TRE Provider

Lina Amy Hack: How are your mind, body, and soul as a Rolfer, meeting this pandemic moment in London, UK? What would you like your colleagues to know about your experience?

Naomi Wynter-Vincent: Here in the UK, we saw the COVID-19 situation coming at us from some weeks' distance. We could see what was happening in Italy, in particular. When the entire Lombardy region was locked down, it became clear to me that something big was coming our way. It was always obvious that COVID-19 would get to us: London has two of the biggest global hub airports in the world, and I knew it had to have passed through Heathrow [international airport].

My first potential brush with COVID-19 came on 2nd of March: a lovely client had opened a work email, literally while walking from the Tube to my office on Tavistock Place, instructing her to take two weeks off work with immediate effect, because a colleague (who worked in another building) had been diagnosed with COVID-19. We stood, at either end of the long corridor in the building where I work, not quite knowing what to do. She was happy to 'go away' and forego her session, more for my sake than hers, and I was happy to waive my usual late cancellation. We decided instead to proceed with a careful, shorter session, my client lying prone. Face masks, even at the beginning of March, were nigh-on impossible to buy anywhere online or in the shops, but I had found a hardware store selling builders' masks that were almost comically unwieldy. My client agreed to wear one, and I will never forget the helpless comedy of our mutual discombobulation as she stood for the body reading.

LAH: Masks are so strange, inventive to go to hardware store for the heavy-duty kind.

NWV: We were officially 'locked down' (i.e., required to stay at home unless we were essential workers or going out for food or medicine) on 23rd of March, but much of the country had moved to lock down more informally about a week before. My partner and I made a last, faintly 'reckless', trip in to London together on 15th of March, to see the Derek Jarman film, *Caravaggio*, at the British Film Institute; that was also the first time I wore a mask in public, when it felt very strange to do so.

I saw my last client on the 18th. I locked up my office the next day, laden with as much stuff from my office (books, potted plants) as I could carry. That day there was a rumor building that London was going to be 'locked down' that very evening; that the army had been drafted in to enforce a surprise curfew. That didn't happen, of course, but it's a good illustration of the general confusion and misinformation that was circulating at the time. I cancelled all my other clients, and went home.

LAH: That sounds like a clean break between working and not working.

NWV: Depending on how people set up their business, people in my position have received a variable amount of government financial assistance. I was one of the very fortunate ones: I had previously paid myself a regular salary, and so was able to access the 'furlough' (job retention) scheme, paying 80% of my usual pay for several months. Others were not so lucky. For me, the enforced rest has been beneficial: it's felt like a necessary correction to my previous work-life imbalance. I used to work five or six days a week, across two locations, and every weekday evening. Commuting into London by train every day, I never got home before half eight in the evening, ate dinner late, and never spent time in the garden over sunset.

Spring 2020 was truly exceptional, gloriously hot and sunny (most likely, as I must always remind myself, for all the wrong reasons – climate change may initially take the edge off our chilly climes). I did things I hadn't made time for in a long while: a daily Ashtanga practice, reading novels, baking cakes, growing my nails long. We finally had time to adopt a rescue cat. Every Friday I wrote and printed a local newsletter that my partner and I delivered down our street. I am conscious that I had the luxury of time where many others did not: no childcare responsibilities or endless working-from-home Zoom calls.

If that initial period of lockdown was a kind of limbo, I nevertheless prefer it to what we have now, as we talk here at the end of October. There was a brief, arguably imagined, period of something resembling national unity during the initial lockdown. Keep in mind that this is the country that very narrowly voted for Brexit in 2016: we have been a bitterly divided country in deep political turmoil ever since, families torn apart by confected 'culture wars'. During lockdown, stepping outside one's front door to cheer loudly for the National Health Service (NHS), every Thursday at 8 pm, became a national obsession: you could hear the pot-banging and applause for miles around in big towns and cities. We are now in a more muddled situation.

For personal reasons, I decided not to return to work as soon as I might have done, which was from around the beginning of August. I was about to re-start in November, but we have just learned that we are going again into a one-month lockdown. I have masks, and a visor, an air purifier, and gallons of antiviral spray, but I work in a small office and a cold country, where I can't keep the windows open as we go into winter. I fear not being able to re-find the ease and creativity of touch that is such a part of Rolfing work.

LAH: I identify with that; I've had to prolong my leave of absence from my clinical work for personal reasons. And exactly, I think that part of my work is very much eye contact, talking, and my warm facial expressions. I anticipate it's going to have to shift how I work with a mask on.

NWV: To give an example, at an earlier point, I toyed with the possibility of offering 'safer' Rolfing sessions that were more restricted in scope (or 'off-Recipe'), such as a session dedicated to the feet (similar to a session two). I could undoubtedly offer a good hour's work at the feet, and most clients would benefit from it. Client and practitioner would be breathing at a safer one to two meters distance from each other the whole session. But would it be Rolfing SI?

For me, the enforced rest has been beneficial: it's felt like a necessary correction to my previous work-life imbalance.

Rolfers are never only working in one place: we make connections between the feet and the back, the back and the head. Our hands are always gesturing to a larger territory beyond the specific area of intervention. We have a 'Recipe', but we don't do things by rote: we have the client lying, standing, sitting, and walking. I worry that these transitions will flow less smoothly if we are unwrapping an umpteenth sterile change of blankets, or spraying the wall with antiviral solution before the client touches their hands to the wall, if therapeutic touch no longer feels 'safe'.

A majority of my clients are fairly pragmatic people, and I suspect they'll have no qualms to receive treatment, but there will be others who are more fastidious or more vulnerable. Added to that there is the question of *my* nervousness – about infecting someone or becoming infected. I remember an alarming occasion when a client casually told me at the start of a session that he'd just 'had a touch of flu this week' (he meant to say, a cold). I jumped out of my skin, as I *really* didn't want to catch the flu. When we realised the miscommunication, we laughed it off and I took the risk of treating him. How would I react to him now?!

LAH: Totally, I think about exactly that too, I'm prone to allergic reactions to people's products. What used to be a simple sneeze has changed. You and I were talking before the interview, and you introduced me to the construct 'therapeutic stoppage', can you tell us about the dynamic of therapeutic stoppage?

NWV: During lockdown I've been reading Eugene Gendlin's *A Process Model* (2018). Gendlin is probably best known within our community for his earlier book, *Focusing* (1978), and his idea of the 'felt sense'. If you've read *Focusing*, you might be surprised by *A Process Model*; it's by no means an easy read, reflecting the fact that he was, first and foremost, an academic and philosopher (at the universities of Wisconsin and Chicago). But *A Process Model* repays the effort of leaning into the sometimes dizzying array of terms that he sets up to describe the relationship between an organism and its environment. And his idea of 'stoppage' struck me especially forcefully while I myself was 'stopped' from going about my usual work and play.

Gendlin defines stoppage as a stopped process *implied* (a technical term within his model) by an organism in its interactions with its environment. For some reason, a process stops, possibly because the conditions for achieving the implied next step are no longer available. It made me think of lockdown; it made me think of any number of processes (which we might more humanly think of as strivings, intentions, or simply the implicit intention in our ways of living and being) that are stopped by circumstance, by the environment, and by our own internal obstacles.

What are the stopped processes that we are carrying?

The Japanese psychotherapist Yoshihiko Morotomi has developed the therapeutic aspects of stoppage, noting that Gendlin describes the stoppage as arising from a 'missing experience' that the person nevertheless continues to try to create in their life. Within the stopped process, he argues, there is the possibility for something new to emerge. Gendlin (1997) himself illustrates the idea of stoppage with the image of a trapped insect:

> The insect hits the window pane again and again, beginning to fly out to the light only to hit the glass painfully. But after a while it makes little tries, bzzz, bzzz, bzzz, bzzz, but these are no longer those awful first few hits when the bug smashed into the window pane as its body implied flying out to the sun. Now they are little rhythmic starts, almost continuously, along the window surface, as if exploring, maximizing the chance of finding an opening if there is one. . . . By [doing this], the organism stays in the field of the stoppage. It remains at the spot, and under the conditions, of the stoppage. It would have spent only a moment there, if the process had not stopped. Now new events might occur from with the environment, which could not have formed before the stoppage (Gendlin 2018, pg. 74).

When a process stops, the organism (unless it dies) doesn't also stop: the stopped process is rather carried within another process (sincerely, if perhaps ineffectually). In this I am deeply reminded of Rolfing SI. 'Keep looking at the body as something that has been through a process', Dr. Rolf tells us, but if that body is not dead, the process is ongoing.

A person's body, their habitual ways of being, may literally be *carrying* their own stopped processes, and we might fruitfully ask the question (of ourselves, and our clients): *what are the stopped processes that we are carrying?* The *obstinacy* or *perseveration* that we sometimes encounter in our clients – their tendency to 'keep going on' about a particular topic, or 'keep keeping on' in persisting in habits, patterns, and activities that we might consider to their detriment – might be more helpfully (and hopefully) reframed as an organism's attempts to restart the stopped process. For many of us, the experience of 2020 has been like that of the insect that can't seem to find their way forward; staying close to the infuriating 'bzzz, bzzz, bzzz' might yet yield a new solution.

LAH: Yes, I dig where you are going with this. Thank you so much for sharing your thoughts.

Naomi Wynter-Vincent is the founder of London Rolfing and is the Europe Editor for this journal. More information about Naomi can be found at londonrolfing.com.

Lina Amy Hack is an Advanced Rolfer practicing in Saskatoon, Saskatchewan, Canada. She is also Co-Editor-in-Chief of this journal.

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Interview with Jeanne Vadnais, Certified Advanced Rolfer™, Rolf Movement® Practitioner

Lina Amy Hack: How are you doing? How is Rolfing SI in Seattle? You probably did shut down for a time back in March.

Jeanne Vadnais: It's good. Yeah, I personally decided to close my practice on Friday March 13, I'll never forget Friday the 13th. Every day that week leading up to that Friday, those first known Kirkland

I took what felt like an overwhelmingly long period of time to get my process in place [in order to open]. I wrote an entire checklist for all my office processes.

COVID-19 cases were just a ten-minute drive from where I live. Every day I wake up and I'm like, "I don't know if I should be working today." I had already started wearing masks when I was working, and I started asking people how they felt. My 'spidey sense' on Friday morning, the 13th, was: "This is the last day."

LAH: Right, the Seattle area had the first big COVID-19 outbreak in North America. You had to think on your feet. I know in Washington state you need a licence to touch, was there guidance?

JV: So, they actually never told us we had to close. They said we could work on urgent medically necessary cases. Even though I do work with health, I don't think of myself as a health-care worker. That's not my preferred lens to think of myself or refer to myself. I was part of the crew, like, "let's not overwhelm the medical system." People really have to make hard decisions, so I closed.

On May 18th the governor of Washington made a proclamation that applied to non-urgent medical workers, and we were allowed to reopen, but there were criteria. There was a checklist of sort of things you had to do, you have to have personal protection equipment (PPE). Well, nobody could get PPE at that point. I'm not an anxious person at all, [yet at that moment] I had incredible anxiety, and I had no idea I was depressed.

I used to be a project manager in corporate America, so I feel comfortable to rest into process. So I took what felt like an overwhelmingly long period of time to get my process in place. I wrote an entire checklist for all my office processes (see Figures 1 and 2).

JV: This is my office. I have a separate back door. So now people come straight into my office. This is my clean table [JV shows a standard pop up table against one wall]. Kind of like surgery, I've created a clean side to my office with this clean table and a dirty side. So, everything is disinfected before the client shows up. Then, if I take something, like a pillow case that the client has touched, when I take it off the table then I consider it dirty. Dirty objects, it all goes to the other side of my room, that's my dirty table [JV shows an identical pop up table on the opposite side of the room]. My dirty table has my hand sanitizer, which I use a lot, and then this is what I use for disinfecting – hypochlorous acid. When my session is over and client leaves, after I wash my arms, my hands, up to my armpits, I come back in, and I just start disinfecting the table.

I got rid of all my nice furniture. I have a plastic chair, and a plastic table, and a touchless hand sanitizer. And this was kind of a barrier with my desk. I focused on what makes people be far apart from me. Figuring out all that stuff took time, and then I practiced with my husband. A mock-up. It was like, "Wait no, you can't put that on the clean table, you just touched that. You have to put it on the dirty table." Like if I picked up my foot model to show people, I put it on the dirty table, and then I sanitize my hands, and then I work on them. The more that I wrote all of these steps down, and [thought about] what I wanted on my clean table at the beginning of every session, so I don't have to open any plastic tubs, or do this or that . . . . Now it's so routine I don't think about it at all.

LAH: Nice, I would never have thought of that detail, so helpful.

JV: I have a physical checklist. Do you know the author Atul Gawande? *The Checklist Manifesto* (2011) is a famous book and he talked about how he lowered the incidence of infection in hospital settings. He's an orthopedic surgeon. People get tired and they forget, it's the fourth surgery of the day. Just by doing these checklists, this made surgery safer. For me, this was like, "I know I'm going to be anxious." So, I literally wrote it down.

LAH: This is all so smart. I've had to close my practice due to COVID-19 and then I had some personal loss, so I haven't started again. I'm starting to feel ready but I don't know how to start. This checklist idea is so helpful.

JV: Yeah, I'm super happy to share these ideas, and you take what works for you.

LAH: Incredibly helpful. And I really identify with this new anxiety feeling. What are you doing for yourself to help ground? How have you adapted?

JV: My anxiety is managed because I know I have a checklist that I have practiced. It is written down; I can check it as I go along. I had a client take off their mask last week because they had to sneeze. And I thought "What just happened?" You know, so I literally just said, "I need to go wash my hands." And I stood out there, and then I was like, "Okay, you're going to go back, and you're just going to assess where you are, and you need to look at your checklist."

The second thing, this is very procedural related because my brain works that way. I called 110 clients when I was about to go back to practice and said I updated this on my website, "If we're going to work together, we have to talk first, and make sure we're in similar places, how we're living." The words I use consistently are, "I'm running a conservative, and very cautious practice, to protect me and my family, but also all of my clients." Everybody gets to make their own choices. It took eighty hours to actually call and talk to everybody but I haven't had any problems.

And I say, "I have people with cancer in my practice, and I have people in their eighties. And so you can do what works for you and your family, but we need to be in a similar place." I ask people, "So tell me about what's life like in the pandemic?" I talk about traveling explicitly, so I ask people, "Are you flying on planes?" I'll only see people on day fifteen after travel. It doesn't mean that I won't see you, I tell them I'm being cautious, so we'll all reschedule. The more irritated people are with this conversation, the more my red flags go up. I think to myself, "We're probably not living in the same life." I have said to some clients, "I'm just not the right practitioner for you right now." I've turned people away for different things.

LAH: Smart. Calling everybody, that created safety for you. I'm going to borrow from your ideas here, this is just the kind of help I needed as I think about getting back to work.

JV: So glad to help. Think about: (1) the checklist that fits your practice and space, (2) the prescheduling interview, and then I added an automated thing (3) automatic email ahead of session. Three days before their session, they get a new email, "Hey Rolfing during COVID-19 topics." It reminds them about my travel restrictions and my expectations that we already talked about. I always remind people, "You have to be able to answer 'Yes' to all of these questions." That email really helps, since they scheduled, the email will remind them "Oh yeah, I forgot I went to the coast, I have to reschedule." So, I get those cancellations three days before session time. It gives me time to fill that spot. I've always had a strict cancel policy, unless you don't feel well. Now, I say to clients, I trust you, and especially now more than ever, if you don't feel 100%, don't come in. But that seventy-two-hour email has caught so many people.

The next part to think about is, when people come, I start with them in their car [with a phone call]. I explain, the goal is that we talk the least amount in person. We will talk in person, we'll both wear masks, I've got windows open, in and out with air. I have one window open with a fan pulling air in, another window open pushing air out. I have the air purifiers running thirty minutes before they arrive.

LAH: An acquaintance said to me, they want to have their touch work on sheets that get thrown out after the session, which caught me by surprise. But I see they're thinking about these things that are touching them. I wonder what you think about this?

JV: Well, I have become less worried about surfaces. I still disinfect, but Lina, there seems to be a correlation with the amount of virus that you actually ingest, and how sick you get, and where it can live – on surfaces versus in the air. So, I'm more worried about the air. That's why I have three air filters, the HEPA filters. Back to your question about sheets, I actually have a [linen] service. I get my stuff delivered every two weeks. And this works great because they know the virus actually survives less time on porous surfaces. I have a storage place that's outside my physical office. It doesn't even come into my office until it's already been sitting there for over a week. People aren't walking by it or sneezing on it. I have tons of totes where my clean sheets sit away from people.

Excerpt from Jeanne Vadnais' Checklist
for Starting Rolfing Session under COVID-19 conditions

Section 1 – phone call stage:
- ☐ Welcome: are they feeling well? Have questions? Explain telehealth reduces the amount of in-person talking in an enclosed space and may lower our risk.
- ☐ COVID-19 health questionnaire (they'll sign in person upon entering)
- ☐ Ask if they have a mask today – no valves and no bandanas?
- ☐ Typical Rolfing session conversation begins: check in how they are feeling; sensations in their body? Reports since last session? Questions on Homework?
- ☐ Invite to meet me outside at the top of back stairs to have temperature taken and oxygen

Section 2 – prepare to meet client at top of stairs:
- ☐ Put **phone** away in cupboard and turn off.
- ☐ Sanitize **hands**.
- ☐ Don **PPE** face mask & eye protection (goggles or facemask).
- ☐ Grab pulse **oximeter** & **thermometer** and meet client at door.

Section 3 – client temperature & oxygen:
- ☐ Verify client is wearing a **mask**.
- ☐ Use touchless forehead thermometer to take **client temperature**; healthy range is < 100.4 degrees Fahrenheit.
- ☐ Take **client O_2 level** with pulse oximeter; healthy range is typically 92 – 100.

Section 4 – client enters Rolfing office & legal paperwork:
- ☐ Invite client in; let them know I'll take care of the door (ask if it's ok to leave open?)
- ☐ Invite **client** to **sanitize hands** using automatic touchless sanitizer dispenser on client table.
- ☐ Invite client to use the small table for personal items.
- ☐ Invite client to **review and sign COVID-19 health questionnaire**.
- ☐ First session back: Invite client **to sign Consent Contact Tracing form** for COVID-19.

Section 5 – in-person touch base:
- ☐ Allow a chance for in-person discussion for things missed during telehealth phone check in.

Figure 1: Session start checklist by Jeanne Vadnais.

After my last client leaves, and I disinfect everything, everything is wiped down, everything is clean, back on the clean table, I change my clothes. In Washington state, you don't have to change, but it's strongly recommended. So, I bought scrubs, I wear a new pair of scrubs for every client. Once I'm clean, my room is clean, I change my clothes, and I've had my air filters on for the thirty minutes between clients, which is new. Then I take out the clean sheets for the next client.

LAH: Gold standard right there. I'm sure I'm not alone in that this COVID-19 pandemic completely knocked me off my feet. Coming back to my practice, I feel more vulnerable. It's overwhelming to think about teaching myself a whole new set of procedures.

JV: I'm remembering now that you've said that, the first week I saw one person a day, so I didn't feel crunched. And I handpicked the people that I wanted to work with, and I told them, "This might be bumpy, or I might have to stop and look at my checklist." And they were like, "We love that you have a checklist, we love that you are opening, and being safe." So, I did one client a day the first week, two clients a day the second week, and then three people a day the third week. I worked up to it. I was more exhausted because I think I was just nervous. Gradual was a nice way to ease into it. If you have one and it goes sideways, you get to nourish yourself and do whatever you need to do for the rest of the day.

LAH: That is exactly the stage I am at, just thinking about how to accomplish that one client in the best way possible for everybody. Does the work on the table feel like the same work even though you have all these conditions? Does it feel like the same job?

JV: I wear an N95 mask under a cloth covering over it, for me it seems less medicalized. And it makes my N95s last longer, so I'm less of a burden to the supply chain. And I change that for every

The first week [back at work] I saw one person a day, so I didn't feel crunched. And I handpicked the people that I wanted to work with. … [then] two clients a day the second week, and then three people a day the third week. I worked up to it.

client too. Now, I don't even notice the masks. Before I went back, this was the thing I worried about, I'm like "I'm going to be so hot, and I'm going to breathe through my mouth." And now it's just normal. I've been back for four months and everything now feels normal. I have a new normal. The only thing that is not normal is the Seventh Hour. My intraoral training showed me how to teach the clients to address this work themselves. That instructor said "do the Seventh Hour with your client at their house." You give them gloves, and talk them through it. I haven't don't that yet but I have a couple of clients who are game. We can coach our clients to do self-care stuff.

LAH: I wonder when we get to a post-COVID-19 time . . .

JV: What it will look like?

LAH: Yeah, will we just go right back?

JV: I'm going to keep my disinfecting procedures. I'm making my own hypochlorous acid, I let it sit wet on surfaces for ten minutes. I bought this machine that makes hypochlorous acid, it's not toxic as long as the pH is right. And it just requires water, two grams of non-iodized salt, and vinegar to get the pH right. Now I have no dependence on the supply chain and there's no off-gas. People are like, "Wow, it smells so neutral."

LAH: So good, what a full meal of a conversation we've had. Thank you so much for your time and insights. They will be useful to our readers. All the best to you.

Jeanne Vadnais completed her Rolfing SI training in 2013, her Advanced Training in 2016, and her Rolf Movement practitioner education in 2017. She practices in West Seattle. More info about Jeanne can be found at westseattlerolfing.com.

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References

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Excerpt from Jeanne Vadnais' COVID-19 Checklist
for POST-SESSION Clean and Disinfecting Routine (with PPE still on):

POST-SESSION Clean and Disinfecting Routine (with PPE still on):

- ☐ Wash arms, elbows, and hands.
- ☐ Turn air filters to high and open all windows and outside door.
- ☐ Put sheets, pillowcases, and blankets into dirty laundry receptacle.
- ☐ Move dirty items from session which I clean/handle end of week (dycem, client files in small clear tub, cash and checks from clients) into dirty tub.
- ☐ Clean and disinfect massage table and vinyl pillow case covers.
- ☐ Clean and disinfect client table, chair, and plastic walkway.
- ☐ Clean and disinfect door handles, light switches, window cranks, & remotes.
- ☐ Clean and disinfect items used in session and return to clean table.
- ☐ Take off dirty clothes and put them in the dirty tub to go home end of week.
- ☐ Clean and disinfect 'dirty table' items and table where items used in session were put.
- ☐ Sanitize hands.
- ☐ Take off my PPE.
- ☐ Sanitize hands again.
- ☐ Put on clothes for next client.
- ☐ Wash hands, elbows, arms, and face.
- ☐ Take next client's clean linens and blankets out of plastic tubs and make up table.

Figure 2: Post-session clean and disinfecting routine checklist by Jeanne Vadnais.

Dancing with the Breath in Rolfing® SI

Pre-movement, Orientation, and the Cycle of the Breath

By Lael Katharine Keen, Basic and Advanced Rolfing Instructor, Rolf Movement® Instructor

Lael Katharine Keen

ABSTRACT *How we breathe is how we live, and the ways that we occupy the spaces of our breath reflect distinct physiological and psychobiological potentials. The author deftly describes our different modes of breathing and encourages us to strive for balance, teaching us how we can help ourselves and our clients.*

Author's Note: I have opted in this article to use the pronoun 'they' when speaking about people in a general way. This is out of respect for the cultural moment in which we find ourselves when gender is no longer a binary process. As the 1960s brought the freedom to use the pronoun 'she' instead of the classic 'he', so this new century brings the freedom to not be identified either as a 'she' or a 'he'; and thus, 'they' is my pronoun of choice.

Beginning Considerations

An average human being breathes anywhere between 17,000-25,000 times per day. Even with a margin of error of 8,000 breaths, it is still safe to say that breathing is one of our most repetitive movements, and as such, one of the most potent factors in creating our structures.

We breathe as long as we are alive. When we stop breathing, we die; thus, breathing is life. The way that we breathe or do not breathe is intricately related to our autonomic nervous system, to our emotions, to our beliefs, to the way that we orient in the world, and to the way we relate to ourselves and others. Breathing is one of our oldest and deepest automatic movements; and yet, to a degree, we can also override the autonomic signals and take conscious control of our breath. Breathing is one of the places in our body/beings where conscious and unconscious, nature and will, meet each other.

When we speak or sing, we take control of our breath causing it to flow across our larynxes in such a way as to produce sound. Speech is one of the functions that makes us fully human and allows us the many nuances of verbal communication that are part of our complex social interactions. Our capacity to exhale in a slow, steady fashion – which is also linked to the deep coordination of core stability – is inextricably intertwined with our capacity to communicate.

We find our breath at the center of movement where conscious and unconscious meet and in the place where function creates structure; and structure, in its turn, feeds

back into function. When we consider working with someone to help them create changes in their structure, we address only a part of the issue if we do not take into consideration their habitual patterns of movement, especially breathing,

When we ask what constitutes a healthy way of breathing, the answer is as varied as all the activities that the human being may perform. Breathing adjusts to the ever-changing landscape of the body's necessities, running the gamut between 'thoracic and fast' when the need for oxygen is high, to 'slow and abdominal' when we are in a predominately parasympathetic state. A healthy breathing capacity, then, is one which can adapt to the situation in which we find ourselves.

When we think of some of our clients, we quickly realize that some bodies are more adapted to certain kinds of breath than others. For example, think of the person with a rib cage that is caught in the movement of inspiration. The sternum is high and forward; the front-to-back depth dimension predominates over the side-to-side dimension; and the erector spinae (specifically the iliocostalis) are tonic and overworking. This is often a person who is active, excitable, and has a hard time slowing down. This is a person for whom abdominal breathing and the parasympathetic activities of moving slowly, resting, silencing, and grounding may not be fully supported by their structure.

A healthy capacity for breath involves a structure, both physical and psychobiological, that is adaptable and able to embrace all kinds of breathing and multiple internal states. On the other hand, an adaptable breathing pattern will create a structure that is flexible and fluid, able to adjust easily to different necessities for oxygen and different levels of activity.

Like the proverbial chicken and egg, physical structure and habitual movement patterns flow into and create each other – often so seamlessly that it is difficult to tell where one begins and the other ends. In the case of breathing, because it is such a repetitive movement, the movement itself needs to be addressed if a lasting structural change is to be obtained.

Breathing – Willingness as Opposed to Willfulness

How then, do we address breathing? It is very tempting to just try to make it happen, to breathe in deeply, and to push the breath out with a forced exhalation. But the profound automatism of the breath can only temporarily be overridden, and this control has a high price.

The breath is modulated by the respiratory centers in the brainstem that have chemical and mechanical receptors. When the CO_2 levels in the brainstem reach a certain level, the inspiratory centers will stimulate the phrenic nerves to contract the diaphragm; and we breathe in. When stretch receptors in the lungs indicate to our brainstem that the lungs are full and CO_2 levels in the blood decrease, inspiration is inhibited, and expiration follows. Expiration, when we are not in high physical activity, is a passive movement in which the diaphragm relaxes and returns to its high dome-like position. Elastic recoil in the lung tissue also helps the return of the diaphragm.

In the brainstem resides our body's deep organic intelligence. It knows best when it comes to modulating the breath. However, there are many factors in our bodies and our lives that can alter this somatic intelligence in ways that do not support our highest state of well-being. Poor posture, sedentary lifestyle, breathing difficulties (such as asthma or bronchitis), or chronic emotional states are a few of the factors that can kidnap the autonomic intelligence of our breathing.

Thus, we may encounter a client with a collapsed, expiration-preference rib cage who can't get a full thoracic in-breath because of myofascial restrictions. Another client, who may have a tendency towards anxiety, has co-opted the breathing pattern into short, shallow breaths where neither the in-breath nor the out-breath ever get a chance to complete. A client with asthma or a drowning incident in their past may never complete an exhalation because of the fear imprinted in the body from these experiences. (The body is loath to release the last of the air in the lungs when it does not know if it will be able to get sufficient air on the next in-breath.)

Telling the client to take conscious charge of their breathing will last only as long as the client's concentrated attention and may often do more harm than good. As an example, we can think about the out-breath – a moment when the body in quiet activity oscillates naturally into a parasympathetic state. As the diaphragm lets go and moves upward inside the rib cage, back to its relaxed, dome-shaped position, the intercostal muscles release; and the rib cage becomes soft and pliable. The ribs ripple downwards, one at a time, like venetian blinds closing, and the belly softens. The lumbars rest back into a 'de-lordosed' position.

But what happens when we try to push the breath out to consciously create this moment of rest and ease? When we expel the breath, the intercostal muscles, instead of softening and releasing, they contract. The differentiated venetian blind movement of the ribs in exhalation is lost, and the rib cage becomes a solid unit. This is what our rib cage does to stabilize when we prepare for effort or impact. Our body listens to proprioceptive input more than it does to cortical intention; so the effect of pushing the breath out is that we do not relax. Instead, our body prepares for impact and upregulates into sympathetic activity, and the moment of parasympathetic release is lost.

Breathing, Orientation, and Pre-movement

The optimal time to change any movement, including breathing, is in the pre-movement – the moment that our body prepares for the movement that we intend to do. At this moment, the entire body, from head to toe, organizes itself to be able to maintain balance while the movement is performed. Once this full-body orchestration has occurred, it takes a lot of energy to reroute the movement. For example, anybody who has raised their fist to punch a pesky little brother only to have their mother walk into the room, knows that it is almost impossible to disguise the pre-movement of a punch as something more harmless, such as scratching one's head. In the shifting of weight and the tonic preparation from head to toe, the body's intention for movement is expressed; and the movement itself is determined. Thus, timing is of the essence!

To change the movement that will emerge, we have to change the pre-movement. In other words, we have to change the way that we conceive of that movement, and thus, the body's preparation for the movement. We make this change, not by willing or controlling, not by acts of tension, but by acts of attention and imagination.

In the split second in which we prepare for movement, we draw upon immense archives of information – both internal and external. Only 2.5% of the neurons in the motor cortex descend to the pyramidal system from where movement is determined. The other 97.5% of these neurons are interneurons that make connections to bring in information from

The optimal time to change any movement, including breathing, is in the pre-movement.

the body, the environment, and from the rich internal databank of associative information. These interneurons offer us information about the context in which we are moving and the meaning of the movement that we are doing. To return to the above example, although scratching my head and punching my little brother both involved raising a closed hand, the intention is very different, as is the tonic preparation for the movement and the result!

One of the big sources of external information that we rely on to organize our movement is orientation to our environment. According to Hubert Godard, researcher, founder of the Department of Dance Movement Analysis at the University of Paris and Rolf Movement Faculty, we have two basic modalities of orientation. We orient downward to ground, gravity, and to our surroundings; and we orient out into space, to other, to connection. When our capacity to orient to gravity and to space is balanced, the information that our body receives to organize movement is also balanced. Then, in the pre-movement, the spine lengthens, the joints open, and the movement that emerges manifests grace and ease. However, most of us have a preference for orienting in one of these directions; and this preference creates an imbalance in the way that we organize movement.

To give a simple example: someone who orients more to ground than to space will rarely trip over irregularities in the ground, but may easily be surprised by an overhanging branch that knocks their hat off before they see it. This person may be more introspective and will often demonstrate a preference for either abdominal breathing or the phase of expiration.

Someone who orients more to space will rarely be surprised by overhanging branches but may easily trip when they encounter a hole or obstacle on the ground. This will often be a person who is more interactive with others; and who has more breath on the phase of inhalation rather than exhalation; and who gets more air into their thorax.

The above examples are gross over-simplifications, but they do give us an image of what each orienting preference may manifest. If we examine them further, they will also yield information about how we may work with the cycle of the breath in such a way that we engage the client's act of attention and allowing instead of willing or forcing.

Learning to 'Inhibit the Inhibition'

The cycle of breath is one of the best places to start to help the client to balance their breathing. For our interests, we will consider the cycle of breath as having three phases: inspiration, exhalation, and the pause between the end of the exhalation and the next inspiration. We will not consider the possible pause at the end of inspiration because this pause, when it occurs, tends to activate the client sympathetically and locks the breath. As such, it is not nearly as interesting for helping the client to find a smooth easy flow of breathing.

When we work with the cycle of the breath, our goal is to help the client to find the optimal breathing rhythm of their body in a way that is easeful and free of effort. Depending on the client's habitual pattern of breathing, this may require the Rolfer™ to suggest new ways of orienting and to encourage the client to, in the words of F.M. Alexander, "inhibit the inhibition."

Inhibiting the inhibition means that when we discover ways in which the client does not allow the breath to flow freely – ways in which the client is inhibiting their breath via patterns of habit, incomplete orientation, or trauma, to name only a few – we help the client to become aware of the moment when this inhibition occurs. From there, instead of proceeding with the habitual coordination sequence, we encourage the client to inhibit this sequence and offer the system other information so that something new can occur.

As an example, let's take a client who had asthma as a child. Although it has been many years since the last asthma attack, the patterned response is still there in the client's coordination. So, this client, as they exhale, may not allow the exhalation to complete. Instead, halfway through the out-breath, they switch to an in-breath. The in-breath that comes is unconsciously colored by the panic of past asthma attacks.

The scalenes, which in normal breathing give the very slightest pulsation at the beginning of inhalation, come on full force. We can see the neck activate; sometimes the sternocleidomastoid and even the platysma contract visibly as the body remembers the 'state of emergency' that it once lived through. In this breathing sequence, the exhalation is not completed; and the pause at the end of the out-breath never occurs. Besides this, the overactivation of the auxiliary muscles of breathing gives the body a continual message of alert and panic, which makes it hard to return to a more normal rhythm of breathing.

With such a client, 'inhibiting the inhibition' might start with helping the client bring their attention to the fact that while they continually feel that there is never enough air, that in truth, they are never releasing more than 30% of the air in their lungs. This, of course, means that at most, they will only manage to get 30% of their lung capacity in any given breath. Usually, helping the client to notice this will be sufficient to catch their attention and curiosity – especially if the feeling of never having enough air is something that causes them discomfort.

Inhibiting the inhibition means that when we discover ways in which the client does not allow the breath to flow freely . . . we help the client to become aware of the moment when this inhibition occurs.

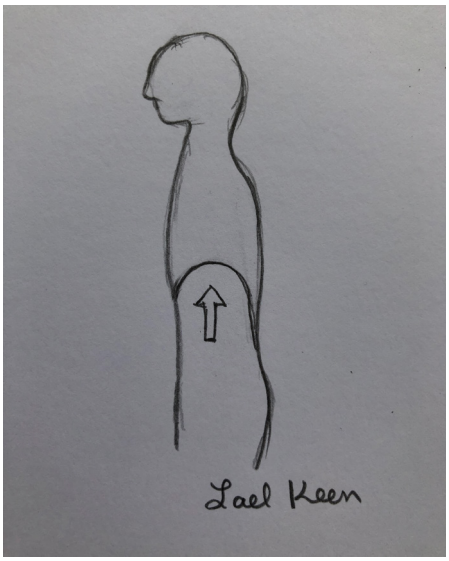

Figure 1: Out-breath.

Once the client's curiosity has been engaged, we begin to encourage them to attend to the coordinative *crossroads* where the habitual occurs. Instead of allowing their body to follow the grooved path of habit, we ask them to wait just a moment at the crossroads to see if the body (which always orients to maximal health and well-being when we allow it) will find a new path forward. At this moment, helping the client to orient to a sense of gravity – the weight of their back on the table, becoming slightly heavier as the breath flows out, and the softening of the ribs as the rib cage settles back towards the table – may be sufficient for them to allow a slightly longer out-breath. This time they may release 50% of the air in their lungs and thus allow 20% more of their lung capacity to come online. In this way, the client has allowed more air to go out with the exhalation, not by forcing or expelling the air, but simply by waiting and allowing the natural movement of the out-breath to come closer to completing.

The Cycle of Breath

Let us now examine more closely each phase of the cycle of the breath.

The Out-breath

One of the most useful points of entry into the client's breathing pattern is the out-breath. In normal quiet breathing, the out-breath is a passive movement when the diaphragm, which contracts and flattens downward on inspiration, relaxes and returns to its dome-like resting position, aided by the elastic components of the lungs (see Figure 1). The out-breath is the phase of the breathing when the autonomic nervous system oscillates into a slight parasympathetic activity, and we relax and release. When performing other functions, such as talking, singing, or preparing for various types of effort or impact, the exhalation goes from being a passive movement to an active movement. For this, we have the auxiliary muscles of breathing (i.e., the intercostals, the abdominals, and pelvic floor, to name a few). As we modulate the flow of air across the larynx to vocalize or push the air out and lock down in preparation for lifting a heavy weight, these muscles contract, and the out-breath becomes a moment of activity – no longer a release and letting go.

Our body, in its wisdom, has as many different responses and coordination patterns as it does activities. The problem comes when the coordination of one movement gets confused somatically with a different movement. This frequently happens with the out-breath, which becomes an active movement of expelling the air, even when no other function has been engaged. When this happens, we miss not only the moment of parasympathetic release, but also the possibility of softening and differentiation that occurs between each individual rib as the wave of relaxation moves downward through the belly when the out-breath is released instead of pushed.

Another important aspect of the out-breath is that our body knows it is safe when the out-breath is slightly longer than the in-breath. A longer out-breath not only deepens the moment of parasympathetic release, but it also sends an uncontestable message to the body that we are in a situation of safety. Why is this? Because in any situation of danger or impending danger, one of the first things that happens is that our heart rate and breathing rate increase so that we may have a larger and more efficient delivery of oxygen in preparation for fight or flight. At this moment, the in-breath will become salient, as the body focuses on bringing in the maximum amount of oxygen. And as happens so often, the underlying coordination and physiology of the body gives us a strong, unconscious message about what is happening in our environment. Therefore, a longer out-breath that is released, instead of expelled, is a robust contribution to a body-based sense of security.

The orienting direction that offers the most support for the out-breath is orientation to gravity and ground.

The Pause

When the breathing pattern is healthy, a pause comes at the end of the out-breath. In the time when the breathing apparatus is not actively engaged, the oxygen/carbon dioxide exchange is occurring within the cells in the farthest corners of the body. This pause is a moment of limbo, and it is also one of the most powerful moments to help the entire breathing pattern to reset. As we help the client to rest into the pause, instead of reflexively pulling in the next breath of air, a very profound relaxation becomes possible. In the space where we are neither inhaling nor exhaling, we can rest and settle. This becomes a moment of deep parasympathetic activity and letting go.

The orienting direction that most supports the pause at the end of the exhale is ground or gravity orientation.

The In-breath

From the pause, the body naturally moves into breathing in. Here, we find that whether or not we have allowed the pause to be present has an immediate effect on the quality of our next in-breath and can determine whether this in-breath comes from the deep bodily intelligence of the brainstem or from a voluntary override mechanism. During the pause, the carbon dioxide levels in the blood slowly rise. One of the main stimuli that causes us to breath in is the increased acidity of the blood that occurs from the buildup of carbon dioxide. As the concentration of carbon dioxide in the blood increases and the ratio of carbon dioxide to oxygen also increases, chemical receptors in the aortic and carotid bodies and the brainstem detect this; and the inspiratory center in the brainstem stimulates the phrenic nerves so that we begin to breath in. This inspiration, when it is initiated by the respiratory centers in the brainstem, will respond to the exact qualities and quantities of breath that our physiology requires in that particular moment.

A metaphor that is often used to speak of the breath is 'waves in the ocean'. If one sits beside the sea and watches the waves, one will quickly notice that each

wave is completely unique, in size, in shape, and in timing. As the waves are determined by multiple factors under the influence of the entire ocean, tide, moon phase, wind, shape of beach, etc., so each in-breath, when orchestrated by the body's organic intelligence, is also a unique response to changing levels of activity, need for oxygen, emotional state, and expectation of immediate activity. A lower level of activity and a calm emotional state, for example, will call forth a predominately abdominal breath that moves into the belly, the lower back, and the sides of the rib cage; while, on the other hand, an agitated emotional state or a high level of activity will call for a more thoracic breath. If we rest into the pause at the end of the out-breath, the next wave that comes – the next in-breath – will be the body's perfect response to the needs of the moment. The sensation is that we are being breathed. There is minimal, if any, effort. If we override the pause and breath in before the inspiratory centers in the brainstem have had time to fire, our in-breath will be an act of doing.

The orientation direction that gives support for the in-breath, especially an in-breath that moves upward into the chest, is space orientation.

The Cycle

Each phase of the cycle of breath influences the next one. If the in-breath is pulled in, upstaging the impulse that comes from the brainstem, it is very likely that the out-breath will be pushed out forcibly instead of released; and the pause will be overridden again. As such, it is very easy to find oneself in a pattern of *doing* – pushing and pulling each breath instead of *allowing* the in-breath, releasing the out-breath, and resting into the pause. When we think of these two contrasting qualities of breathing, multiplied by 17,000-25,000 times per day, we begin to perceive the immense difference that this can make in life. Does one of our most basic life movements come from effort or ease? What is the underlying psychobiological belief system of someone who must work for each breath, as opposed to someone who trusts the basic physiology of the body?

Does one of our most basic life movements come from effort or ease?

Interventions for Working with the Cycle of the Breath

In this section, interventions for aiding the client with each phase of the cycle of breath will be offered. It is essential to remember that any change that creates more ease will come from an act of attention and willingness, rather than an act of will or imposition.

Interventions for the Out-breath

An out-breath is the best point of entry for most clients when working with the cycle of the breath. When we work with the client's out-breath, we are thinking of two issues: (1) allowing the breath to flow out without pushing or forcing and (2) giving the out-breath time to complete and settle into the pause.

We start by slipping our hands underneath the client's upper back and encouraging them to simply notice how the weight of their rib cage drops back into our hands as they breathe out. This is a natural movement; and as they bring their attention to it, it will increase. For some clients, this may be all that is necessary. As they notice the weight of the rib cage settling, they will let down and the length of the out-breath will increase naturally, as will the softening and relaxation of the rib cage on the exhale. Sometimes if the Rolfer places a hand lightly on the rib cage (the Rolfer's hand is like a leaf that drifts down on the wave of the breath) and helps the client to feel the settling of the weight from above, this may further help the client to notice the differentiated movement of the ribs, rotating caudally, as the movement of exhalation passes through the rib cage. Eventually, if the client continues attending to this, they may begin to drop into the pause and rest there.

For other clients, it may not be so easy. Often there is a habit of pushing out the breath that is so deeply engrained that it feels natural and normal, and this habit is one that may take some time and persistence to address successfully. There is a simple way to know whether the client is letting go or pushing the out-breath. Any time the breath is forced out, we will hear it. This refers to even a very small sighing sound. When the sound of the out-breath is audible, this means that the auxiliary muscles have engaged; and the breath is being expelled instead of released. Often some education may be needed, as the audible out-breath is a hallmark of many yoga, exercise, and meditation practices that teach this as a way of relaxing.

It helps to have the client place their hands on the Rolfer's rib cage while the Rolfer releases the out-breath (hoping here that the Rolfer has embodied this quality!). The client should be able to feel the softening of the rib cage and the differentiated movement of each rib. Then have them place their hands on their own rib cage and feel how it hardens and solidifies as they push the breath out. Inviting the client to release the breath without making a sound (almost as if they were sneaking it past the Rolfer's hands), and then, when a softening, releasing breath occurs, validating it by

Sometimes if the Rolfer places a hand lightly on the rib cage . . . and helps the client to feel the settling of the weight from above, this may further help the client to notice the differentiated movement of the ribs . . . as the movement of exhalation passes through the rib cage.

asking them what it felt like, can be helpful. How was that breath different from their habitual way of breathing?

Helping the client to return again and again to the out-breath that softens and releases, getting them to notice how it feels, and identifying what they did differently is the road to help the breath to change. It does take time and persistence. When I work with someone who has this kind of breathing pattern, I will usually identify it and help them to notice it sometime in the first session; and I will return to it, even if only for a moment or two, in each subsequent session. Having them notice the relief and ease that occurs when they do let go is an important motivator for them to take on the daily path of playing with the breath, bringing their attention there, and patiently inhibiting the inhibition so that something different and more enlivening can occur.

Another challenge that can emerge when the client is invited to stretch the out-breath and then rest into the pause is that the client may feel as if they can't get enough air. This can obviously be frightening and a deterrent to further exploration. What is usually happening when the client presents this issue is that, over time, the client's system has become accustomed to a pattern of over-breathing (over-breathing, defined here as breathing more than the body's current need for oxygen). Over-breathing is often accompanied by a tendency to breathe through the mouth with high shallow thoracic breaths. When this has become a habit, the body undergoes a series of physiological changes that cause the client to feel as if they do not have enough air, even when the breath begins to come closer to the body's real need for oxygen. This is called hyperventilation syndrome and must be treated gently and slowly.

If this is the case, it will take time for the body to reset; and we must work within the client's comfort zone by allowing the out-breath to release just a little bit longer than the habitual exhalation – long enough to begin to stimulate a change but not long enough to set off a fear response. Helping the client learn to allow the air in through the nose can also be helpful in this case, and we will discuss this more in the section on the in-breath. Stimulating the client's curiosity and desire to continue to engage this pattern over a longer period of time is also important. Something that may help to motivate this long-term commitment to playing with the breath is the fact that often patterns of over-breathing are accompanied by anxiety. Sometimes, with just a little shift in the breath, the client will be able to feel their anxiety levels drop.

Interventions for Working with the Pause

In the section above, we discussed the pause at the end of the out-breath and its importance to the entire cycle of the breath. To work with the client's pause, first and foremost, we need to help them to release enough of the out-breath that they can find the pause. This may be challenging for some of the reasons already mentioned and can require patience and persistence – two qualities that are richly rewarded if we can help the client to stay with it long enough to encounter the pause.

Once the client is able to release more of the out-breath, we begin to encourage them to rest into the pause. This encouragement happens when the Rolfer is attuned to the client's cycle of breath and able to give the client both verbal and touch cues, timed to the moment of the pause. These cues help them to feel the pause and allow it to stretch out – just a little longer – and then they can notice the sense of relaxation that appears as they surrender into it.

Helping the client to return again and again to the out-breath that softens and releases, getting them to notice how it feels, and identifying what they did differently is the road to help the breath to change.

Interventions with the pause are simple: they consist of helping the client to rest into and feel the space between out-breath and in-breath, to notice its salutary effects on their system.

When the client is able to be present with and settle into the pause, the next inhalation will come from the body wisdom of the brainstem. An in-breath, directed by the impulse emerging from the brainstem, leads to an exhalation that is released instead of pushed, which leads in turn to a pause, and the whole system can reset once again. Soon we find ourselves in a rhythm where the breath expresses itself naturally with pleasure and ease.

Interventions for Working with the In-breath

When thinking of the in-breath, it helps to consider the three different segments of the body that can receive the breath: the belly, the chest, and the upper airways of the nose and nasal passages.

Chest and Belly Breathing

We will discuss thoracic and abdominal breathing – two qualities of breath that are different and complementary, which contribute, each in its own way, to balanced breathing.

When we begin to inhale, the central tendon of the diaphragm, which is high inside the rib cage, moves downward. A look at an anatomy book will show that the diaphragm looks a little like a child's drawing of a sun with fibers that attach both into the central tendon and all around the periphery of the rib cage. Initially, as these fibers contract, the fixed point of the movement is the attachments around the bottom edge of the rib cage and the mobile point (the central tendon and the center of the diaphragm) moves downward.

As the central tendon descends, placing pressure on the abdominal organs, the belly and lower back swell, the sacrum counternutates, and the pelvic floor widens and drops. This is the moment of abdominal in-breath (see Figure 2). Because of the movement of the sacrum, it stimulates the parasympathetic nervous system and has a calming effect. This first phase of the inspiration represents about 25% of our respiratory capacity.

At a certain point, the central tendon of the diaphragm can no longer move downward for two reasons: (1) it bumps into the subdiaphragmatic viscera, and (2) it reaches the elastic endpoint of a

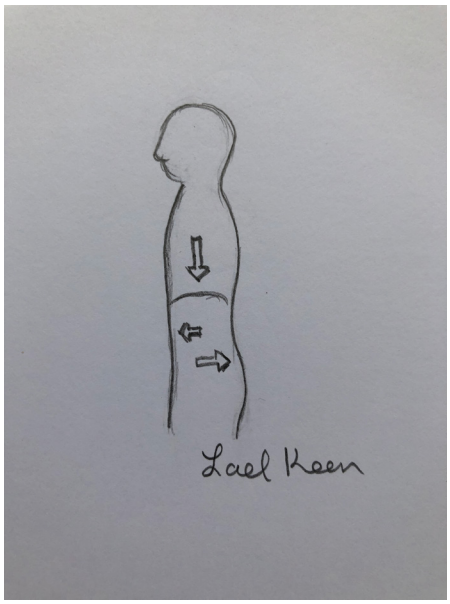

Figure 2: Abdominal in-breath.

chain of connective tissue that runs all the way from the fascial ring that attaches around the base of the foramen magnum to the diaphragm. This continuous fascial connection, which bears different names depending on its various attachments, runs from the foramen magnum down through the middle fascial layer of the cervical region; becomes the pericardial ligaments that bind the pericardium into the sternum and the front of the thoracic spine; and eventually becomes the fibrous base of the pericardium that attaches on the upper side of the central tendon of the diaphragm.

As the central tendon of the diaphragm moves downward in the first phase of the inhalation, this line of connective tissue stretches and eventually reaches capacity – about the same time that the diaphragm can no longer descend. At this moment, the fixed point/mobile point of diaphragmatic movement reverses. The central tendon stabilizes atop the pillar of the abdominal organs, and here the capacity for containment and stabilization offered by the transversus abdominus is essential! The perimeter of the rib cage begins to lift as the fibers of the diaphragm continue to shorten – only now with a different fixed point. It is during this second phase of the breath that the rib cage expands in all three dimensions; and the air flows upward into the thorax (see Figure 3).

Thoracic breath represents about 75% of our respiratory capacity and includes a slight oscillation of the autonomic nervous system towards sympathetic activation. The sympathetic chain runs down both sides of the thoracic spine; hence our intercostal spaces are home to many sympathetic receptors. Thus, the breath brings an energizing quality as it moves through the thorax.

Balanced Breathing

For balanced breathing, we need both the calming and less active abdominal breath as well as the stimulation and higher oxygen capacity of the chest breath. Working with the client's inhalation often means working to stimulate the area into which the breath flows less habitually.

Belly Breather

When the client is a 'belly breather', often their chest will be quiet and have an expiration preference in its posture/positioning. Because 75% of our respiratory capacity is thoracic, we know that this client is not receiving their full allotment of air, and thus, is not fully adapted for vigorous activity – neither physical nor mental.

There are two issues to address with the belly breather. The first one is for the belly breather who pushes their belly outward with each in-breath. This is a client whose sacrum does not counternutate as the breath comes downward, nor does the lumbar region drop back to the table. Instead of there being a widening all around the lumbo-sacral-abdominal perimeter, there will be a distension of the belly wall forward with each in-breath. This particular pattern of breathing breaks down core stability by overstretching the transversus abdominus and disorganizes the viscera that rely heavily on the tonic presence of the transversus to keep their places.

Often, as the belly pushes forward, there is simultaneously a downward pull through the fascial chain that goes from diaphragm to foramen magnum; and the person's head pulls downward towards the center of the diaphragm. For this type of client, we need to help them learn the art of 'sacral breathing', allowing the downward movement of the breath not only into the belly but also into the lumbar region. Then we help them to feel how the sacrum rocks into counternutation as the breath comes in. When the expansion of the abdominal breath comes into the whole lower region, not just the front, the client will then be able to profit from the moment of parasympathetic stimulation as well as prepare for the next phase of the in-breath, i.e., when it moves upward into the thorax.

Helping the client who pushes their belly forward with the in-breath may involve working with the rectus abdominus. Often with this profile of breathing, the client, besides having a prominent belly, will also have a breakdown in the smooth, wavelike coordination of the fibers of the rectus abdominus. Some of the packets will be overly fibrous; others will be atrophied and they will no longer work together. Working with touch to soften the fibrous packets and wake up the atrophied packets can be helpful. Working with the sacrum to help restore its rocking movement into counternutation (sacral base dropping posteriorly) as the breath flows downward is essential. Helping the client to again feel their weight dropping back into the table can be an important part of this.

The second issue to address with the belly breather is to help the air move up into the thorax, and this already brings us into the realm of chest breathing. When the air, as it moves downwards in the first phase of the in-breath, pushes into the abdomen and distends the abdomen forward, the transversus abdominus gets overwhelmed and stretched with a quality of stretching that becomes static and flaccid. It is then unable to offer its

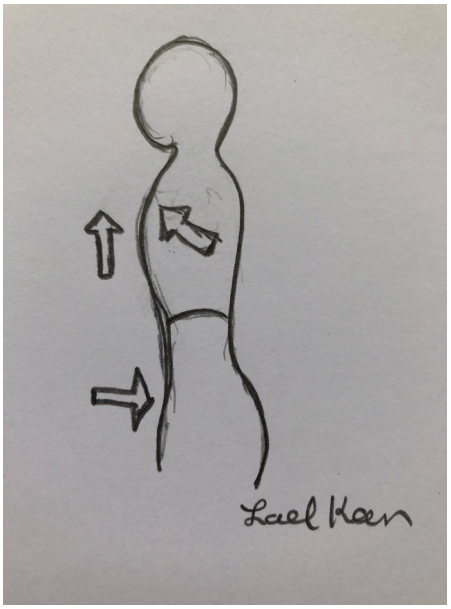

Figure 3: Thoracic in-breath.

essential help to the movement of the air upwards into the thorax.

By contrast, when the movement of the breath downwards widens the whole lumbar-sacral-abdominal area, the transversus abdominus is gently stretched all through its extension from the insertion along the lumbars to the insertion in front. This, in turn, sets off a stretch reflex that causes the transversus to gently contract (just enough to stabilize the abdominal area) so that the central tendon of the diaphragm encounters the necessary support from the abdominal viscera and the fixed point of the diaphragm can shift. This allows the ribs to lift, and the rib cage to lengthen vertically and to widen side to side and front to back as the air flows up into the thorax. At this moment, not only does the fixed point of the diaphragm shift; but also, as the transversus abdominus comes online, the sacrum nutates. This, in turn, sends a wave of extension all the way up the spine to the head.

Aiding the In-breath to Move Upward

When the breath does not move naturally up into the thorax, one of the most common reasons is that the client's space orientation is not fully online. The reader may feel how space orientation or lack thereof contributes to the capacity of the breath to move upwards by trying this simple exploration – best done in a seated position with the spine straight and the weight of the upper body balanced easily over the sit bones.

> Start by looking down at the ground around your feet. Breathe in and notice how far up into the rib cage your breath moves. If you continue to look down while breathing in, you will probably feel that only the bottom of your rib cage can fill.
>
> Now let your eyes find the level of the horizon and gaze slightly above the horizon. This time, as you breathe in, notice how far up in your rib cage your breath can move. If you continue to orient just above the horizon, you will probably notice that air can come in all the way to the upper ribs now without exerting any extra effort.

So many of our clients who present with an expiration preference rib cage – the 'caved-in' chest – have a very simple underlying problem. Their attention and orientation are primarily ground focused. They do not bring their awareness to the upper portion of their perceptive field or kinesphere. This is the kind of person mentioned above, who, when walking down the street, will not trip over irregularities in the sidewalk but will get their hat knocked off by low hanging branches. As in the exploration above, simply raising their eyes and their attention at the moment that the body prepares to breathe in will often be sufficient stimulus to get the air to move upward into the thorax.

For this intervention to be most effective, some education is necessary. While they are lying supine on the table (and then later while seated), the client's eyes can be used as an effective aid in directing their orientation. Just as the client begins to breathe out, we invite them to close their eyes and leave the eyes closed as the expiration completes and settles into the pause. The closed eyes facilitate orientation to ground – feeling the weight of the body resting into the table and dropping inside. Then, at the very end of the pause, just as the body begins to organize itself to breathe in, we invite the client to open their eyes and look very slightly upward (if their brow tenses or furrows, they have gone too far).

The gaze that most supports the upward movement of the breath is a wide gaze, more peripheral than focused, and is directed between 10˚-20˚ above the level of the client's horizon. The open eyes that look gently upward facilitate orientation to space and thoracic breathing. Then, as the wave of the in-breath gets close to peaking, we invite the client to close their eyes again in preparation for the out-breath. This simple exercise is something that the client can do on their own, seated or lying down, to help potentiate the cycle of their breath. It is also something that we, as Rolfers, can teach them to do as we work to facilitate the change we hope to bring about with our hands.

Another interesting fact about breathing that may help our work with the tissue is to know that the iliocostalis, the most lateral of the erector spinae in the thoracic region, are designed to begin each in-breath with a pulse of activity. This contraction is timed to stabilize the back of the rib cage, so that, as the breath begins to move upward into the thorax, the ribs may lift and rotate upwards in front. Without this stabilization from the iliocostalis, much of the opening upward of the rib cage would get lost into movement in the back. However, since the iliocostalis are also part of the erector spinae group and, thus, part of the muscles of posture, often they can get overinvolved in maintaining the erect posture of the spine in such a way that they lose their capacity for this pulsation of movement at the beginning of the in-breath. In this case, the iliocostalis will be like ropes that are holding all the time - without nuance or rhythm.

The Rolfer can help to restore this pulsating rhythm and, in so doing, also encourage the in-breath to move upward. The intervention is simple; but for it to work, timing is of the essence.

Intervention to Restore Rhythm

With the client lying supine on the table, the Rolfer slips their hands under the client's back and finds the iliocostalis that are on the same side of the client's body where the Rolfer is seated. In the pre-movement of the in-breath (which occurs at the very end of the pause), i.e., the moment that the body prepares to breathe in, the Rolfer lifts gently (in the direction of the ceiling) on the iliocostalis, simulating the pulse of contraction that would occur if these muscles had the ability to pulse. The Rolfer continues to stimulate the iliocostalis by almost pulling the breath into the thorax and taking the client's thorax anterior and then encouraging the fibers to differentiate throughout the inhalation. Near the peak of the in-breath (the moment when the body begins to prepare the out-breath), the Rolfer softens their hands and drops them back towards the table, creating a vacuum into which the client's back drops and settles for the duration of the out-breath and the pause. Then, in the pre-movement of the in-breath, the Rolfer stimulates the iliocostalis again. This intervention on the part of the Rolfer, along with the client directing their gaze to open the orientation that favors each phase in the element of the breath, can be a powerful help to the client in re-owning the movement of their breath.

Nose and Mouth Breathing

No conversation about breathing would be complete without mentioning the difference between nose and mouth breathing – and how this difference impacts our breathing, our physiology, and our structure.

To begin with, the reader may try a very simple exploration to feel some of the differences.

> Breathe in through the mouth. Notice how the air moves into your lungs. If

you are like most people, you will feel that the air goes directly to the top part of the lungs, very quickly creating a sensation of over-fullness.

Now breathe in through the nose. What you will probably notice is that when the breath comes in through the nose, it goes to the bottom of the lungs, which then fill from the bottom upward, creating a deeper and more comfortable breath.

There are many reasons to favor breathing through the nose. The circuitous pathways within the nasal passages warm and filter the air before it reaches our lungs. The fact that our lungs fill from the bottom upward makes sure that the calming properties of the first part of our inhalation – the phase of abdominal in-breath – do not get skipped. Breathing through the nose slows down the inhalation, thus nipping in the bud many patterns of over-breathing that can lead to anxiety and, interestingly enough, to the sensation of lack of air. Breathing through the nose is indicated for people who suffer from asthma and other breathing difficulties.

However, when we decide to breathe through our nose, very often what happens is that we begin to use our will to control the movement, instead of finding ways to remove the obstructions that prevent the movement from occurring naturally.

Breathing through the nose happens most naturally when we allow the passageways at the base of our nose to widen and open, giving space for our orientation to move upward, and allowing our sense of smell to function fully. If the reader thinks of sitting in a garden in the spring with all the smells of freshly turned earth and the sweet fragrance of different flowers in the air, and then imagines that they are simply allowing the scents from the farthest ends of the garden to come into their nose, they will most probably get a sense of what a natural breath in through the nose feels like. They will feel the internal spaces in their face widen – along the cheeks, behind the eyes, and up into the forehead – as the air flows into the maxillary, sphenoidal, and frontal sinuses, respectively.

In contrast, when breath is drawn in through the nose by an act of will, very often the nasal passageways narrow (a result of trying to suck the breath in through the nose). Frequently, this is accompanied by a pulling down of the chin that locks the floor of the mouth and hyper-straightens the cervical spine, thus cutting off the movement of the breath into the neck and head at the very same time that one is trying to get it to happen.

For the breath to be able to come in adequately through the nose, the head needs to be in a balanced position, i.e., where the weight and position of the occiput and chin balance each other like a seesaw that hovers in the horizontal position. The nose needs to be open and to be curious, and orientation is outward to the world. When this happens, the face relaxes, the eyes soften, and the breath comes in through the nose without effort.

Again, learning to allow – especially when there has been a long habit of 'efforting' and fear of lack of air – is not something that happens from one moment to the next. To make a lasting change in the habitual movement of breathing means making a commitment to acts of attention and curiosity again and again throughout the day for a significant period of time. At an even deeper level, it means developing a different kind of relationship with one's body: a relationship where one listens and pays attention, and where one is continuously willing to pause for an instant, to simply not do the habitual and to allow an easier more fluid movement to come through.

To change a deep automatic pattern of movement, the author recommends to her clients that for a minimum of ten times a day, they stop what they are doing for less than a minute – just long enough to feel themselves at the coordinative crossroads between the habitual and the new – and give themselves the time and space to choose something different. This intervention practiced over time will change even the deepest patterns and will lead the client to a more empowered relationship with their body, their movement, and their life.

Lael Katharine Keen *has been teaching Rolfing SI for the Dr. Ida Rolf Institute® since 1995. She teaches Rolfing SI at the beginning and advanced levels and is also a Rolf Movement Instructor. She is one of the founding members of the Brazilian Rolfing® Association. In addition to teaching Rolfing, she is also senior faculty of the Somatic Experiencing® Trauma Institute where she teaches Somatic Experiencing at the beginning, intermediate, and advanced levels.*

She has practiced Ki-Aikido since 1976 and taught it throughout North America and Brazil since 1980 holding a fifth-degree black-belt.

Lael is fascinated with movement and the process through which each of us becomes more truly ourselves by uncovering the movement which is our most intrinsic and authentic potential.

She continues to study and learn about what it is to be a human being and how we can heal at all levels, body, mind, soul, and spirit. She also holds certification as an Anthroposophic Art Therapist and recently completed a training in the Bates Method of Vision, which has helped her to deepen her understanding of how the way that we orient relates to structure, movement, perception, and health.

Breathing through the nose happens most naturally when we allow the passageways at the base of our nose to widen and open, giving space for our orientation to move upward, and allowing our sense of smell to function fully.

Three Breath-Centered Yoga Poses to Teach Your Clients

By Michael Black, Certified Rolfer™

Michael Black

ABSTRACT *In this article, Rolfer and yoga instructor Michael Black offers three yoga poses to teach clients to integrate their breath after their Rolfing® Structural Integration (SI) sessions. First is the discussion of direct and indirect language when teaching movement during a Rolfing session. Then, the author describes: (1) three-part breath, (2) thoracic extension and flexion, and (3) child's pose sidebends. There are many breathing movement exercises; the author highlights these three for their ease and effectiveness. The hope is that these breath-centered poses will help clients in their day-to-day life to be empowered so that they can improve and embody a full expansive breath.*

Why Breath?

The first time I took a yoga class I left literally buzzing with energy. After a childhood with frequent bouts of exercise-induced asthma, my lungs and rib cage were tight and locked down (along with the rest of my body). I hadn't taken a deep breath in years. I was quite active in my youth, but came to the realization that I always shied away from anything cardio intensive. Skateboarding? Hell yeah. Running track? No way. I was sixteen when I took that first class and was instantly hooked. That was fifteen years ago and I have never forgotten that feeling.

I have been teaching yoga for ten years now, and I still view breath as the central element to a proper yoga practice. Stretching is great, but flexibility will only gain you so much practical benefit. Rolfing SI, in some ways, is the same – opening the tissue surrounding the rib cage can be life-changing for people like my younger self that hadn't taken a deep breath in years. Teaching clients how to use that space, how to breathe into the newly opened areas, and how to maintain that openness is incredibly important. In this article I'll show you three simple poses to teach your clients that will help them do these things. Of course, these

are not the only poses that achieve these results, but I have found these three are the most simple and direct versions, and can easily be done in one's normal day-to-day life.

The idea of giving clients homework may be a turn-off to some. We have seen in physical therapy settings that non-adherence can be as high as 50%. However, there are several things that can improve these rates and ideas:

- Teach these poses as concepts, not rigid forms to follow.
    - Give your client flexibility to adapt the poses to themselves.
- Anchor the feeling of the pose in their body.
    - How good does it feel to be able to expand breath into the side of your rib cage?
    - What does it feel like after doing the pose?
    - How would you feel if you could breathe like that all the time?
- Start slow.

I often tell people the ideal amount of time to do these poses (e.g., three times a day, seven days a week) and then tell them a more realistic approach (e.g., do five big breaths once a day). I have seen significantly greater adherence to these types of homework assignments when you give people a bit of a false dichotomy – you can either do it a lot or do it a little – but definitely do it. Set up the expectation higher than you anticipate and then allow them to fall back to a level that feels good for them.

Language: Direct vs. Indirect Cueing

The final thing I'll talk about before getting to the poses themselves is language and cueing. There are two ways I cue yoga poses: direct and indirect. Much like with hands-on work, some people respond better when they hear things literally. Some respond better when they can use their imagination and visualization. Oftentimes it's a bit of both in the same person. To most Rolfers this will not be a new concept.

Direct cueing is basic and to-the-point: bend to the side, breathe into your middle ribs; try to get them to expand more; feel your rib cage moving. I often reference anatomical names and talk about the muscles directly, and the direct feeling associated with the movement. Do you feel that expansion? Can you get your serratus anterior to engage? Can you feel the lats lengthening?

Indirect cueing is broad and imaginative. I often call on visuals, ask them to imagine something that's rooted in their own experience. There are a few that come directly from the yoga world that I love to use:

- Light:

  Visualize a bright blue light at the center of your core. As you bend to the side, use your breath to draw that light from your core to the side of your rib cage. Feel that light expanding and energizing your rib cage, allowing it to move more freely.

- Water:

  As you breathe, imagine your torso like a large cup of water. Breathe in and allow it to fill the bottom of the rib cage, then the middle, then the top. Allow it to flow to the sides of your rib cage and the back of your rib cage, and then allow it to fill all the way to the top.

- Negative space:

  Can you feel the space around your rib cage? As you bend towards the side, allow your rib cage to expand into this space. Feel the sense of inhabiting that space, of existing in the space around you. Allow your breath to carry you into and out of that space.

The indirect method can be as broad as you like. A few other examples are calling on objects that may be familiar to the client (balloons, inflatable balls, etc.). I encourage you to engage in the type of language that would be correct for that person.

Poses

Now on to the poses themselves. The descriptions I use here are meant for clients, and thus are relatively simple and sometimes anatomically inaccurate, but serve to guide the feeling rather than exactness. For example, of course we don't really 'breathe into our core', but it sure feels like we do.

(1) Three-Part Breath

Purpose

I'm cheating a bit here because the first exercise isn't really a pose, but rather a pattern of breathing. The three-part breath is one of the first things you'll learn when starting yoga. It teaches students how to engage the full torso with each breath.

Contraindications

None

Pose Description – Direct Cueing

Sit with a tall, easy spine. Place one hand on your belly and the other hand on your rib cage or chest. Exhale completely. As you inhale, inflate the belly by drawing air all the way down into the core, feeling your belly push out into your hand. Exhale and allow the air to flow out of the core, feeling your hand move back. Inhale again and inflate the belly, then allow the air to move up and inflate the lower ribs. Feel the diaphragm area expanding and the sides of the ribs widening.

Exhale and allow the rib cage to deflate first, then pull the stomach in slightly to push the air out of the core. Inhale once again and inflate the belly, then the lower rib cage and diaphragm, and finally fill the chest and upper ribs. Feel the collarbones rising and the upper back expanding. Exhale and allow the chest to deflate first, then the middle ribs, and finally pull the core in slightly to push the air out of the core. Continue breathing in this same pattern – inhaling belly, ribs, chest; exhaling chest, ribs, belly.

Pose Description – Indirect Cueing

This pose is perfectly suited for watery language. Just like with a glass of water, as you pour water in it fills from the bottom

Visualize your torso as a tall glass, and your breath like water flowing in and out. Take a deep breath in to let the water pour in . . .

Exhale and allow the water to smoothly pour out…

up. Visualize your torso as a tall glass, and your breath like water flowing in and out. Take a deep breath in to let the water pour into the bottom third of your glass. As it pours in, allow your belly to expand to make room. Exhale and allow the water to flow back out. Inhale again and allow your glass to fill up to the middle rib cage. Allow the ribs and diaphragm area to expand to make room.

As you exhale, allow the water to first pour out of the ribs, then belly. Take another breath and fill up your glass completely – first your belly, then your ribs, and finally allow the chest to lift to fill all the way to the top. Allow your shoulders to relax – it's water, there is no need to hold it up. Exhale and allow the water to smoothly pour out opposite of how it poured in, first chest, then ribs, and finally empty the glass all the way from the belly. Take several more breaths, allowing the air to flow like water as it fills your torso from the bottom up, and empties from the top down.

When to Use Three-Part Breath

This is a wonderful exercise to teach towards the end of first session of the Ten Series after working to expand the rib cage and breath. It can be done lying down just as well as seated, though the watery language may lose some effect. I often teach it to clients while doing neck work, especially with slight traction on the neck to give them more of a feeling of lengthening through the upper ribs. If clients are well resourced through their legs, it can also be done during seated back work to really engage the expansion of breath into the back body.

(2) Thoracic Flexion and Extension

Purpose

The upper thoracic spine is one of the harder areas of the vertebral column to move. Likewise, the upper rib cage is one of the harder areas to expand the breath into properly. The idea of being a chest breather is common and often associated with being stressed, but I have never seen a yoga student or Rolfing SI client who was able to properly expand their upper rib cage that I would call a 'chest breather'. I believe a lot of that association comes from a relative restriction of the upper ribs, causing over-emphasis and overuse of the scalenes to breathe upwards, thus the appearance of a chest breather despite not truly having a full breath.

This pose helps with gaining movement in the upper ribs both anteriorly and posteriorly. A nice side effect is that it helps in learning how to properly recruit the posterior chain for neck support and better anterior-posterior neck posture.

Contraindications

Cervical disc or vertebral issues that would be contraindicated by neck flexion or extension.

Pose Description and Direct Cueing

(This pose has two parts – one for extension and one for flexion.)

You can do this exercise either standing, sitting upright, or kneeling in *seiza*. If standing, engage the core and the glutes (tuck the tailbone) to de-emphasize movement in the lumbar spine. Loosely interlace the fingers and bring your palms together so the thumbs are parallel and touching (see Figure 1). Then lift your arms behind your head and place the edge of the thumbs at the base of the skull. Pull your elbows together, lightly squeezing the sides of your head (see Figure 2).

Thoracic Extension: Begin to lift the chest and as you do so begin to press the head backwards into your palms. You should feel the posterior chain engage to help find extension in the upper thoracics. Take a long, deep breath and fill up the chest. It may feel restricted at first, but take several breaths and try to feel the upper ribs moving and opening over time.

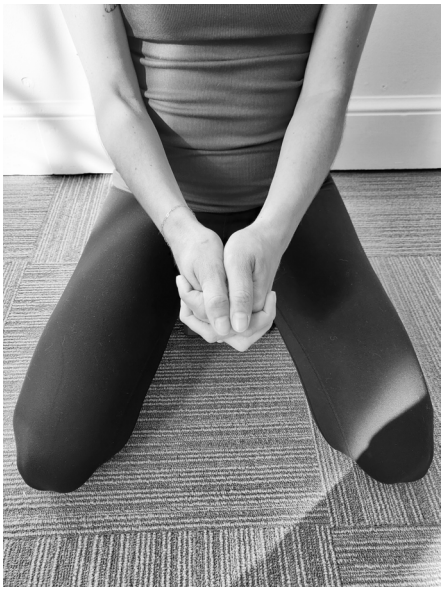

Figure 1: Hand setup for Thoracic Extension and Flexion.

Figure 2: Arm setup for Thoracic Extension and Flexion.

Figure 3: Thoracic Extension – emphasize lifting the ribs, not the backbend.

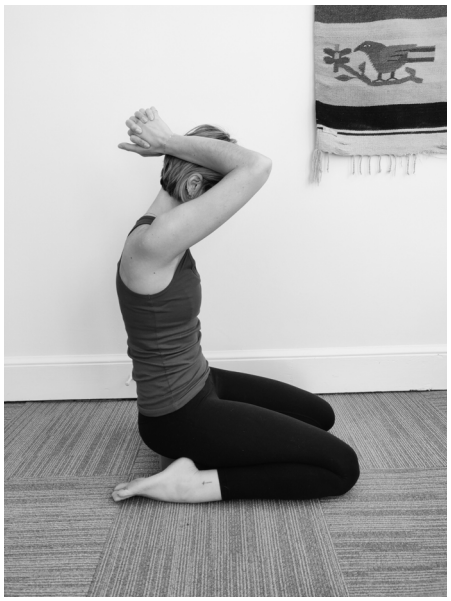

Figure 4: Thoracic Flexion – emphasize the expansion of the ribs, not the rounding of the spine or neck.

Make this position more about lifting the chest than doing a backbend, i.e., don't lose the breath in an attempt to backbend more (see Figure 3).

Thoracic Flexion: Return to a neutral spine with the same arm position, palms at the base of the skull. Allow your head to gently drop forward and the upper back to round. Allow the weight of the arms to drop forward to put a small amount of traction on the spine. Take several deep breaths into the upper back and shoulder blade area. Just like with the extension exercise, it may be hard to engage the movement in the upper posterior ribs. If that's the case, round less and emphasize breathing more. If you're having trouble feeling the breath in between the ribs, think heavy elbows – really allow the arms to hang and the shoulder blades to wrap around the sides of the rib cage (see Figure 4).

Pose Description – Indirect Cueing

This pose takes a lot of upfront direct cueing, so I would encourage taking some time to explain the anatomy of the rib cage and the connections of the ribs before engaging with indirect cueing. At that point, this pose lends itself well to airy language – lifting, floating, and filling, as a balloon.

For example: As you lift your chest, imagine a large balloon under your ribs. Breathe in and imagine the balloon filling from within, gently floating up towards the ceiling. Feel your rib cage becoming lighter with each breath as the air in the balloon rises up and allows the ribs to float.

When to Use Thoracic Extension and Flexion

This pose can be included at any point that you're working with rib cage expansion in the upper thoracics. Session one of the Ten Series is good, but it may be a bit too much if the client does not already have a movement practice. Sessions six and seven may be of the most benefit. After session six it may be very useful with engaging the space opened up from working the posterior chain. Session seven would be of great benefit in learning to lift the upper ribs without over-emphasizing the scalenes, as well as engaging the splenius cervicis and other posterior groups in aiding anterior-posterior head position.

(3) Child's Pose Sidebends

Purpose

This version of child's pose is my favorite way of engaging a full side-body lengthening and teaching clients how to breathe into their lateral rib cage.

Contraindications

Severe knee issues; severe shoulder impingement in overhead range of motion (ROM). However, this pose allows for a lot of modification, and full knee flexion or full overhead arm ROM is not necessary to gain the benefit of the breath expansion in the lateral rib cage.

Imagine the aura of your rib cage being 20% larger than your physical structure.

Pose Description – Direct Cueing

First, get into a wide-legged child's pose. This exercise may be done in a standard child's pose with legs together, but I've found a wider version is less stressful on the knees and allows for an easier sidebend. From an all-fours position, spread the knees to shoulder-width distance and drop the hips back towards the heels (see Figure 5). The hips do not need to make contact with the heels. If there is limited ROM in the knees, a supporting bolster can be of great benefit under the hips, between the hamstrings and calves, or under the torso.

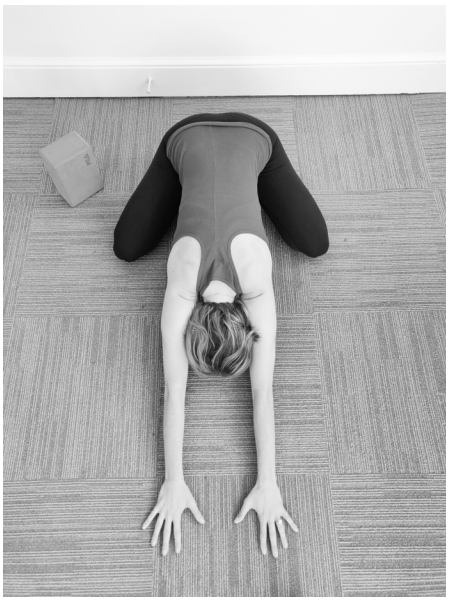

Figure 5: Wide-legged Child's Pose.

Sidebends: From the wide-legged child's pose, reach your arms far beyond your head and begin to walk your hands towards the right side. Bring the right hand to the outside of your right knee and extend the left arm way out towards the right. Spider-walk your fingers forward until you feel a nice stretch along the side of the body. Depending on your angle, you may feel a stretch in the lats, rib cage, or down into the side of the core and hips.

This can be a wonderful side-body stretch, but just as with the other poses, go for a moderate or light stretch to allow for more rib cage expansion with the breath. Begin to take long, deep breaths, directing the breath into the left side of the rib cage. Think about the three-part breath, breathing first into the left side of the core, then into the left side of the rib cage, and finally into the left armpit. Take four to five breaths and return to the center. Repeat on the other side (see Figures 6 and 7).

Pose Description – Indirect Cueing

This can be a wonderful time to think about breathing into the negative space around your rib cage. Once in child's pose, start to visualize the space around the sides of your rib cage. Imagine the aura of your rib cage being 20% larger

than your physical structure. Take a few deep breaths and imagine both sides of your rib cage expanding into that space, inhabiting the aura around you. Walk your hands towards your right side, stretching the left arm out beyond your head. Feel your fingers extending beyond your physical structure, extending your energy towards a point beyond yourself.

If you're on a yoga mat, imagine your arm being able to energetically reach all the way towards the front corner of the mat. If you're inside but not on a mat, think about being able to reach all the way to the front corner of the room. As you begin to do the three-part breath, into the side of the rib cage, visualize the negative space around the left side of your rib cage. Allow your breath to expand beyond your physical structure, into that aura that surrounds the left side of your body. Take four to five long, deep breaths. Repeat on the other side.

When to Use Child's Pose Sidebends

This is most helpful any time you're trying to extend the breath into the side of the rib cage. Session one of the Ten Series may be good if the side wall or armpit area of your client's rib cage is restricted. Session three is an obvious choice for lateral expansion, especially if the quadratus lumborum is restricted. I personally save this for the upper-body integration sessions to enhance the integration between the hips, rib cage, and shoulder girdle. If you ever do back work from child's pose, this can be a great alternative to help cue for breath while doing hands-on work along the spine.

Figure 6: Child's Pose Sidebend towards the right.

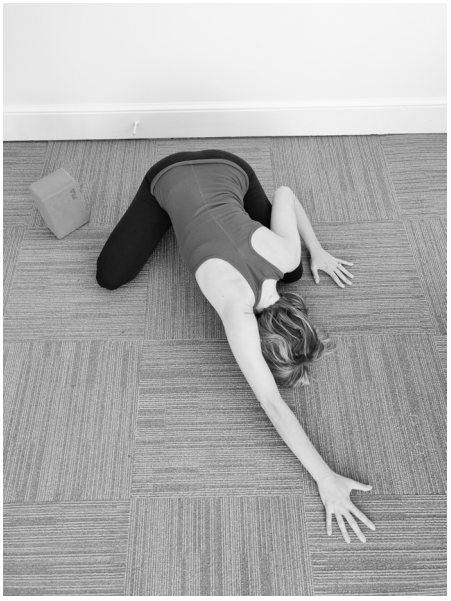

Figure 7: Child's Pose Sidebend towards the left.

Summary

There is a reason Dr. Rolf started the Ten Series with the breath. It is central to our being, our organization, and our structure. It is my hope that these poses will give you some ideas on how to help your clients integrate their own breath for day-to-day improvement between their sessions and beyond. I have had great results with these three poses, and, as I mentioned earlier, these are not the only ones. Work with your clients to see where their interest lies. Some people may love the thoracic flexion and extension because they can do it at their desk at work. Others may love the child's pose sidebend poses because of how relaxing they are. But whatever you do, remind them to breathe.

Michael Black is a Certified Rolfer and yoga teacher in Athens, Georgia. In addition to training at the Dr. Ida Rolf Institute®, he holds 200- and 500-hour yoga certifications, as well as several years of residential study at Satchidananda Ashram in Virginia and the Ashtanga Yoga Research Institute in Mysore, India.

Anxiety, Psychological Tools, and Breath

How Breath Can Assist Rolfers™ to Address Anxiety Symptoms Active During the COVID-19 Pandemic

By Heather L. Corwin, PhD, MFA, Certified Rolfer

Heather L. Corwin

ABSTRACT *This article names one of the symptoms our clients may be facing most prevalently these days: anxiety. With a focus on our adult and children clients, Dr. Corwin discusses tools for Rolfers to practice with themselves, their families, and their clients. The eight breath exercises described are tailored to assist in down-regulation of anxiety states. Corwin invites the reader to know that anxiety is a human state and we can be empowered to address anxiety with our breath.*

The pandemic is impacting our lives in ways we could never have anticipated. While everyone experiences anxiety, some of us have levels of anxiety that require medical or psychological intervention. When working with people as we do through Rolfing® Structural Integration (SI), being able to detect symptoms of anxiety will help support your client while working together to achieve a wellness goal. Some of our clients know when they have diagnosable anxiety. Some are seeking our help because they have not been able to sleep well due to pain that might coexist with anxiety. Others might just feel vaguely agitated and not be able to identify why. The *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5; American Psychiatric Association, 2013), describes generalized anxiety disorder (GAD) as "excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance), and may involve restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances . . . that cause impairment in social, occupational, or other important areas of functioning."

Whether their anxiety is acute or chronic, our clients can benefit from our ability to identify how that anxiety may be contributing to their overall experience of themselves at this time. What has been true during my time practicing Rolfing SI is the type of support we offer through our work usually feels good to receive regardless of a formal diagnosis of anxiety. This point is important right now because of the threat we are facing throughout our global community. In this article, we will explore some of the common affects and effects of anxiety, psychological tools to consider, and introduce some practical exercises you might adopt in your practice to facilitate emotional regulation and anxiety management.

> *Present fears are less than horrible imaginings*
>
> William Shakespeare

Common Elements of Anxiety

Having undoubtedly experienced anxiety, we can, ideally, understand and even magnify our own experiences to empathize with people who suffer more acute levels. For the purpose of hands-on therapy, physical manifestations of anxiety are listed below. Physical symptoms of general anxiety disorder (GAD) might include:

- Irritability
- Trouble sleeping
- Muscle tension and aches
- Trembling, feeling twitchy
- Nervous, easily startled
- Sweating
- Nausea
- Irritable bowel syndrome

Many of these symptoms involve nervous system arousal, which can have many causes. When working with clients, these symptoms are something we usually look for to ensure the pace of our sessions is tolerable and enjoyable. With clients who have GAD, a slower pace is ideal. I allow for time between strokes to check in with the client visually or verbally. Pausing gives the client time to accept the input and prevents the nervous system from overload. Some nervous system responses that indicate anxiety: sweating, short and shallow breaths, eyes darting around even when closed, and more. Attention and sensitivity are required to monitor arousal in your client as well as to avoid stimulating any anxious reaction. Environmental factors might include temperature in the room, surface/table comfort, lighting, sounds. A weighted blanket (with a washable cover) and aromatherapy may help to support some clients. Any one of these sensory assists may help soothe and bring an anxious person back into the moment. Anxiety often involves flights of thought, forecasting into the future or getting stuck in a past event. If our clients communicate with us verbally around such content, we can help interrupt the cascade of anxiety by redirecting them back into their bodies. Some clients may feel less anxious receiving work clothed.

At the root of anxiety is a perceived or real unresolvable conflict. If the person has no ability to solve the problem or conflict, anxiety is produced, and other behaviors will likely pop up to avoid or alleviate the stress and discomfort. As you might expect, anxiety shows up in the body as tension causing a variety of discomforts that can become habits and evolve to protective postural armor or possibly painful holding in the soft tissue. The psychologist and medical doctor Wilhelm Reich was the first to propose we have several bands of tension in the body that require release which are aligned with typical stressors. Today, many health-care providers understand the relationship between tension in the body and psychological well-being.

Powerlessness is a powerful agent of anxiety.

I have noticed in my mental health practice that anxiety is often inflamed when a person is put in a position where they have little power but are expected to make a change or impact in a situation. This is a ripe situation for anxiety to flourish. Most children understand this position because adults have the power. Think back to when you were a child when an adult reprimanded you for something you did not do. How did that feel? *Powerlessness is a powerful agent of anxiety*. The more a person is exposed to this type of interaction, the more likely that person will develop symptoms of generalized anxiety. This can also happen in the workplace with adults. When leadership is weak or does not support 'outside the box' approaches to solving problems, the person who follows her own path can become a source of ridicule without ever knowing why. This could most certainly cause anxiety. Having little control over your environment (which is so much the case for all of us at this time) is likely to produce anxiety. It is easier to normalize anxiety amidst shared experiences, such as what is happening now with the pandemic.

> *There are moments when all anxiety and stated toil are becalmed in the infinite leisure and repose of nature.*
> Henry David Thoreau

Let us take a moment to look at the brain and its role in anxiety. The area of our brain that is responsible for emergencies is the amygdala. This area of the brain is responsible for fear and joy. To borrow a metaphor from anxiety expert Bessel Van der Kolk, the amygdala is like a smoke detector. The smoke detector goes off when we have burnt toast and when the house is burning down, it does not discern the difference, it just tells the body that there is a threat. The amygdala gives the message, *Emergency*!

This is true even when we have a small worry; our stress response has grown to blow up what may actually be a small worry into a big, anxious moment. This is a fundamental operational process of how anxiety operates in the amygdala. What can help us manage the moment is to take a pause to identify our fear reaction. For example, there may be a moment when we are spinning in our minds and we have noticed our belly is starting to ache and we have begun to tremble (common sensations of anxiety). Let us introduce the tool of a 'fear thermometer' (Walker, 2017). If we have a fear thermometer that goes up to ten – ten being the highest or most fear – we may be at a nine (house is burning down). Now insert the fear thermometer for a check on reality. If the thermometer reading is a two or three – more like toast burning – that information can help regain emotional regulation.

Another example: your spouse or child expresses displeasure with your view on a subject. That conflict might activate your amygdala (which has no capacity for nuance) to warn: "Ten! House is burning down!" Insert fear thermometer: "I know that so-and-so is crabby today." Temperature reading is actually two. *Triggers for anxiety have very little to do with what is actually happening.* It's simple but not easy. Managing emotions requires awareness, practice, and patience. With the right skills, a person can learn to modulate the response of the amygdala to engage the neocortex, which is the logical/thinking part of your brain. When a person is able to get logic involved, this gives enough space to recognize the anxiety for what it is. This sounds like a simple process, but it is not. Our fears are hard-wired and so is our body's response to keep us safe. When our systems have become highly sensitized, managing the response to match the event requires time, awareness, patience, and sometimes professional help that goes beyond a Rolfer's scope. Nevertheless, just as we help our clients foster awareness in bodies and sensations, expanding awareness of how anxiety shows up in the body can be profoundly eye-opening

for our clients. Simply naming the fact that anxiety might be present gives the person an opportunity to recognize and even choose how to respond to their experience.

Clients who present with diagnosed conditions such as fibromyalgia or an autoimmune disorder may have been experiencing an exacerbation in their condition during this pandemic. Often, inflammation is involved, which makes tissues more tender and sensitive. We must adjust our input accordingly. It is entirely possible that some clients long-depended on Rolfing SI as a way to cope with anxiety prior to any *sheltering-in- place*. Then, when they most needed us, we were, as *non-essential workers*, unable to help them. Notably, this may have inspired anxiety within our own Rolfing SI community. Some worries may have included or continue to include worry over being unable to help others because we need to remain safely isolated, not being able to pay bills, and not being able to support our clients in ways we have for years.

Working with children around anxiety may involve a different repertoire of intervention. Anxiety does not present differently in children; they simply lack awareness to be able to express or identify many of the elements of what's happening. For example, acknowledging anxiety in daily life includes identifying when the reaction is out of proportion to the event. While an adult client may be able to make use of the (aforementioned) 'fear thermometer', a child may respond more to a visual and metaphorical representation of personal anxiety, such as a 'creature'.

We might help the child to identify this creature's characteristics: what does it look like? Is the creature prickly? Soft? Big? Small? What color or colors is it? Temperature? Does it have special powers? Does it breathe fire? Does it spit water? Can it be invisible? Can it fly? What is the creature's language? When the creature/ anxiety communicates, what does it sound like? A nickname for the creature can also be helpful. Creating a creature can help the child to separate herself from her anxiety: "Look, there's 'Calamity Creature' knocking on the door again!" We are helping her develop a capacity for observation, thus engaging the neocortex/logic part of brain, which can give her a sense of having some control rather than only feeling highjacked by anxiety. See Figure 1, this is an example created by a girl age 9; Cordelia is the bad fairy who represents anxiety. And see Figure 2, Clara, the good fairy who helps identify the appropriate fear response.

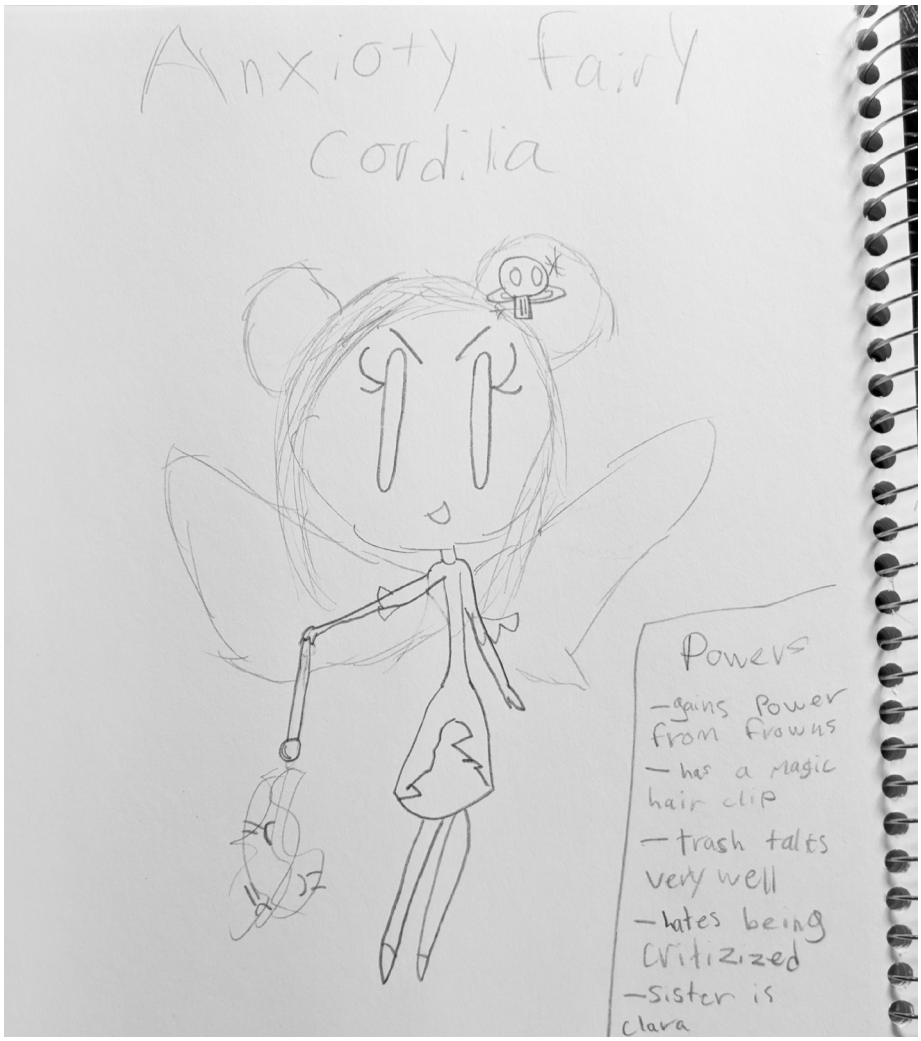

Figure 1: Child's representation of anxiety as a bad fairy.

To be clear, identifying the anxiety does not necessarily take it away. Our reaction to anxiety can change because we can learn to expect our anxious reaction, make it normalized, and then the amygdala will interrupt the anxiety loop (Wilson and Lyons, 2013). What we are doing is finding a way to manage our response to it.

> *Breath is the bridge which connects life to consciousness, which unites your body to your thoughts. Whenever your mind becomes scattered, use your breath as the means to take hold of your mind again.*
>
> Thich Nhat Hanh

For many clients who experience anxiety, *the hands-on element* of Rolfing SI alone can help calm them**.** (Exceptions to this are clients with histories of physical abuse or post-traumatic stress disorder; such clients require specific considerations which we will not explore in this article). During hands-on work, we may ask clients to focus on their experience of physical sensation. Similarly, when the focus is on the breath, the mind's redirection can help to calm them (Telles et al., 2019).

Nervous system down-regulating has an effect on the breath, which may become slower and deeper. You might ask your clients to notice if their breath has changed, as opposed to asking them to change their breath. The role of the breath in managing anxiety cannot be overstated. Taking slower, deeper breaths from the abdomen or diaphragm can lower heart rate can induce relaxation. [See Leyba (2020) for more information about deeper breaths.] Following are some directive breathing exercises I have developed

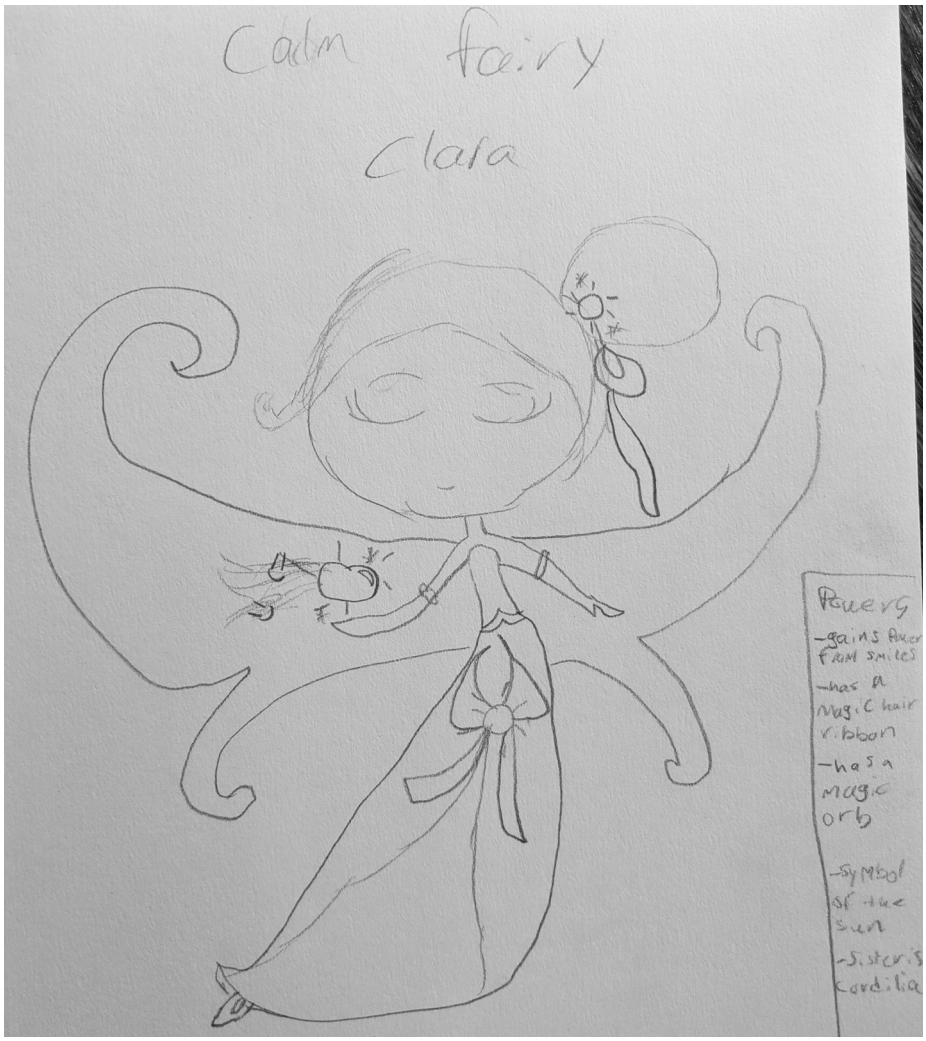

Figure 2: Child's representation of a good-fairy response to anxiety.

to incorporate into our sessions. Italics indicate directions to the client.

1) Slowing the Breath

- Notice how you feel and find an adjective for that feeling.

- Inhale on a count of seven, pause for two, then exhale on a count of seven, pause for two counts.

- Do this for three cycles.

- Rest.

- Inhale on a count of six, pause for two counts, exhale for a count of eight.

- Repeat for three cycles.

- Rest and notice if your breath feels like it is moving in more places in your body.

- Notice if you feel any different in your sensations than you did before you did this breath work.

Note: When making any adaptations to the breath, the nervous system can become aroused rather than calm. If this happens, say to your client: "If you begin to feel agitated, take a break. Sometimes the body is not used to getting so much oxygen. This might make you a little lightheaded or dizzy.."

To help your clients build up their capacity, you can slowly introduce these ideas at the beginning of your session and at the end.

2) The 'K' Breath

- When you are ready for your next inhalation, make a 'K' sound (the same sound as the end of the word 'duck') before you fill your lungs, pause when full, then 'K' sound before you exhale.

- Play with the duration of the breath and where you are filling your thorax. For example, I may focus on my low back ribs to open as I inhale, pause, and then think of that area to empty on the 'K'.

- I may suck in as much air as I can in four seconds, pause and then 'K' out nine seconds.

- The application of this exercise can build breath capacity, which brings more oxygen into the body while it calms/ down-regulates the nervous system.

Invite your clients to consider:

- The great thing about breath work is you can play with it and at any point, you can let it go if you feel like you are squeezing your ribs or breath.

- What "squeezing your ribs" means is you have run out of breath and you are then forced to push air out.

We want to avoid force. The 'K' will help with the ease of breath.

3) The 'Raspberry' Breath

- This is one kids do all the time to make a fun sound, or to imitate a horse's chuff.

- Gently press your lips together and send a steady stream of air through, just enough to be able to vibrate the lips.

This action does not allow a person to go at any rate other than steady, or the lips stop vibrating.

- You can play with how much you purse the lips.

More pursing elongates the breath and might heighten the pitch of the sound (less like a motorboat and more like a blender sound).

- Your lips will feel tingly after this, which is normal.

4) Bubbles

- Let's blow some bubbles! This will definitely remind you to breathe.

Keep a supply of bubbles in your office to give as a gift to practice between sessions. Plus, bubbles are beautiful to look at floating in the world.

5) The 'Huh' Breath

The Huh is a similar sound to a sigh and usually is used with a minimum of three *huh's* on one exhalation.

- Breathe in normally and offer as many huh's on the exhale as you are naturally able to do.

- This may be three times or more.

- Keep in mind, the goal is not laughing, it is to relieve tension in the breathing areas, the throat, and facilitate ease with the sound.

- Try this lying down, seated, and standing to see if one of the ways gives you more access to your breath.

6) Counting Your Breaths in a Minute

- Simply to notice how many breaths you take in a minute.

- Don't try to achieve a certain number.

- Just count.

Since there are cell phones everywhere with a stopwatch app, most people have the ability to do this easily. If they do this a few times a day, they might notice patterns. For instance, during transitions from one part of the day into another, or in tense situations. This type of engagement also helps manage anxiety immediately as long as the focus remains on counting rather than the thought that is causing the anxiety.

7) Alternate-Nostril Breathing

- Breathing only through your nose, cover your right nostril with your thumb on a count of four, pause and uncover right while using your index finger to cover your left nostril and exhale for six counts.

- Repeat four times.

- Rest and breath normally.

- Reverse and use left hand to do the same (left thumb to left nostril, etc.).

- Gently blow your nose as needed.

- Notice what you notice.

In a study looking at how yogic alternate-nostril breathing impacts anxiety, the conclusion found "breath awareness and sitting quietly with eyes closed, also practiced for eighteen minutes each, reduce(s) state anxiety" (Telles et al., '2019, p. 121).

8) Balloons and Straws

If the previous exercises sound like they might be on the edge of where some clients might be willing to go, you can use a good old-fashioned balloon to help remind a person how to access lung capacity. A warmup to the balloon can be using a straw to blow a piece of cotton across a table.

The essence of great breath work is often engaging, simple, and clear.

> *Feelings come and go like clouds in a windy sky. Conscious breathing is my anchor.*
>
> Thich Nhat Hanh

There is no limit to the complementary therapy we can incorporate in our work to help our clients address anxiety. A client can be taught to practice breathing using any one of the exercises above as a mindful meditation. We can suggest at-home practices to empower and deepen the results of our work. Discover what is appropriate for each client. 'Thinkers' might prefer work that is more intricate and detailed; 'feelers' might prefer more sensory-led practices. Since anxiety exists in everyone, stress-management tools that calm the body are valuable and useful with all people.

To sum up, we all have some levels of worry that are more heightened when we are under threat. If you, your loved ones, and your clients have been feeling more overwhelmed these days, that is perfectly normal and to be expected. We are living in unprecedented and uncertain times, involving possible economic insecurity and personal health threats.

As Rolfers, our ability to work may be restricted, and may come and go with the pandemic curves. Conflicting information only adds to the uncertainty. Living with our families around the clock can breed its own levels of frustrations and conflict. If you have young children, you face the additional challenge of at-home schooling. Online technology may be difficult to maneuver. Our lives do not look like they did, which may involve grief. No matter what has fueled your or clients' anxiety, there is comfort in identifying and using tools to manage the feelings, arousal of the nervous system, and runaway thoughts.

I find the words of Paolo Coelho helpful: "Anxiety was born in the very same moment as mankind. And since we will never be able to master it, we will have to learn to live with it — just as we have learned to live with storms."

Heather L. Corwin holds a PhD in clinical psychology with a somatic concentration from The Chicago School of Professional Psychology and a MFA in acting from Florida State University/Asolo Conservatory. Currently, Heather practices as a clinical fellow at Blackbird Behavioral Health and she runs her Rolfing studio, both located in Oak Park, Illinois. As an actor for over twenty years and theatre arts professor at places like Roosevelt University, Pasadena City College, and Northern Illinois University, Heather's research and work examines behavior through the lens of psychology, allowing the flaws of being human to unite us through creative expression. Heather is a Certified Rolfer, a belly laugher, a talk therapist, married to the love of her life, mom to an energetic nine-year-old, and fan of historical romance. To read more publications and learn more about her, please visit BodybyHeather.com or CorwinCounseling.com.

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Breathy Musings

A Rolfer's Experience of Breath

By Eric Maklan, PhD, Certified Rolfer™

Eric Maklan

ABSTRACT *The author's Breathy Musings evoke the many layers of breath in our work and in our bodies. Read it and be inspired.*

It is said that sustained attention is a key that unlocks any door in the universe; that no obstacle can stand against an unyielding focus. But towards what do we focus? It should be a process that is continuously on, ever-present, and always available. The breath is one such object. Everlasting from birth to death. Shaping growth of the physical body. Energizing each movement, new in each moment, and ever-changing during this embodied lifetime.

Practitioners of Rolfing® Structural Integration (SI) have a fondness for the breath. In my practice, I regard fluent breath as among the highest goals. Guiding the client, we free the breath session after session. We direct awareness towards the inhalation and exhalation, noting its rhythm, duration, and natural effortless pauses. If there is a hallmark of successful integration, let it be in the breath.

How do we as practitioners guide clients into the resource and possibilities of breath? How do we use breath to unlock the body?

Too much has been written about breath. There are many techniques in this arena: vipassana, pranayama, mantra, vocalization therapy, Wim Hof method, and so on. Unlimited varieties with a single goal. At least for some time today, may you hold your attention on this one phenomenon.

For this brief time, put aside your work, put aside your play, put aside your identity and be in the breath. What do you feel? What is there beyond the sensation in your nostrils? What is the foundation for this cycle of inhalation and exhalation?

This once happened: a client came to me; "I don't know how to breathe," she announced.

"But here you are, sitting in front of me. This morning you woke up. You brushed your teeth. You ate and drove here. You are alive. I can see that you know how to breathe."

We spoke about her experience of breathing. Primarily she described being disconnected from her own breath, a foreignness in her core. When she directed her attention on the breath, she experienced discomfort. Not physical discomfort per se. She was at odds with her breathing. "Like, a car running in the wrong gear."

I suspect we have all received this client. I suspect further that we have all been this client. As a bodyworker I like to do fancy things with tissue. I want to blame it on forward head posture, a tight pec minor, constricted brachial plexi. Maybe her liver rides a bit too high and that gall bladder should certainly be drained. I have worked this way before, many times. It is okay. But working with the breath is a deeper experience of embodiment. We should treat it with more sophistication than when working a spastic hamstring.

To generate resilience in the body it is paramount to work with the breath. As a Rolfer I want my clients to touch a new dimension of their being – a dimension that can stay present with the discomfort – and when the time is right, to expand into new possibility. Breath is a process of change. Physical and mental discomfort is also a process of change, though we are often less-willing to accept this. The discomfort encountered is inherent to the system. Ida Rolf spoke of getting the discomfort out. It was already there. Our work is to bring it into awareness. When attention is focused on the inhalation and exhalation it is natural to be drawn into the storytelling mind. We feel the constriction and the movement is away. But we must stay present until the possibility of entry arises.

Before undertaking a process of organization, it is best to appreciate the mess. Imagine this car in front of you, running in the wrong gear. For years the car has run this way. It strains and grows louder. The body is like this too. As the system moves towards disorder we detach from the experience. When we direct our attention back, we feel stuck in the wrong gear.

Today is your First-Hour session. We have our marching order, "Free the breath!" But do step back to appreciate the disorder. Our hands contact the body at first in the most superficial of ways. We are just containing the system. Breathe here, just be here. The breath comes in and out. It is like we want to be a passenger in that car. The engine hums, then gets louder, but we are in neutral. "Let the motor roar," I say. Then it goes quiet again. So, what happened? You took your foot off the gas, that is all.

Rolf said, "Go around the problem; get the system sufficiently resilient so that it is able to change, and it will change. It doesn't have to be forced. It's is that forcing that you have to avoid at all 'costs'" (Rolf, 1978, p. 83).

When we hold the attention single pointedly on one object we discover everything that is not that object. Our client experiences a 'click'. Even without the mind's understanding, a foundation is under construction for future change. Now we can pull out the fancy tissue work. We move deeper into layers of tissue, noting the stuck spots where breath has little access. What does it feel like? It feels left out. Movement goes around instead of through. Hold the tissue. Hold the awareness. Whose awareness? Client and practitioner both must stay present in the tissue. I find it helpful to put my breath into the same pattern. Breathing in unison is good. Breathing into that same layer of myself is better. Maybe it is mirror neurons? I have given up on attempting explanations. I just hold my attention and continuously direct the clients into theirs.

What is the feeling of breath in tissue? It is a feeling of change. It is something that practitioner and client both feel. We often have different words for it. "Ouch," may occur. It is like stubbing your toe in the dark. You were walking just fine until something unexpected happened. You hit up against an object that refuses to accommodate your movements. There is a sudden experience of otherness, of confrontation. This is me, and that is that. But this otherness is also you, separated and foreign. A fragment of yourself that confronts you in the habit of alienation.

Breath conjures up many analogies. It is ripe terrain. Waves are crashing onto the beach. The waves are obviously dynamic. But if we watch the beach we see that sand is also moving. The body is like this too. That stuck spot is not inert. There is life there too. Hold the attention. Remember the key. Feel the little in and out, a pulsation of possibility. My hands surround the scapula and clavicle. My palms are in fascia. My thumb rests on the 'stuck' biceps tendon. I find the body often assumes a global reorganization before tissue changes. It is like the system gains momentum. The shoulder girdle swings up with the inhalation like a cresting roller coaster. Every exhalation is a possibility. And this one brings a softness to that biceps tendon. And now that tendon too can participate in the coming and going.

The truth is that a single perfect breath can accomplish what otherwise takes an entire Ten Series. Focus your attention: you will discover that breath takes on a different pattern with each movement of the body. Each posture has a unique rhythm. Like water flowing along a river bed, its speed, turbulence, and depth changes with each bend. There is a possibility for perfect correspondence. Right now your breath is not complete. You are missing a spot here and over there. This is like bubbles trapped in the waterway. The water goes around instead of through. In my experience this sensation creates the feeling of being out of gear. There is unnecessary turbulence in the system.

This happened to me. As a boy I broke my arm jumping from a tree. It was a hairline fracture that would have healed without event except for an infection that took hold. A year later after rounds of intravenous antibiotics and two surgeries I was declared healthy. But growth of my forearm was stopped cold. The epiphyseal plates were destroyed. Moreover, the ulna and radius developed out of sync. To this

The truth is that a single perfect breath can accomplish what otherwise takes an entire Ten Series.

Ida Rolf said, "Put it where it belongs and ask for movement." We may equally say, "Find where it wants to be and wait for breath."

day I have my eleven-year-old radius and twelve-year-old ulna. Many years later I was living in Santa Cruz, California. Every day I rode my bicycle to campus. I carried an over-the-shoulder messenger bag with my laptop and books – maybe ten pounds in total and always on my left shoulder. Every night I climbed at the local gym. I did not think much about the body. I thought even less about my breath. Both were reliable enough to be an afterthought.

I remember straining to catch a hold on the rock face. Afterwards, looking up to belay my partner was agonizing. The next day I could hardly move. I laughed because of the intensity of pain. Laughing also hurt. You know the rest of the story. I went to the doctor. I took the pain pills and muscle relaxers. I sat in my chair for days. It got better. Then I rode my bike or climbed and the cycle repeated. Some small saint intervened. I do not remember who said it but I will never forget the words, "Hey, there is a Rolfer in town, he is good at fixing things." (Side note: Rolfers don't fix things, we integrate. Whatever you call it, sometimes 'fix-it work' is exactly what we do. It is okay.)

Session scheduled and I am on the table. My Rolfer, as he shall be called, is delightfully heavy handed. Just on the edge of tolerability. In hindsight I can see the session was a thorough First Hour. Free the breath! Pec-minor, subscapularis, serratus anterior. My short left arm was all twisted up. My breath was sequestered into whatever spot I could fit it without pain. My Rolfer's hand was fully under my scapula, a space that likely never existed and was certainly not experienced. The roller coaster crested and something changed. Something big changed.

There was an undeniable shift in my discomfort. Like a deep-set thorn was removed, I could breathe again. I felt at home in my body. I could keep my attention on the breath. Not only that but it was wonderful to be in the breath. This little story has all been in service of the next point. I asked him, "Could I have done that on my own?" At the time, his response made no sense. He said, "Sure, you would just have to find it."

My intuition was that 'finding it' meant being able to put my finger on the right spot. It took me years to discover his meaning. I went through the Ten Series, twice. I began a yoga practice. I began to extend with inhalation and flex with exhalation. I held my attention on my breath in every movement.

Like wringing out a cloth I chased the breath in and out of every forgotten hiding spot. I came to see that every sensation had a counterpart in the breath. As every ripple in flowing water has a counterpart in the terrain over which it flows. In time I learned that holding attention single pointedly on the breath allowed me to find space, capacity, and resource within myself. Physically touching the restriction was helpful but unnecessary. As when walking in the dark a flashlight will illuminate the rock in your path, but it is awareness that lets you step over it.

There is no set-in-stone technique for keeping awareness on the breath. It would be good if every day you spent some time watching the breath. It would be better if you spent every session with the breath. Right now, just check and see: "Am I breathing? How about my client?" You are on the right track. You will both be distracted by the engine sounds and lurching gears. Rolf said, "Put it where it belongs and ask for movement." We may equally say, "Find where it wants to be and wait for breath." There will be little 'clicks' along the way. Seek these *aha* moments and allow a deeper embodiment to root.

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Assessing for Sleep-Disordered Breathing

By Jeffrey Burch, Certified Advanced Rolfer™

Jeffrey Burch

ABSTRACT *The author provides a comprehensive view of sleep-disordered breathing (SDB), both sleep apnea and other syndromes, that may be factors behind our clients' musculoskeletal issues. He gives specific attention to when a practitioner may suggest that a client should be assessed for SDB.*

Introduction

This article will describe the several forms of sleep apnea and related conditions, how awareness of these conditions relates to structural integration (SI) practice, and how to recognize the sometimes-subtle signs that a client may have these conditions. In addition to how and why assessing for sleep-disordered breathing (SDB) is important in SI practice, I will detail:

- The four types of SDB
- Twenty signs and symptoms of SDB
- Three levels of medical testing for SDB
- Seven types of treatment for SDB

Here is why this understanding is important to SI practice. Clients come to us with a range of goals including athletic performance enhancement, recovery from injury or surgery, or personal growth. A very common presenting goal is reduction of chronic pain. When working with a client toward any goal, we like to see progress, and we usually do. We also like to see people continue to move forward toward their goals. If situations of reduced mobility, undesirable alignment, pain, or other problems repeatedly return, we investigate what is leading to the backsliding.

One line of questioning is, "What did I as a practitioner miss?" or, "What did I work on that was a compensation, leaving an underlying situation in place so that the

body re-established the compensation?" Another line of questioning is, "What are the stressors in the client's life that the body continues to respond to in this way?" There are many such possibilities having to do with many physical and emotional facets of life. To name a few:

- Occupational activity
- Recreational activity or lack of it
- Air quality
- Sitting
- Shoe choice
- Belief systems

One important factor is *quality of sleep*. Everything has a use and maintenance cycle. Printers need new toner cartridges, other parts, and cleaning on a regular basis. Automobiles have regularly scheduled maintenance. The maintenance schedule for humans is intensive. Each day we are on duty for about sixteen hours, followed by eight hours of sleep maintenance every night. One missed night of sleep leaves us feeling pretty bad. A week in a row of poor sleep leaves us physically, mentally, and emotionally ragged. Factors disturbing sleep can be large or small. I routinely work with people on what is called 'sleep hygiene' and its supporting factors:

- Quiet
- Dark
- Comfortable temperature
- Exercise
- Regular sleep hours
- Mattress quality
- Hydration management

An important factor of sleep is breath at night. There are distinct patterns of not breathing enough at night. The collective term for these conditions is sleep-disordered breathing. *An estimated 20% of the general population does not breathe enough at night. The incidence of SDB among people with chronic pain is much higher.* With all forms of SDB there are two physiologic problems: (1) not enough oxygen on an intermittent but frequent basis; and (2) frequent partial waking, so sleep is interrupted often, with a particular poverty of the deepest, most restorative sleep.

There are four forms of SDB, all of which I will lay out for you. If a person has SDB, his/her body is being beaten up every night. What should be the maintenance and restoration cycle of sleep literally becomes a damage cycle. This will affect some parts of the body more than others. Some features of this pattern of destruction are common, and some features can be very individual.

The internal organs in general and the brain in particular are quite vulnerable to low oxygen levels. Muscles and ligaments are less quickly damaged by low oxygen levels. When the brainstem registers low oxygen levels, an early response is to constrict arteries to the musculature to conserve the available oxygen for the brain and other organs. This arterial contracture usually starts at the periphery and, as the SDB event continues, progresses toward the core of the body.

The level of oxygen in the blood is measured as a percentage of maximum possible oxygen concentration where 100% is full oxygenation. The blood oxygen level is measurable by looking at the color of the blood: oxygenated blood is red, and as the oxygen level in the blood goes down, the color shifts toward blue. The oxygen concentration in blood is very well inferred by the color of the blood and this color measurement can be done with a simple device clipped on a finger called an oximeter.

Ideal blood oxygen levels are 96%-100%. Levels of 91%-95% are viewed with concern. A level of 90% is considered critically low. In a medical setting, if blood oxygen levels are persistently at 90% or lower, oxygen will be administered. During SDB episodes, levels will descend much lower than this, easily into the 80s in terms of blood oxygen percent, and may go as low as the 60s. The consequence of frequent low oxygen levels for body tissues is serious damage. Some tissues are more quickly damaged by low oxygen levels than others. Muscles and ligaments are more tolerant than some tissues, but prolonged and/or repeated low oxygen levels still damage them. The nervous systems, both peripheral and central, is most easily damaged, and nervous system damage can be serious and permanent.

At the end of each SDB event the person wakes up, either fully or partially. This is one of the ways that insomnia happens. Often this does not reach a level of memorable consciousness, but it takes people out of deeper sleep up into the lightest levels of sleep, or minimal wakefulness. This severely limits the amount of deep, restorative sleep a person can get. The combination of frequently repeated deoxygenation events and partial waking events is quite destructive.

Twin benefits of screening for SDB conditions and making a referral to sleep clinics for further evaluation are that: (1) we will see a lot less recurrence of the problems we strive to set right in our practices, and (2) the client's health will be considerably improved on a long-term basis.

Four Forms of SDB

Below I will discuss four forms of SDB. The first two are forms of sleep apnea. The two additional syndromes are not quite sleep apnea, but share the features of inadequate oxygenation during sleep and frequent waking. It is common for a person to have both types of sleep apnea, as will be discussed. In addition, a person can have any combination of any two, three, or all four of the SDB syndromes.

Obstructive Sleep Apnea

Obstructive sleep apnea (OSA) is the most common kind of SDB. In OSA there is a mechanical closure of the airway in the throat that may last a variable amount of time. The medical criterion is that the throat closure must last at least ten seconds to qualify as an apneic event. This makes sense: holding one's breath for ten seconds is not usually harmful. The longest recorded OSA event is almost four minutes long. Not breathing for thirty seconds to a few minutes is long enough to drive blood oxygen to

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damagingly low levels. Obstructive apneic events may occur several times per hour. Medically, three or more events per hour is considered enough to warrant treatment. Insurance companies will often begin to pay for treatment if there are five or more events per hour. Five events per hour means the person is being de-oxygenated, and then partially woken up an average of once every twelve minutes. Consider how a night of that would feel, or how living with every night so disturbed would feel. Severe apnea is considered to be thirty or more events per hour, in other words every two minutes or less. Severe sleep apnea feels terrible and the damage from it soon leads to other serious health conditions.

There are several variations of how the mechanical closure of the throat can happen. The closure is always in the throat between the beginning of the oropharynx at the back of the mouth and the beginning of the trachea, where the cricoid cartilage marks the division between the trachea and the esophagus. The airway closure of OSA does not involve the nose. Nasal restrictions are important but are not in themselves part of OSA.

Closure can involve:

- A physically small airway
- Damage from prior sore throats or from physical injury to the throat
- Weak throat musculature
- Certain specific fat distribution patterns

OSA is best described as a syndrome. Remember the distinction between a syndrome and a condition: in a medical condition there is a single situation with a particular cause (the disease malaria is an example); syndromes are presentations of symptoms that may have any of several different conditions creating the symptom picture (dementia is an example of a syndrome).

While OSA always involves closure of the airway in the throat, stopping breath intermittently during sleep, the exact mechanics of this stoppage are diverse. There is a characteristic breath pattern with OSA: breath stops; then after tens to hundreds of seconds breath restarts with a sharp inhale gasp; breath is then briefly faster than usual. While the sharp inhale gasp is the characteristic sign, sometimes it is subtle or even inaudible.

Central Sleep Apnea

Central sleep apnea (CSA) is the second most common type of sleep apnea. 'Central' here refers to the central nervous system. In CSA, the brainstem and pons do not send adequate signals to the person's respiratory musculature to initiate breath. Central apneic events again can last from ten seconds to minutes and may be repeated several or many times per hour. While CSA does not usually involve closure of the throat, there are two things to know about this:

1. There is an uncommon variant of CSA where the problem is not a lack of instruction from the brain to the muscles of respiration, but rather a lack of contractile instruction to certain small muscles of the mouth and throat. This allows the throat to collapse, so the airflow is mechanically stopped as in OSA, but it is CNS-driven, rather than a local problem in the throat.

2. It is possible for a person to have both OSA and CSA. This is fairly common. One way this often plays out is if a person has OSA first, then over time with repeated deoxygenation events and sleep deprivation the brain is damaged, including brainstem damage initiating CSA.

The breath pattern with CSA is simply stopping for ten or more seconds, then starting again. The sharp inhale on restart, characteristic of OSA, is not heard. The restart will be softer and may be more gradual.

The brainstem problem can have any of several origins. *The single most common source of CSA* is central nervous system depressant medication or substances, such as opioids, benzodiazepines (Valium, Xanax, etc.), barbiturates (phenobarbital etc.), and alcohol. Other causes of CSA include stroke, traumatic brain injury, tumor, brain surgery, or history of other kinds of SDB which incrementally damage the brain.

Upper Airway Resistance Syndrome

Upper airway resistance Syndrome (UARS) is a partial closure of the airway similar to OSA, but not a complete closure. The airway in the throat may be closed 80%-90%, so that airflow is severely restricted. The breath sound is frequently raspy. The abrupt restarts of OSA are not heard, although a person may move in and out of having a raspy breath. Blood oxygen level with UARS may not go as low as with OSA or CSA but can remain low for longer periods of time. One minute of oxygen level at 80% is harmful. Ten minutes of 87% oxygenation may do as much damage.

If a person has more than one kind of SDB, these can interact synergistically to create more damage. For example, if a person has both UARS and CSA, many minutes of UARS-induced low oxygen levels may be followed by a CSA episode where the already low oxygen level falls to extremely low levels. Alternatively, a CSA episode with very low oxygen levels may be followed by a UARS episode giving the deoxygenation a long, if lesser, tail.

Obesity Hypoventilation Syndrome

Some, but not all, patterns of obesity can limit breathing at night. Obesity hypoventilation syndrome (OHS) is an insufficiency of breath not a stoppage of

breath. As it is a syndrome, there is more than one picture of this type of reduced breathing. One picture is enough fat *inside* the abdominal cavity to prevent the descent of the respiratory diaphragm or to at least seriously limit it. It is important to distinguish the anatomical picture of this. Fat on the outside of the abdominal wall does not do this. The picture is of a person with a bulging belly which, when palpated, has not so much fat outside the abdominal wall, but the muscular abdominal wall itself is bulged forward by the great amount of fat inside the abdomen in the greater omentum and in the mesenteries of the intestines. The other fat distribution possibility for OHS is a lot of fat on the chest wall so that the muscular effort required to elevate the ribs is greatly increased.

A person can have one, the other, or both of these obesity pictures. Either way, the person is not able to get a full enough breath. This may reduce oxygenation somewhat while awake, but usually while awake one is able to work through the resistance of the extra fat enough to stay adequately oxygenated. But, during sleep, without that conscious effort, oxygen falls to harmful levels. As with UARS, the blood-oxygen levels during an OHS event may not go as low as they do with OSA or CSA, but may stay low for a longer time, even for the whole night.

It is important to distinguish some things related to OSA. Obesity is correlated with OSA. Remember correlation is not causation. Here are two features of this complex correlation:

1. Fat deposition can take many patterns on the body. In most areas of the body, fat does not cause OSA. The specific fat deposition pattern that can cause OSA is fat on the throat, a double chin. When a person with throat fat lies supine, the extra weight of the fat compresses and closes the throat. It is recognized in the medical literature that larger neck diameter is correlated with OSA and UARS. However, simply measuring neck diameter is not a sufficient criterion. Some people are just built with bigger necks. It is specifically an anterior neck fat pad that is associated with OSA and UARS. Also, more recent research has shown that a fat tongue is a frequent component of OSA. A fat tongue and double chin commonly, but not always, occur together.

2. A common response of the body to having any form of SDB is to deposit more fat. This is a generalized stress response: the body recognizes there is something stressful happening persistently and seems to think the stressful episodes could lead to starvation, so better store up more calories in fat. In this situation there is a correlation between obesity and SDB, but the causal relationship is not that being fat causes SDB, rather SDB is more likely to cause obesity. Of course, there can be a bit of both, a two-way street. For example, a person could have a bit of a fat pad on the neck which tips them into UARS. This scares the body, leading to more fat deposition and now tipping the person into OSA, which further frightens the body so fat deposition continues to increase. It is also essential to recognize that not every body responds to SDB by adding fat. People's physiologies are quite diverse. Some bodies do not deposit fat in response to SDB, or may even go in the opposite direction. Slender people can have any and all forms of SDB.

Speaking of epidemiologic relationships, it is well known that the incidence of all forms of SDB increases with age. Men are more likely to have SDB than women. However, it is important not to think that only fat old men have SDB. I have found SDB in slender little girls. Some babies are born with OSA, CSA, or UARS. Some babies grow out of these conditions. Others do not.

Potential SDB Signs and Symptoms

There are four kinds of SDB. There is testing, which I will describe, that can determine if a person has SDB or not, and if so which kind(s). Signs and symptoms that a client may report are useful, but very few of them are definitive for these conditions. Each person's body has unique features. Each person's awareness is unique. How SDB presents is highly variable. It is essential to look at many factors and to be alert to sometimes subtle signs a client may present. Since the presentation of these syndromes is highly variable, the description of signs and symptoms comes with 'if', 'but', and 'maybe'.

Daytime sleepiness: People with all forms of SDB usually wake up slowly in the morning, feeling groggy. They are likely to feel more focused and lively after being awake for about two hours, but usually feel somewhat sleepy all day. Falling asleep during the day while sitting, reading, watching TV, or even while driving is common. This daytime sleepiness is the single most common sign of SDB, but daytime sleepiness is neither a universal nor a definitive sign. People may be sleepy in the day for other reasons. Sleep may be disturbed by other things such as noise, a baby, or bodily pain. A person may have had the SDB condition for a long time, even his/her whole life, so s/he may not recognize the sleepiness. S/he won't know what feeling really rested feels like; s/he has never experienced it.

Sudden falling asleep in the daytime can be mistaken for narcolepsy. Narcolepsy is a brain condition different from CSA. In apparent cases of narcolepsy, it is important to rule out SDB as there is some similarity in the presentation of the two conditions. It is also important to realize that a person can have both SDB and narcolepsy.

Three kinds of breath sounds: Next I'll describe three kinds of breath sounds that may occur during sleep and may indicate SDB. Ask your clients about their awareness of their breath at night, and as they may not be aware, also ask them to ask their bed partners. Moreover, if your client falls asleep on your table, listen. Even falling asleep on your table is an indication of daytime sleepiness**.**

Snoring: A majority of people with OSA or UARS also snore. On the other hand, a large minority of people who snore also have OSA or UARS. Snoring is a yellow flag for OSA. The correlation between these forms of SDB and snoring is large enough that people who snore should be screened for SDB.

Snort-restart of breath: People with OSA will usually have the characteristic sharp restart of breath. Most of the time this does not wake them up enough for them to remember it. But if the person has heard it in themselves even once . . . as it's said, where there's smoke there's fire. A bed partner is usually more informative than the client. Like other signs, the sharp breath restart may not be present. I know a couple where the woman had insomnia for many years, a pattern where she would sleep about two hours, followed by two hours of wakefulness, repeating this pattern twenty-four hours a day. Many

things were tried to resolve her insomnia with little success. Her husband is a health-care provider very well attuned to SDB. The woman did not snore, and was not obese. One night the husband heard his wife give a very subtle snort-restart of breath. He recommended she be tested for SDB, and the results showed she averaged thirty-five OSA events per hour (severe OSA). What had apparently been happening was she would get two hours of low-quality sleep followed by two hours of adequate oxygen, on a repeated cycle. Anyone who has displayed even one apneic snort restart of breath should be screened for SDB. People will often say, 'Oh, it just happens once in a while', but a person with OSA will usually not wake fully enough to hear the snort-restart. If the person hears it occasionally, it is happening frequently and should be evaluated.

Raspy breath: As described above, people with UARS will have intermittently raspy breath during sleep. Usually this will be frequent. The person may or may not be aware of it but their bed partners will. Raspy breath while sleeping is a red flag for UARS. Anyone exhibiting this sign should be screened for SDB.

Undershot jaw: Among the many features of facial structure, there is the prominence of the jaw. There is a big range from protruding 'lantern' jaws to receding jaws. Jaws that protrude more forward tend to hold the throat more open; receding jaws tend to let the throat close more, predisposing to OSA and UARS and adding to the possibility of OHS. Lengthening undershot jaws is one of the more successful surgeries for OSA and UARS. Having an undershot jaw adds some weight to the scale toward screening for OHS.

Dental development: There is an interesting economic and cultural correlate. The incidence of OSA and UARS is much lower in developing countries than in the industrial world. If a child frequently eats food that requires more chewing, teeth will end up more splayed out with more space between them. This positioning holds the upper part of the throat more open. Children who grow up eating soft food, requiring little chewing, develop dental occlusal patterns where the teeth are relatively angled in and crowded. This positioning does not hold the throat as open. Another dental issue is that some orthodontic procedures have involved pulling some teeth and then drawing the others in. There is an aesthetic preference among orthodontists to have little space between teeth. Thus, a history of receiving orthodontia may predispose to OSA or UARS, or both, and even make OHS a little more likely. How crowded versus open the dental line is, or a history of orthodontia, or both, tips the scales towards screening for SDB.

Gastroesophageal reflux disease (GERD) and heartburn: Dysfunction of the gastroesophageal (GE) sphincter is well correlated with OSA and UARS. The interactions between GE sphincter dysfunction and SDB are complex and not fully understood. One feature is that when the GE sphincter spends too much of the time open, hydrochloric acid fumes flow up the esophagus to the throat, pharynx, and mouth. This is known to cause tooth decay and chronic sinus inflammation. The chronic presence of hydrochloric acid fumes will etch the inside of the throat and pharynx, often contributing heavily to OSA and UARS. Both heartburn and GERD are yellow flags for SDB. It is my considered opinion that people with chronic heartburn or GERD should be evaluated for SDB.

Musculoskeletal pain:

Back pain: I mentioned that with all SDB conditions the brainstem will direct arterial contracture to reduce blood flow to the musculoskeletal system, sending the blood instead to the brain and other internal organs. Usually this blood flow reduction starts with the hands and feet and progresses toward the trunk. However, different people's systems are tuned differently, and there may be other underlying vascular damage or occlusion so that trunk muscles may be affected earlier. This is one cause of back pain.

Waking with stiff, achy hands is a sign of SDB. Again, the sign is common but neither universal nor definitive. The damage to the hands and wrists, including the nerves to them, often leads to carpal tunnel syndrome, de Quervain's tenosynovitis, or ulnar neuropathy. Of course, repetitive strain is a player in these conditions also. Either repetitive strain or SDB can cause carpal tunnel syndrome. Often there is a synergistic combination of both. It is my considered opinion that all cases of hand neuropathies and tendinopathies should be evaluated for SDB.

Waking with stiff, achy feet is similarly common with SDB, but again neither definitive nor universal. There is a strong correlation between plantar fasciitis and SDB. If the feet are oxygen deprived every night, the foot tissue is damaged. SDB by itself can cause plantar fasciitis. Foot overuse or misuse patterns or poor shoes can by themselves cause plantar fasciitis. SDB and dysfunctional use patterns are synergistic to cause plantar fasciitis. It is my considered opinion that all cases of plantar fasciitis should be evaluated for SDB.

Chronic pain returning after SI: While musculoskeletal pain is more common in the periphery with SDB, due to the quirks of individual nervous systems and circulatory systems the musculoskeletal pain may be anywhere in the body. Chronic musculoskeletal pain is one of the most common reasons for people to present for SI. Often, we are successful at resolving these complaints. If we see musculoskeletal pain returning after our work, and movement habit sources of this pain are ruled out, then SDB is a likely culprit and should be investigated. Recall that 20% of the population has some form of SDB. The incidence of SDB among people with chronic pain is much higher. Since chronic pain is the most common reason for people to seek SI, it follows that a substantial percentage of our clients have one or more forms of SDB. In my practice it is a rare week in which I don't ferret out SDB in at least one client.

Chronic fatigue syndrome (CFS): CFS is a syndrome, which is to say it is not a single condition; rather, it is a symptom picture that can be the presenting feature of any of several different conditions. As its name indicates, people with CFS are tired all the time. The single most common disorder presenting as CFS is SDB. Chronic fatigue syndrome is a red flag for SDB. All persons with CFS should be screened for SDB.

Fibromyalgia is a common comorbidity of CFS. Again, this is a syndrome, not a specific condition. The symptom picture is a set of tender points on the body. A lot of different things can create tender points on the body. The single most common disorder presenting as fibromyalgia is SDB. Fibromyalgia is a red flag for SDB. All persons with fibromyalgia should be screened for SDB.

Myofascial pain syndrome (MPS): The presentation of MPS is similar to fibromyalgia, but is more specifically muscularly located. As with fibromyalgia, the correlation of MPS with SDB is substantial. MPS is a red flag for SDB. It is my considered opinion that all persons

with myofascial pain syndrome should be screened for SDB.

Heart rate response to SDB events: If heart rate and breathing are recorded together, the usual pattern in an SDB event is that the breathing stops or is diminished, soon followed by an increase in heart rate up to twice normal. During each SDB event the brainstem measures less oxygen in each unit of blood. An early solution the brainstem tries is to direct the heart to pump more units of blood, and heart rate will commonly double. If the SDB event continues, eventually there is not enough oxygen in the blood to support heart muscle activity and the heart rate may fall to half of normal. Somewhere along this course the person's system will be alarmed enough that the person will at least partially wake up. If the person wakes earlier in this cycle, they will wake with their heart pounding. They will usually wake with some sense of struggling for breath.

Attention deficit disorder syndrome (ADD): There are many causes of ADD. The single most common driver of ADD is SDB. It is easy to see how, if a person has not had a good night's sleep in years, or ever, they will have difficulty staying focused. ADD is a red flag for SDB. All persons with ADD should be screened for sleep apnea.

Atrial fibrillation: Atrial fibrillation is strongly correlated with SDB. As mentioned earlier, as the blood oxygen level falls at the beginning of an SDB event, the heart accelerates to about twice its normal rate. Then, as the blood oxygen level falls farther, the heart rate falls to half of normal as the heart muscle is not adequately supported with oxygen. Repeated over time, this deoxygenation can damage heart muscle. As mentioned earlier, the nervous system is particularly vulnerable to low oxygen levels. This includes the sinoatrial node, which is the metronome for the heart. Medically, it is recognized that even if SDB is not the original cause of atrial fibrillation, use of a CPAP machine as supportive therapy is usually beneficial. Atrial fibrillation is a red flag for SDB. It is my considered opinion that all persons with atrial fibrillation should be screened for sleep apnea.

Heart failure is a description of weakened heart muscle, so that the heart cannot pump out as much blood as arrives at the heart. This condition can range from very mild to fatally severe. Many different things can weaken heart muscle. As mentioned in the discussion of atrial fibrillation, SDB is one of these things. If a person has heart failure, then the weakly-pumped blood arrives late at the blood oxygen sensors in the brainstem. Seeing older blood, the brainstem lacks current information about the blood and will not recognize that the blood oxygen level is a little low; thus, it does not direct the body to breathe. This is a common way for OSA to occur. There is a nasty feedback loop where the low blood volume pumped by the heart misleads the brainstem, so the brainstem fails to request breathing; the resultant low blood oxygen level can further damage heart muscle. Any degree of heart failure is a red flag for SDB. It is my considered opinion that all persons with heart failure should be screened for sleep apnea.

Type II diabetes: There is a strong correlation between SDB and Type II diabetes. It appears that the low blood oxygen levels and sleep deprivation of SDB often trigger Type II diabetes. The mechanism is not well understood, yet the causation is clear. This includes but is not limited to the interaction of obesity, which is known to trigger Type II diabetes. SDB-induced obesity may further cascade into Type II diabetes. There are certainly other causes of Type II diabetes, including genetic propensities and persistent dietary indiscretions. Type II diabetes is a yellow flag for SDB. The correlation is strong enough that people with Type II diabetes should be screened for SDB.

Type I diabetes: While Type II diabetes has long been recognized as having a strong correlation with SDB, more recently Type I diabetes has been found to have a 30% correlation with SDB. While the mechanisms of this are even less clear than with Type II diabetes, the correlation is strong enough to wave a red flag. Anyone with Type I diabetes should be screened for SDB.

Insomnia is another syndrome and has many causes. With insomnia it may be difficult to fall asleep; or initially falling asleep may be easy, but it is hard to stay asleep. A person can experience both. With SDB a person is partially woken often during the night; this can look like the kind of insomnia where it is difficult to stay asleep. Since sleep is literally dangerous to a person with SDB, a kind of sleep-phobia can set in making it hard to fall asleep. Insomnia is a yellow flag for SDB. Testing for SDB may not be the first line of investigation for a sleep doctor looking at a patient with insomnia, but as other lines of investigation prove fruitless, SDB rises as a possibility. Or, if a person has insomnia and one or more other signs of SDB, then SDB becomes an earlier candidate to investigate.

Adrenal exhaustion syndrome: There are many ways to arrive at adrenal exhaustion. If a person has not had a good nights' sleep in years, this can easily present as adrenal exhaustion. Adrenal exhaustion is a yellow flag for SDB. The correlation is strong enough that people with adrenal exhaustion should be screened for SDB.

Kidney Disease: We are born with much more kidney function capacity than we need. A measure of kidney function capacity is glomerular filtration rate (GFR), which is measured with a blood test. As we age, our kidney function capacity decreases. At age twenty, we have a GFR of about 140. We only need 70 to function well. On average, our GFR decreases one point per year (10 points per decade). No problem is noted with kidney function until the GFR falls below 70. Having SDB is well known to damage the kidneys. While there are certainly other things that will damage the kidneys, SDB is an important player. If a person's

If we see musculoskeletal pain returning after our work, and movement habit sources of this pain are ruled out, then sleep-disordered breathing is a likely culprit and should be investigated.

Since the success rate of manual therapy [for sleep-disordered breathing] is low, the client should not wait to pursue other methods of treatment.

GFR is falling early in life, this is a yellow flag for SDB. It is my considered opinion that people with kidney disease should be screened for SDB.

Depression and anxiety are two of the most common psychological syndromes. They are both syndromes, as these psychological pictures can represent many different underlying situations. Not sleeping well for years leaves one depleted. This can fit the diagnostic criteria for depression. If the person still has some fight left in them, SDB may leave the person anxious. Consider how irritable you can feel after missing a night's sleep. The correlation between both depression and anxiety and SDB is strong enough that it is my considered opinion that people with either of these conditions should be screened for SDB. Many conditions are multi-causal. A person may have emotional history that makes good sense for developing depression or anxiety. That does not rule out the possibility that s/he could also have SDB.

How the Various Forms of SDB Are Diagnosed

In the presentation so far, I have made it clear that while there are many correlates of the four SDB syndromes there are few definitive signs. The snort-restart of breath is definitive for OSA; raspy breathing is strongly suggestive of UARS; and that is about it. Many health and behavioral situations can point to SDB. The demographic correlates of greater age, male gender, and obesity are useful for describing populations, but are not definitive for any individual. As I mentioned earlier, there are skinny young children with raging SDB. There are also fat old men who do not have any form of SDB.

Diagnosis requires testing. There are three levels of testing: (1) The simplest test is two nights of wearing a recording pulse oximeter. This test provides enough information to recognize that a person has some form of SDB and a general idea of how severe it is, but this test alone cannot distinguish between the four forms a person might have. Overnight oximetry is useful as a screening test. It is easy and cheap. If a person has one or two yellow flags, this simple test may be a good starting place. (2) A home test is often used, in which the person wears a recording pulse oximeter and a band around the chest which monitors breath movement, plus a nasal canula similar to those used to give a person oxygen, but which instead measures the oxygen concentration in the exhaled air. This kind of test usually gives enough information to make a diagnosis of whether or not a person has any form of SDB, if so which kind(s) of SDB the person has, and how severe the condition is. (3) Overnight in a hospital wearing all the gear from #2, an electroencephalogram net on the head, and a night vision camera with technicians monitoring live. Results from this type of testing are highly definitive.

Treatment of SDB

Several approaches to treating the various forms of SDB have been tried with varying success. These are discussed below.

Muscular retraining: Some versions of OSA and UARS have a muscular tone component. Retraining these muscles can reduce the severity of the disorder. Speech therapists are skilled at assessing facial structure and use of muscles associated with speech to design and implement muscle retraining programs. Many studies have been published in the speech therapy literature on corrective exercises for SDB. A meta-analysis of this literature suggests that speech therapy can reduce the number of incidents per hour in OSA by about 30%, and reduce the level of de-oxygenation in events by 2-3 percentage points.

Manual therapy: SI and other forms of manual therapy have been tried for OSA and UARS with little success. There are occasional case reports of success. Since use of manual therapy methods is likely to improve other things including neck range of motion and comfort, it is worth trying. Since the success rate of manual therapy is low, the client should not wait to pursue other methods of treatment. Our principal task is to look for signs and symptoms from which to make referrals to sleep doctors.

Central nervous system (CNS) medication abatement: Recall that taking CNS depressant medication is the single greatest cause of CSA. It follows that if a person is diagnosed with CSA and is currently taking CNS depressant medication, it is valuable to take a look at the medical condition(s) for which this medication is prescribed and to refer them to a physician to seek other ways of managing those situations without CNS depressant medication.

Weight loss: If a person has one of the patterns of obesity known to create an SDB syndrome, i.e., deep belly fat, chest-wall fat, double chin, or a fat tongue, then weight loss may be useful. Since SDBs also commonly cause weight gain there may be staged treatment where other methods are used for a period of time to mitigate the effects of the SDB so that weight loss becomes possible. Trying to lose weight while suffering from an untreated SDB is like trying to walk up a down escalator.

Positive air pressure devices: These are portable, nightstand supported electromechanical devices that supply air under carefully regulated, modest pressure to the patient's nose or mouth or both. The air pressure flowing through the throat with each breath reduces the likelihood of the throat closing and can gently blow the throat open if it does close. The original devices blew air at a constant pressure and were known as continuous positive airway pressure (CPAP) devices. Over time, continuous pressure devices evolved into bi-level positive airway pressure (BiPAP) devices, which offered two pressure levels: a higher level of pressure as the person inhaled and a lower level of pressure as they exhaled. The next generation of devices has sensors that can vary the pressure level depending on how a person is breathing. Variable positive airway pressure (VPAP) devices, in addition to lowering pressure on exhale, also notice if a person stops breathing and respond by gradually increasing pressure until the airway is blown open.

Although most PAP devices today are VPAP, they are still commonly referred to as CPAP as this is the commonly known name. VPAP machines are adjustable for the needs of each person. Some now have smart computer chips that adjust the pressure as the person's condition evolves over the years. In addition to the variable pressure, modern devices also warm and humidify the air. Masks, nose pillows, and headgear have evolved to be lighter weight and more comfortable, considerably improving patient compliance. Many different versions of headgear are available to meet the needs of each person. Sometimes it takes trying several types to find the best individual solution. PAP machines are the most common and highly successful treatment for all forms of SDB.

Oral appliances: Dentists with specialized training will craft carefully constructed bite guards that bring the mandible forward enough to hold the throat open wider, without being so forward as to harm the temporomandibular joints. In milder cases of OSA and UARS, these mandibular repositioning devices provide effective treatment. In more severe cases, these devices alone are not effective. In the worst cases, a patient may both wear an oral appliance and use a VPAP machine. Patient compliance tends to be better with oral appliances than with VPAP machines. In situations where a patient can't or won't tolerate a VPAP machine, an appliance may provide at least partial correction, reducing the number and length of apneic events.

Surgery: For OSA and UARS, various surgeries have been tried. The type of surgery used varies with both the particular biomechanics of the condition and the understanding of each surgeon. Success rates with such surgeries are low. One sleep doctor whose presentation I attended described success rates for surgeries for SDB as around 10%.

Relationships of SDB and COVID-19

Clinical monitoring has shown an elevated incidence of OSA among patients with COVID-19. It appears that having OSA is a risk factor for COVID-19. (I am not aware of studies correlating other forms of SDB and COVID-19.) In addition to OSA being a risk factor for getting COVID-19, having any form of SDB would complicate treatment of COVID-19 and could easily lead to a poorer outcome. The symptoms of COVID-19 vary from person to person but more often than not include difficulty breathing. If the person already has a condition that makes breathing more difficult, such as SDB, emphysema, or obstructive pulmonary disorder, the combined reduction in oxygenation from two or more conditions would easily lead to a poorer outcome.

Some COVID-19 patients need assistance breathing. This may include being put on a respirator. Some hospitals have been overwhelmed with COVID-19 patients, with not enough ventilators available. One solution is to use CPAP machines. CPAP machines provide less robust breathing assistance than a ventilator, but are valuable for some patients, certainly more valuable than no breathing assistance. A problem with use of CPAP machines for COVID-19 patients is air filtration. CPAP machines filter the incoming air so the patient has cleaner air to breath, but do not filter exhaled air. Thus a CPAP machine used by a COVID-19 patient will actively blow virus-laden exhaled air into the room, increasing the risk of infection among attending health-care workers. If a CPAP machine is used for a COVID-19 patient either as a substitute for an unavailable ventilator, or due to the patient having an SDB comorbidity, the CPAP machine must be adapted with additional air filtration for the exhaled air.

Jeffrey Burch received a BA in biology from the University of Oregon in 1975, after which he trained at The Dr. Ida Rolf Institute® in Boulder, Colorado, receiving his Certification as a Rolfer in 1977. He has been in continuous practice since then. Jeffrey received his Rolfing Advanced Certification in 1990, after which he again began studying at the University of Oregon where he received a second BA in psychology in 1993 and a Master of Science in Counseling in 1995. His master's thesis "Alexithymia and Dissociation" explores topics related to psychosomatic conditions. In 1998, Jeffrey began intensively studying craniosacral therapy through the Upledger Institute, cranial manipulation with French osteopath Alain Gehin, and visceral manipulation with Jean-Pierre Barral and his associates. Jeffrey completed the apprenticeship to teach visceral manipulation. He independently offers specialized courses in visceral manipulation with the permission of Jean-Pierre Barral. He also offers foundational courses in assessment methods and treatment methods. Starting in 2010 he began to develop groundbreaking new methods to assess and release adhesions and contractures in joint capsules, bursas, and tendon sheaths. In 2015 he began to teach these methods to other therapists.

Similarities and Synergies Between Rolfing® SI and Acupuncture

By Naoki Hattori, Certified Rolfer™

Naoki Hattori

ABSTRACT *Naoki Hattori has been a practitioner of acupuncture and traditional Oriental medicine for more than fifteen years. Ever since gaining his certification as a Rolfer in 2014, he has been fascinated by the similarities and synergy between the two systems and how they can be effectively combined to provide enhanced treatment modalities. In this article, Naoki explores these issues and shares some of the insights he has gained integrating both systems in his practice.*

My Mission

I started my career as a practitioner of the traditional Japanese healing methods of acupuncture, shiatsu, and Japanese osteopathy. I was very fortunate to have had the opportunity to learn the essence of Oriental medicine from many senior teachers and masters. As a practitioner of the traditional Japanese healing arts, my therapy is always grounded in the essential Oriental philosophy that human beings are strongly influenced by changes in the natural cycle – the interaction between life and the environment.

Unlike the vast majority of my fellow practitioners of Japanese healing modalities, however, I was also lucky enough to have discovered Rolfing Structural Integration (SI) and to have recognized the potential synergy between the two systems. My life's work has now become the integration of Oriental medicine and Rolfing SI, based on the organic relationship between mind and body – the body/mind unity.

My major focus in this is the development of harmonized treatment modalities that can structurally, functionally, and energetically combine Oriental medicine and Rolfing SI, making use of their similar somatic philosophies. This combined treatment system is very much in line with an amendment proposed in 1998 to the World Health Organization's (WHO) definition of health, "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity." In the end, the WHO (perhaps under political pressure) didn't accept this definition, but as a practitioner of Rolfing SI and Oriental medicine, I continue to embrace it and help spread this twenty-first-century redefined concept of health. We all, as

We all, as holistic-care practitioners, should help our clients understand that the real meaning of 'health' is more than a mere absence of pain or disease. Instead, health is a holistic condition that implies a great expansion of our own potential while better adapting to our environment.

holistic-care practitioners, should help our clients understand that the real meaning of 'health' is more than a mere absence of pain or disease. Instead, health is a holistic condition that implies a great expansion of our own potential while better adapting to our environment. My experience has shown me that the combination of Rolfing SI with Oriental medicine provides practical and embodied methods for the realization of this goal.

The Gravitational Field Is the Therapist

> *Practitioners of SI do not feel ourselves to be therapists. The gravitational field is the therapist. What we do is prepare the body to receive the support from the gravitational field which gives a greater sense of well-being.*
>
> Ida Rolf

From the viewpoint of traditional Oriental medicine, the longitudinal flow of energy along the twelve meridians structures human beings' verticality. This concept of supporting the longitudinal vector is similar with Rolfing SI's concept of the 'Line'. As Monica Caspari (2005) explained in "The Functional Rationale of the Recipe":

> *We have been better at defining the static line than the dynamic line in motion. Accordingly, we have been better at working with the body in a static state than with the body in motion. While the structural work liberates fixations in the tissues, functional work addresses fixations in movement patterns. While structural work gives conditions for the appearance of the Line, functional work gives the line life.*

Caspari's recognition of both static and dynamic aspects to the concept of the Line is crucial to understanding health. It helps us to understand how various elements of ourselves are nurtured by interconnection and cooperation. This understanding can serve to better organize bodily structure (what our bodies are), movement coordination (how we function in motion), spatial perception (how we perceive the world around us), and cognitive shape (how we think, behave, express ourselves, etc.) Broadly construed, Rolfing SI is a process that facilitates the exploration of how the human body/mind relate to each other. To understand what it means for the body and mind to relate, we have to first understand what our bodies and minds are. This includes how we function in every motion as well as how we perceive our circumstances and how we behave or express ourselves in the world. Aligning the static Line and the dynamic Line of our clients is the vitalization process through which we as Rolfers help them to experience themselves as being physically integrated and consciously embedded in the greater *body of life*.

"Life is about action," Caspari (2005) explains in the same work quoted above, "especially interaction and exchange with the environment and others. This dynamism of life is the key to its capacity to renew itself. It differentiates living organisms from machines." We are continually under the influence of gravitational and energy fields from the entire universe. If we think about the influence of these fields, it could be said that they comprise a kind of biorhythm of the circulating universe. This is reflected in Oriental medicine's specific consideration of life's seasonal rhythms as, for instance, in the ancient Chinese *I Ching* (*Book of Changes*). The basic truth of the I Ching is that everything in the manifested universe is in a constant state of change. Nothing in the world is stagnant or fixed. We understand that both nature and life are constantly changing and never stop. In fact, change is just what life and nature are. This change can only come about, however, if its fundamental root – its underlying reality – is eternal and unchanged. A flower, for example, depends on a stable ground in which it can fix its roots. In philosophical terms, our perception of change is conditioned on our intuition of permanence as a backdrop. We have a foot in both worlds, as it were. As a result, we are able to discern, in the world of constant change, the immutable truths and laws that underlie it. From this condition, our consciousness and active participation in universal change can arise. Looked at another way, from the standpoint of Rolfing SI and acupuncture treatments, we can say that gravity is the unchanged background, while other forces comprise the ever-changing energy field.

Pendulum of Life

The ancient Chinese explained the forces and cycles of nature through the fluctuation of the principles that underlie them. Most fundamental are the primordial principles yin and yang. This duality can be conceived in a variety of ways. The well-known *yin/yang* symbol (Figure 1), for instance, expresses these two principles as a kind of circular motion. They may also be imagined as the swinging of a pendulum back and forth between two poles. Another foundational notion of ancient Chinese metaphysics is the concept of the *Five Elements* – Wood, Fire, Earth, Metal, and Water. These are in a constant state of mutual generation and destruction in relation to each other and this elemental interaction is the dynamo that drives the incessant and manifest changes in 'the 10,000 things' of outer nature.

Nature is in a continual state of flux and life emerges as an organization and rhythmatization of this flux. The essence of my treatment is to attune the client's energy with the cosmic rhythms of yin and yang – to help the client align on both physical and energy levels with the movement of the yin/yang pendulum (see Figure 2).

Bipedalism

True or constant bipedal walking is a unique activity that is performed only by human beings. Kangaroos, for instance, are bipedal in some respects, but not consistently like humans.

Bipedalism is an inherently unstable act, which requires constant – but unconscious – balancing and re-balancing of the whole

Looked at another way, from the standpoint of Rolfing SI and acupuncture treatments, we can say that gravity is the unchanged background, while other forces comprise the ever-changing energy field.

body. Standing on two feet involves constant adjustment. As an acupuncturist, I see this postural fluctuation as almost identical to the energetic one between yin and yang. When, as a Rolfer, I attempt to evoke and integrate the client's center of gravity and vertical axis, it is similar to the acupunctural work of balancing the yin and yang principles in the person's constitution.

Rolfers are helping clients to evolve vertically by improving their balance under this inherent instability. As Jim Gates (2018) expresses his understanding of our work, "I am contributing to human evolution, both personal and cultural, by organizing people's physical, emotional, and energetic bodies around a central line in relationship to gravity." To me, this bears clear similarity to what I am trying to do when I work as an acupuncturist.

Circulation

We often refer to the SCPM-G (Structure, Coordination, Perception, Meaning, and Gravity) relationship, as is shown in Figure 3. It is difficult not to notice the parallel structure in Figure 4, which is a depiction of the Five Elements of ancient Chinese philosophy. Just as Rolfers strive to encourage circulation and interplay throughout the SCPM-G elements, so Oriental medicine emphasizes the circulation and interplay of Fire, Metal, Water, Wood, and Earth as a hallmark of health.

The ancient Chinese carefully observed the continuous, organic changes in nature and the universe, which they found to be integrated by the influence of the sun. They discovered that these natural cycles result from the fluctuations of yin and yang and the orderly interaction of the Five Elements. The Five Elements are all related to each other and each of them affects the others. They discovered a universal law that recognizes the nonlinearity of complex systems as the organized interaction of nature.

In one primary variant of classical Chinese thought, the Earth element is located in the center of the circle, with the other four elements in orbit. Thinking about the constant cycle of generation, Earth is the center of our bodies and beings, and the center of the elements. Especially during the transition to the next element, the Earth element is always involved.

I think that this connection can shed light on the role of gravity in the SCPM-G system. Creating better organization with how each of the four aspects relates the gravity can improve bodily structure, movement coordination, spatial perception, and cognitive shape by providing them with a center of integration and locus of orientation.

The interrelationship between static and dynamic Lines is a key concept of Rolfing SI, which forms the basis of much of our work. I believe that the efficacy of our work will be enhanced by adding the Oriental concepts of the fluctuations of yin and yang and the constant generation and overcoming cycles of the Five Elements into our consideration. It is my belief that this could help us more effectively orchestrate and harmonize the static / dynamic Line interaction.

The twelve meridians organize the static and dynamic Line properties, because the concept of the meridians involves physicality, functionality, perception, and cognition. Yin/yang and the Five Elements underlie and support the twelve meridians. Rebalancing the twelve meridians has the potential to help you relearn your body-mind and enhance the experience of ordinary life in subtle and profound ways. As well as psychic and emotional experiences, these can even be muscular sensations you have not had before and bone sensations that had gone unnoticed.

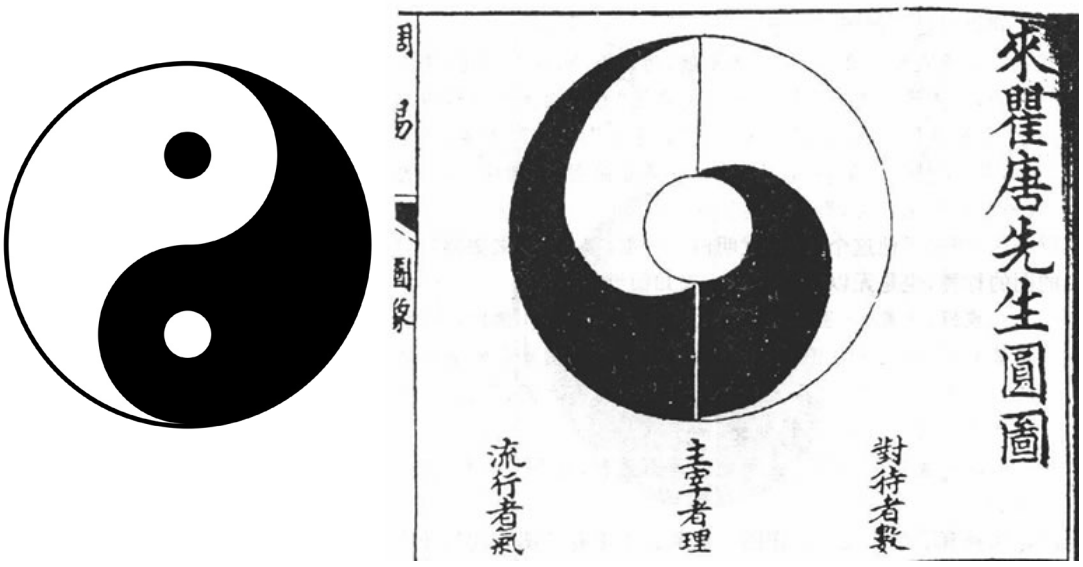

Figure 1: Two versions of the yin/yang symbol.

Credits: image on left by Gregory Maxwell, from File: Yin yang.png, converted to SVG by Gregory Maxwell, public domain, https://commons.wikimedia.org/w/index.php?curid=364239; image on right, public domain,https://ja.wikipedia.org/wiki/太極図#/media/ファイル:LaishiTaijitu.jpg.

Figure 2: Balancing under inherent instability. Photo by Edwin Li, https://www.flickr.com/photos/edwinylee/2822415750. CC BY-ND 2.0

Clinical Perspective: The Relationship Between Meridians and the Interosseous Membrane

Since I first learned about interosseous membrane work in my Rolfing training, I have been fascinated by it from the perspective of Oriental medicine. In this chapter, I wish to explore this relationship between Oriental medicine and the forearm interosseous membrane. I hope to consider this relationship from the perspective of Oriental wisdom and scientific research into acupuncture, as well as my own firsthand experience.

During my initial Rolfing training, I was introduced to an interview that Valerie Berg (2009) conducted with Jan Sultan, in which they discussed the interosseous membrane. Sultan recounted:

> I had been observing for years that when you work on the interosseous membrane in the forearm, there would be a corresponding volumetric change in the thorax. Lower-leg work would correspondingly affect the intra-pelvic volume. When both distal arm and leg were done together, the rib cage and pelvis would shift accordingly . . .
>
> Working flexors and extensors and hands, not purely but including the interosseous membrane. This would reliably create volume in the thorax.

I was delighted to discover a reference to Oriental medicine later in the same interview:

> Acupuncture meridians are at the surface on the extremities and it is at the elbow and knee that they dive and go to the organs. In order to get to the interosseous membrane in the extremities, you have to go through the surface, so it occurred to me that maybe what was happening was an information barrage that was released by doing extremity work that informed the whole energetic system in the traditional Chinese medicine paradigm. This is exemplified in the microcosmic orbit. The apparent opening of vitality in people might have something to do with the set of reflexes set along the meridian lines.

I would like to further explore this issue from the perspective of Oriental medicine. There are two meridian lines that regulate the interosseous membrane of the forearm: the Pericardium Meridian and the Triple Warmer Meridian. The Pericardium and the Triple Warmer are channeled, paired meridians related to the Fire element.

The Pericardium Meridian

The Pericardium Meridian (see Figure 5) follows the flexors on the forearm and traverses nine different acupuncture points. For the purposes of this article, I would like to focus on one of them, the Nei Guan (PC6; see Figure 6) as an especially representative point.

About the Nei Guan (PC6) Acupuncture Point

According to traditional Chinese medical literature, the main usages of the Nei Guan point are for the treatment of sensations of fullness or illness in the abdominal region, especially nausea and vomiting, as well as cardiac disorders such as chest pain and palpitations.

Western-style medical research performed in China has revealed that Nei Guan (PC6) can regulate neurophysiological issues, including hypothalamic rostral ventrolateral medulla (RVLM), arcuate nucleus (ARC), ventrolateral periaqueductal gray (VLPAG), and medullary raphe. It can also serve as a means to address neurotransmitter issues such as excesses or deficiencies of GABA, opioids, 5-HT, etc. Modulation (acupuncture treatment) of Nei Guan is, therefore, believed to be effective for the treatment of cardiovascular disorders (see Li et al., 2012). Another study (Zhang, 2014) found that needleless transcutaneous electroacupuncture (TEA) stimulation at the Nei Guan (PC6) and Jianshi (PC5) points could have antiemetic effects that are possibly mediated via mechanisms involving serotonin and dopamine.

Both of these references are research studies of acupuncture and needleless TEA conducted according to the standards of Western medicine. In addition to these individual studies, a major meta-analysis of research findings regarding the effectiveness of acupressure applied to the Nei Guan (PC6) acupuncture point (Yang et al., 2019) concluded with encouraging results. The authors describe their study as the first systematic evaluation of the effectiveness and safety of acupressure on the Nei Guan (PC6) point compared with different antiemetic drugs. It is suggested that stimulating Nei Guan (PC6) may

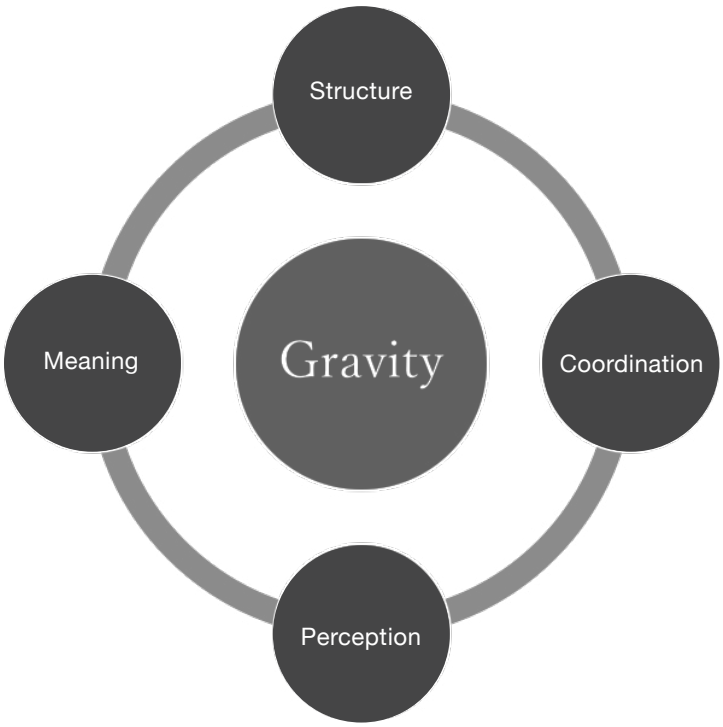

Figure 3: SCPM-G relationship. Image by Naoki Hattori.

affect the body's endocrine system by regulating the level of beta-endorphins in cerebrospinal fluid as well as enhancing the transmission of endogenous opioids and 5-hydroxytryptamine in serum. It is also hypothesized that stimulation of this point may inhibit the secretion of gastric acid and regulate gastrointestinal function, thus stopping nausea and vomiting.

The Triple Warmer Meridian

While this article mainly focuses on the Pericardium Meridian, I would also like to briefly discuss the relationship between the interstitium and the internal organ associated with the Triple Warmer Meridian (see Figure 7). The Triple Warmer Meridian follows the extensors along the upper side of the forearm. See Benias et al. (2018) for a scientific study on the global distribution of the interstitium through the physical structure of the body.

In traditional Chinese medicine, every meridian is associated with an organ, but among them the Triple Warmer organ is unique. It is referred to as an organ that has function but no form. According to the traditional Chinese medical literature, this function is the production and circulation of nourishing yin energy and protective yang energy. It is not a single self-contained organ, but rather a functional energy system involved in the regulation of the activities of other organs.

The image traditional Chinese medicine practitioners have of the Triple Warmer organ is a combination of space and fluids that wrap and network throughout the body, enabling the transformation of qi (the Oriental concept, also called chi or ki, and sometimes conceived of as 'life force' or 'life energy') and the metabolization of bodily fluids. According to the scientists (Benias, et al., 2018) who (re)-discovered the interstitium (after Ida Rolf spent the greater part of two decades pioneering the method of SI that bears her name and that assumes the notion of an interstitium as a postulate), it both relates and differentiates all the major organs of the body. This includes the lungs, the digestive system, the urinary tract, blood vessels, and fascia (as regarded from the narrow standpoint of standard anatomy). In other words, given the integrative function of the interstitium, all of these seemingly discreet organic instruments function as a symphony. Of course, for Rolfers, 'fascia' has always implied this integrative function. In fact, the Rolfing community has already conducted a number of studies on the connective tissue system, and it has been a topic of discussion at the Fascia Research Congress meetings for many years.

In any case, Dr. Michael Nathanson, Professor of Medicine and Cell Biology and Chief of the Digestive Diseases Department of Yale University's School of Medicine, said of the interstitium: "I would think of this as a new component that is common among a variety of organs, rather than a new organ in and of itself. It

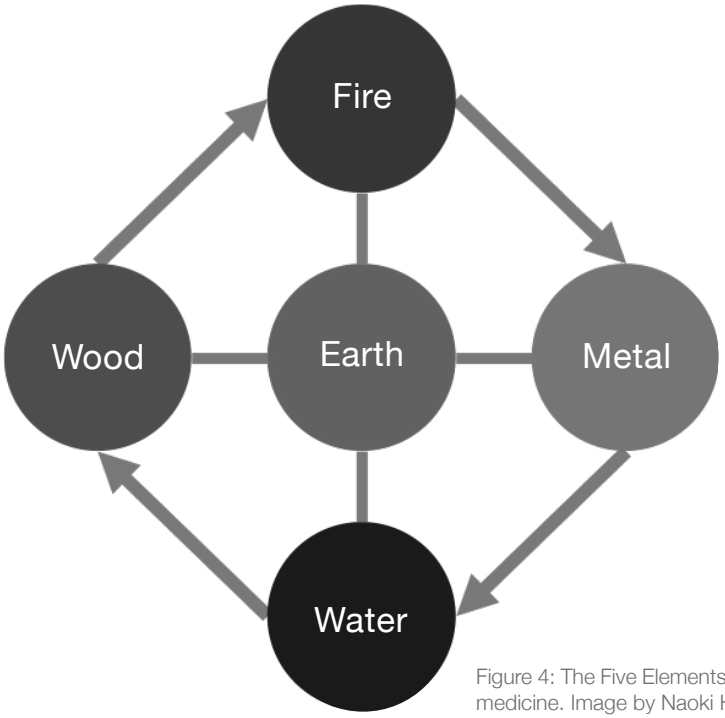

Figure 4: The Five Elements of traditional Oriental medicine. Image by Naoki Hattori.

would be analogous to discovering blood vessels for the first time, in that they are in every organ but they aren't an organ themselves" (Howard, 2018). If anything, Nathanson may be faulted with a lack of originality, but not with a fundamental mistake in his understanding. In the research to which Nathanson referred, it was asserted that the interstitium also performs the function of transporting and metabolizing fluids throughout the body. The researchers' description of this function is remarkably similar to the ways the Triple Warmer Organ is discussed in traditional Chinese medicine.

To summarize the manner in which the Pericardium and the Triple Warmer are conceptualized according to traditional Chinese medicine, they are channeled, paired meridians that both correspond to the Fire Element. The Triple Warmer also bears a secondary relationship to the Water Element, which is responsible for the movement and transformation of various solids and fluids throughout the body. Based on Five Element Theory, the Fire and Water Elements have a closer connection to the fluctuations of yin and yang than the other elements of Wood, Earth, and Metal. When acupuncture treatment dissolves blockages along the Pericardium Meridian, it decreases excessive Fire energy (yang) and simultaneously rebalances the Triple Warmer Meridian, which can then activate Water energy (yin) and the system's fluid regulation. Traditional Chinese medicine's twelve-meridian theory stemmed from the concepts of yin/yang and the Five Elements having both static and dynamic properties that involve physicality, functionality, perception, and cognition.

Combining the results of Western research such as the interstitium report with traditional Oriental wisdom has enabled me to deepen my understanding of various physical and energy systems, as well as potential treatments of conditions related to them. For example, it has helped me understand how pressure applied through the flexors to the interosseous membrane – along the Pericardium Meridian – can modulate neurophysiological and neurotransmitter issues globally and also effectively regulate thoracic and abdominal cavities locally. Similarly, pressure applied to the interosseous membrane through the extensors – along the Triple Warmer Meridian – can be effective for fluid regulation globally and dealing with issues related to the connective tissue around the lungs and the digestive system locally.

Case Studies

Below I will present two case studies to show how I incorporate Oriental medicine into my Rolfing practice.

Case Study 1: Focal Dystonia

My client is a pianist who suffers from focal dystonia. Standard Western medicine regards focal dystonia as a strictly neuro-kinetic issue, but looking at it from the standpoint of both Rolfing SI and Oriental medicine, we find that it also has a psychosomatic aspect.

My main goals and challenges for her initial Rolfing ten-session course of treatment were:

- the release of connective-tissues units
- the relationship of cervical and lumber lordosis and the ligaments of the thoracic cavity
- re-educate her movement coordination pattern
- how to set up the longus colli before starting to move (pre-movement aspects)
- bringing about re-awareness of her spatial perception
- where to and how to sense the outer space around her upper/middle back (kinesphere aspects)

Her right hand was the focal point of her disorder and the right side of her diaphragm was stiff due to the influence of her right forearm. She has also had functional scoliosis due to years-long compensation, especially while she is playing the piano. In addition, the tonic function of her pelvic floor was insufficient to support her movement.

From the perspective of Oriental medicine, the condition of her right side is related to the Liver and Gall Bladder Meridians. Notably, the tightness in her right diaphragm can indicate that it is necessary to pay attention to its relationship with the emotion of anger. She had also been suffering from some other emotional issues, including anxiety, impatience, despair, and resentment. These were largely the result of a positive-feedback cycle due to the fact that her condition had not improved for a long time prior to the start of my treatment. Primarily through Rolfing SI, I was able to sever the unhealthy cycle of emotional reactions that had been restricting her body's functioning in terms of the static and dynamic Line properties.

As I had hoped, this led to significant improvement. Regarding the condition of her interosseous membrane, the extensor side – corresponding to the Triple Warmer Meridian – was tight. To encourage holistic improvement, it was important to use acupuncture treatment to regulate fluid metabolism in the thorax region.

Although her focal dystonia has been gradually improving, she is not yet in

Figure 5: The Pericardium Meridian, Chinese book art, 17th/18th century. "This meridian begins in the middle of the chest, at the pericardium. A branch descends internally through the diaphragm to the upper, middle, and lower burners – triple warmer. From the starting point a branch of the main channel crosses the chest to emerge just outside the nipple. It then ascends on the surface around the front of the armpit and flows down the arm, through the biceps muscle. At the elbow crease it passes just to the inside of the biceps tendon, then down the middle of the front of the forearm, between the heart and lung channels to the wrist. It crosses the middle of the palm to PC8 where it divides. The main channel continues to the outer corner of the middle fingernail" (Natural Health Zone). The image comes from Wellcome Images, a website operated by Wellcome Trust, a global charitable foundation based in the U.K. Refer to Wellcome blog post. CC BY 4.0, downloaded from Wikimedia Commons.

remission and is continuing with ongoing sessions after the initial course, based on a movement and awareness-oriented approach integrating both Rolfing SI and acupuncture. In working with her, I have seen how the perspective of Oriental medicine can be a key to grasping how functional compensation develops and accumulates.

Case Study 2: My Gravity-Meridian Method

A client came to me with pain in her left shoulder area and limited range of motion. In such cases, acupuncturists think first about which meridian might be blocked. After this diagnosis, the treatment ordinarily involves a regulation of the stagnated meridian and/or energy nourishment of the effected organ, etc. In general, this and other acupuncture treatments are performed only with the client in a lying down position.

After administering general acupuncture treatment, I had her assume a standing position and inserted one or two needles just 2-3 mm deep on specific calf points related to gravity and corresponding meridians, creating an effect similar to *tracking* under gravity. Because the calf muscles (i.e., gastrocnemius and soleus) play an important role in maintaining an upright posture while standing, shoulder motion is dependent on the condition of the calf muscles.

Figure 6: Nei Guan (PC6) acupuncture point.

Photo credit: Naoki Hattori.

Of course, this is well understood by Rolfers, but how to correctly identify the specific point or tissue where the root problem lies is very important for our clinical practice. Depending on the specific case, this point can be located on either the ipsilateral side or contralateral side. Releasing the flow of energy along the meridian enables the practitioner to locate the problem point on the calf muscles, and leads to a great reduction in shoulder pain and improved range of motion in many cases. I call this technique the Gravity-Meridian Method.

Moreover, many clients feel a great improvement while standing during and after treatment with the Gravity-Meridian Method. In my experience, it also helps to improve movement coordination and reshape the client's negative cognitive images. Put another way, it helps break down the client's negative *gestalt* and mental barriers, and encourages transformation into a more positive state. Gravity can also influence the meridian itself. For me, the traditional Oriental medicine concept of meridians becomes even more meaningful when combined with the Rolfing concept of gravity. Incorporating Rolfing's philosophy and techniques into an acupuncture session (or vice versa), can facilitate the gravity integration process, especially as it relates to the aspects of re-education and re-awareness.

Conclusion

> Some people understood that clients were to be evaluated based on the degree to which their structures were congruent with the Line of gravity – verticality in relation to the ground. Rolfing was directed to the liberation of soft-tissue restrictions to permit the emergence of a higher level of organization around a central vertical axis, and they believed that the goal was to harmonize each person's reality, within the limits of each person's individual process, with an ideal. That ideal was, in fact, unattainable (Prado, 2009)

Since I started practicing Rolfing SI, *integration* has become a very major theme in my acupuncture practice as well. From the standpoint of traditional Oriental medicine, integration means finding a central point, called Taiji, in which the fluctuations of yin and yang can be transcended (see Figure 2). Taiji is the fundamental root – eternal and unchanging even amidst the flux of the 10,000 things. Discovering this universal central axis, which Rolfers may recognize as the Line, and incorporating it into your life is an ongoing integration process that is coextensive with life itself. Through this we learn to accept constant change and adjust to the organized fluctuation of life.

Figure 7: The Triple Warmer Meridian, Chinese book art, 17th/18th century. "The Triple Warmer Meridian originates from the tip of the ring finger, by the outside corner of the nail, passes between the knuckles of the fourth and fifth fingers, on to the wrist. From here it ascends between the two bones of the forearm (radius and ulna), through the tip of the elbow, and up the back of the arm to the shoulder. It moves forward into the chest to connect with the pericardium, the upper burner, the abdomen and the middle and lower burners. Re-emerging from the chest at the collarbone, the meridian ascends the side of the neck and around the back of the ear" (Natural Health Zone). The image comes from Wellcome Images, a website operated by Wellcome Trust, a global charitable foundation based in the U.K. Refer to Wellcome blog post. CC BY 4.0, downloaded from Wikimedia Commons.

Because the calf muscles (i.e., gastrocnemius and soleus) play an important role in maintaining an upright posture while standing, shoulder motion is dependent on the condition of the calf muscles.

In my practice, I have seen that there are many similarities and synergies between Rolfing SI and acupuncture, and I have attempted to present some of the most important ones in this article. On the surface, these two systems might seem quite different, but when we examine them more closely – and especially when we experience them for ourselves in our practices – we find that they are really two sides of the same coin. Connective tissues are essential elements through which we can bridge the two paradigms. Moreover, as I hope to have shown, it is largely a difference in nomenclature that conceals profound similarities in the philosophies that ground Rolfing SI and acupuncture. I believe that an understanding of this connection can serve to deepen our appreciation of the profound genius of Ida Rolf. By herself and in her own way, she directly connected to the collective consciousness of traditional healing wisdom. I might even venture to say that she was passed the sacred baton of healing directly from our ancient collective healing wisdom. Now, it is our turn to emulate our founder and carry her work forward. With her as our guide, but also following our own intuition and learning from other synergistic traditions such as acupuncture, we can continue to contribute to the health and wellness of our clients.

In more than fifteen years as a professional practitioner, Naoki Hattori has treated a wide variety of clients from all over the world. This has led him to think deeply about what good health really means, and the kinds of treatment that can help achieve it. Using both acupuncture and Rolfing SI synergistically, he developed The HATTORI Method, which is specialized for treating the musculoskeletal issues and is very effective for any kind of pain or discomfort, including stress, anxiety, and other mental conditions. In the summer of 2019, he and his wife moved to Chamonix, France, where he now carries on his practice and continues to explore the synergy between acupuncture and Rolfing SI. To find out more about Hattori and his work, please visit https://chamonix.naokihattori.com. He can also be contacted at mail@naokihattori.com.

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Nothing Is Everything. Everything Is Nothing. (It All Depends on Your Viewpoint)

An Interview with Yoshitaka Koda

By Anne Hoff and Yoshita Koda, Certified Advanced Rolfers™

Anne Hoff

Yoshitaka Koda

ABSTRACT *During her lifetime, Ida Rolf taught her work in the United States primarily. In subsequent years, Rolfing® Structural Integration (SI) has spread to numerous countries, often through the pioneering efforts of a few individuals. Yoshitaka Koda was the first Japanese person to train as a Rolfer, and for many years was the only Japanese Rolfer. Besides introducing the work to many people, he also has been a support to the Continuum Movement®, osteopathic, Feldenkrais Method®, and other somatic communities through his work as an organizer and translator for foreign teachers in Japan, allowing many forms of work to gain in popularity there.*

Editor's note: This interview was conducted in the autumn of 2019, with some additions made before going to press.

Anne Hoff: It's really nice to meet you. I lived in Tokyo for some years in the 1980s and 1990s. When I first heard your name and that you were a Rolfer, you were living in Kyoto. Other than you, it was foreigners doing Rolfing® Structural Integration (SI) in Japan at that point in time.

Yoshitaka Koda: I lived in Boulder for a while, and I came back to Japan in 1989. There was Richard Podolny and some other Rolfers like Christine Faris, Ashuan Seow, Lloyd Kaechele coming back and forth, and Daniel Mills. Those are the ones I knew that were living in Tokyo, but I didn't know you were also.

AH: I wasn't a Rolfer at the time. Richard was my first Rolfer, and I thought, "Wow, this is great. Sometime I want to be a Rolfer." And then I left Tokyo in 1994 to go study Rolfing SI.

YK: Okay.

AH: I would hear your name, and I know that you were the only Japanese Rolfer for quite a number of years.

YK: Yeah, for a while.

AH: How did you hear about Rolfing SI?

YK: Well, I read an article in a little book that was based on a lot of information about the spiritual world. It had a section about spirituality based on the body, and [mentioned] Rolfing [SI], and Feldenkrais, and Gurdjieff. I heard that Ida Rolf was a

If I hadn't gotten involved with Rolfing SI, I would be a totally different person. My understanding of the body is that it never stays the same anyway, whether we get Rolfing sessions, or anything else, or nothing. Regardless, we keep changing toward growth and decay to death. We Rolfers in our work can only offer a suggestion of certain directions for our ever-changing existence. In my own case, I notice that the direction taken would have been quite different if I have not had Rolfing sessions; I would be in a totally different place now, but I cannot imagine where I would be.

friend of one of his students, J. G. Bennett. For some reason it had these three, maybe that was the only information the authors had. So I read the book, and I got curious about Rolfing [SI].

AH: Was the book in English or Japanese?

YK: Japanese. They included information from here and there, and they picked up, from somewhere, the article about Rolfing [SI].

AH: I wonder if the author had experienced Rolfing sessions.

YK: I think it was just translated, or modified from some article in English.

AH: Where were you living when you read this?

YK: I was living in Osaka. I was born and grew up there. I was a college student when I read that, and I was curious, but I had no idea where I could get Rolfing sessions or anything. Hopefully I could study it, but I had no idea how. My fourth year of college, I had to decide whether to get a job or try to find how to study Rolfing SI. I chose to find out about Rolfing [SI]. But I had no English skills then, so I first went to States to study English, and meanwhile to get Rolfing sessions and to ask how I can study Rolfing SI. That way I would find out whether it's a thing I could really study or not. And if I couldn't, I'd give up [the idea].

AH: Where did you go in the U.S.?

YK: Initially, since I didn't have English skills, I wanted to have some Japanese around. An agency for a language school recommended Seattle, so I went there first, for eight months of English-language school. I also needed to experience Rolfing sessions so I went to see Jack Donnelly, who was an older man who I guess had studied with Ida Rolf. I got sessions, and asked him how I could study Rolfing SI, and he said he would write a letter to the Institute and see, because you needed to have a written recommendation then. They didn't have as formal a training as now; you had to meet certain requirements, submit a paper, and do an interview, stuff like that. I didn't feel I met the requirements so I almost gave up, but then I got a leaflet about the new foundational bodywork program, it was called the Comprehensive Study Program (CSP). [Editor's note: This was a precursor to what is now Unit I.] They were just starting it to see if it would be helpful for people who wanted to study Rolfing SI but didn't meet all the requirements.

But my English still wasn't good. Japanese people are good at writing or reading English, but not listening or speaking [because our school system in Japan focuses on taking tests]. So I moved to Colorado and enrolled at a college in Denver. I was trying to get closer to Boulder. I took a premedical course for a semester and a half, then entered the second offering of the CSP.

AH: What did your friends and family in Japan think? You were at the age where most Japanese men are becoming office workers, and you took this completely different journey to study something they had never heard of.

YK: Yeah, they don't know anything about Rolfing SI of course, nobody in Japan knew. My friends didn't care about it, they just thought, "He's a weird guy doing something like that." My parents also didn't know what I was trying to do, but were very helpful in supporting me [whether it worked out or not]. They saw me getting closer and closer as I went along, so they kept supporting me.

AH: That's very fortunate that they were willing to support you for something that they had no clue about. Let's go back to where you first read about Rolfing SI in an essay about the body and spirituality. What was your experience receiving Rolfing sessions, did it fit that?

YK: The truth is that I didn't feel much other than feeling temporary ease or lightness. I totally agreed with and trusted what I read, but it didn't happen for me the way I expected. I see now that I shouldn't have expected anything – expectations disturb the experience. I was expecting dramatic change, and there was nothing dramatic. And since the way I used my body hadn't changed much, probably my patterns came back. Since my English communication skills weren't good enough, I guess my Rolfer couldn't really tell me how to maintain changes, or how to keep changing, or how to sense. Actually, that's the most important part, he didn't really try to make me feel or sense. I didn't know that I had to pay attention to sense a change in what was going on. I thought it just happens automatically. Sometimes it does if you are lucky, or generally sensitive, but it wasn't possible in my case. But I was still interested to study Rolfing SI and learn what it is.

AH: When did you experience something that was closer to what you felt was the potential of Rolfing SI?

YK: There was no particular moment, but I got so many sessions from different Rolfing instructors after moving to Boulder. By and by, getting sessions, paying attention to my body, understanding the principles, I know it's now different, and that there's also been personal growth. If I hadn't gotten involved with Rolfing SI,

I would be a totally different person. My understanding of the body is that it never stays the same anyway, whether we get Rolfing sessions, or anything else, or nothing. Regardless, we keep changing toward growth and decay to death. If we live to be 100 years old, we have had 36,500 days to live. We don't get old in one day (although there may be some fluctuation in the rate of aging) but are constantly changing (dying) each day until the end. We Rolfers in our work can only offer a suggestion of certain directions for our ever-changing existence. In my own case, I notice that the direction taken would have been quite different if I have not had Rolfing sessions; I would be in a totally different place now, but I cannot imagine where I would be.

AH: How long did you stay in the U.S. in total? And how did you decide it was time to go back to Japan?

YK: I stayed five and a half years. I'm the first son in my family, and [in Japan that's] usually the one who takes care of the parents. My only sibling is my sister. So, I was supposed to come home anyways at some point. I was almost twenty-nine years old, and felt that if I wanted to have a career in Japan, I had to start early enough, it might be harder later. And also, there were visa issues with staying in the U.S. So, I decided to go home.

AH: So, how did you start your practice? Japan has a lot of people doing shiatsu and acupuncture, so there's a history of people being individual practitioners, but how did you step in as a Rolfer?

YK: I didn't do anything in particular. A practitioner named Mark Caffel connected me to his friend in Japan, a college professor, who wanted someone to do sessions. She was interested in referring people, but also didn't know who I was or how I worked, so she suggested that I give her and a couple of her friends Rolfing sessions and see how they feel. She ended up organizing clients for me for quite a while. This was in Nagoya. For a long time I was the only Rolfer in Japan outside of Tokyo, and the only Japanese Rolfer, so I would get clients coming from far away. So, in that sense, I had a lucky start.

AH: Yeah, there were some foreign Rolfers in Tokyo, but as I recall none of them spoke much Japanese, so you were the first person who could really communicate to Japanese clients in detail. That's important, as you said about your own initial Rolfing experience. And you could speak both English and Japanese.

YK: Right. I had a quite a lot of foreign clients also, when I started.

AH: So you started in the Kansai region, going to Nagoya, and then you lived in Osaka or Kyoto?

YK: I lived in Osaka. But I was already going back and forth between Osaka and Nagoya and Tokyo. The president of a school in Kobe wanted to have all the students get Rolfing sessions. The school's name was Biodynamic Institute but it had nothing to do with cranial biodynamics. They also had classes in Tokyo, and I was asked to do sessions for the Tokyo students also. Then my Tokyo practice grew beyond that contract, I was getting outside clients, so I rented an office there. Eventually I met my wife, who lived there, so I moved to Tokyo in 1997.

AH: For how many years were you the only Japanese Rolfer?

YK: Probably about ten years. In 1994, I organized a craniosacral class for Jim Asher, and three from the participants later became the next Japanese Rolfers – Kayoko Toyoda, Chiharu Nunome, and Hiroyoshi Tahata. Now there are close to 200 Japanese Rolfers.

AH: That's stunning to me, how fast it grew after a certain point.

YK: I think that was because of Hiro [Hiroyoshi Tahata], who is now on the Rolf Movement® faculty. Hiro was really the one who got local training started, organizing them. Earlier, Christine and Ashuan and I had tried to find a way to start it, but it was never possible. Hiro organized the first training in Tokyo. Since then, it's more and more. They had a second training, and a third training . . .

AH: I know that you organize and translate for a lot of different workshops. Do you teach also? Because you've been in practice for a long time now.

YK: I teach Continuum Movement® and sometimes I teach a little bodywork. I used to teach Jim Asher's style of craniosacral work, as a gateway to classes that Jim would come to teach. But I stopped doing craniosacral work the way I used to, so I don't do that anymore.

AH: How did you learn Continuum; did you go to the U.S. for that also?

YK: Gael Rosewood brought Continuum to the Rolfing community, that was pretty much when I was in Rolfing training in Boulder. I asked Gael to come to Japan to teach, but she [wasn't comfortable teaching abroad yet] so she recommended Susan Harper, who came. So, I was studying from time to time and came to the U.S. to take Emilie Conrad's class, and I organized classes for different teachers. I became a Continuum Movement teacher three or four years ago, after Emily had died.

AH: So, Rolfing SI, biodynamic cranial work, Continuum . . . I know you've been studying esoteric healing as well.

YK: Well, I also do the Feldenkrais Method® of somatic education. A lot of this stuff is because I translate for various workshops. I translated for the Feldenkrais training. There was an Israeli man who organized the first Japanese training for the Feldenkrais Method and he was trying different translators including me. I end up translating the whole second program. Then they asked me if I would like to be a practitioner in the third training. So I was translating for that training while at the same time being a student. So organizing workshops in Japan, and translating for them, leads me to different things where I end up becoming a practitioner. Tom Shaver, D.O. was teaching Esoteric healing classes, which I organized for a while, but then we stopped as he got too busy teaching biodynamic stuff. He looked for someone else to come, and recommended me. I organized classes for other teachers, then they asked me if I would like to be a teacher. No one else was on that route, so I decided, yeah, I will. But it's taking me a little while.

AH: It sounds like you have interests you pursue, but also sort of flow with life. You're open to see what comes your way.

YK: Yeah, it's like that.

AH: You've been a Rolfer for many years now. Over time people often develop their own style, bringing in things that interest them. Do you have a particular type of client you like to work with? A particular way of working?

YK: Not particularly. [I've been doing fewer sessions] these days, because I am doing so many other things, but I would like to come back to private sessions. People know me more as a Rolfer than anything else. If they ask me to do a Rolfing session, then I do that. If they say whatever I do is fine to help them out, then I try to find out what works best for the person.

In terms of Rolfing style, initially I had a very hard core, strong style, because I think that my experience of sessions from Emmett Hutchins was most effective for

my system, and his style was very, very strong. But this style, how can I say it, it's the attitude – it's not the effect of the work per se, but if it's so painful and you're willing to receive the pain, without resisting or disassociating (which can happen) . . . you have to be right there with awareness, not resist, but confront . . . cultivating that attitude as a client was a great help for me, for later on, for whatever I did, but actually my character tended to be like that already.

But I no longer do a strong Rolfing style because I'm not interested in the pain/intensity like I used to be. I was getting older, and people in general don't like pain anyway, so despite my own good experience I cannot push that to others who don't have as strong a will as I did. I was determined to study Rolfing SI and to get this, but other people are not.

AH: How did you learn to use your hands in a way that was easier for people, that had less pain? Did you make that bridge yourself? Or did you learn from somebody who had developed other techniques?

YK: I haven't studied from Rolfers in a long time, probably since my last training in 1997 or so. I did the Advanced Training with Jan Sultan, Michael Murphy, Ray McCall, and Karen Lacritz. Since then, I haven't taken any workshops with Rolfers, other than workshops I organized for Konrad Obermeier and Jim Asher.

In making the work softer, you make it easier, but it still has the same effect. There are many ways to do it. I get things from osteopathic stuff and Feldenkrais, etc., ways to use much less pressure or whatever. Biodynamics is totally different. I don't think it goes along with Rolfing sessions, I can't mix them. I don't mean it's bad to mix them, it's just that I can't. Let me clarify it a bit more. As a Rolfer I have certain ideas for what I would like to happen for a client, and intend to help that. I have an intention and suggestion through my hands and words. On the other hand, with biodynamics, I have no intention other than to be there with the client to support whatever is going on in this person's whole system, and causing as little disturbance as possible by being there. So I try to do nothing but be engaged, which is almost impossible for me.

I don't define the way I work as a style. Some Rolfers incorporate different techniques into their style of Rolfing work, and then they share their style of Rolfing work in a workshop. I don't have that kind of defined, definite style. But I'm open in the moment, and however I can figure it out, I do that. And then I don't try to keep whatever I do as the way to do it. So, each time, whatever comes up, that's that. And although I said I don't have a particular style, I notice that I do have a tendency to do the work in a certain manner, so maybe you could call it a style.

AH: So, it's in the moment.

YK: In the moment, because, for me, Rolfing SI is not a technique, but a way of thinking and a way of seeing. So, if I have the way of seeing, and try to perceive, then how to do it comes of its own accord. But for that to happen, you have to have many different things. You have the idea of what to do, or how to do, but that doesn't become a technique. It's just a toolbox. It's the tools and not the style of techniques.

So, the idea, the Rolfing way of thinking, needs to be there. I'm often asked, in different classes, do you mix something with Rolfing SI or keep it separate? And if separate, how do you maintain the distinction? All I do is change my frame of mind. If I'm doing a Rolfing session and using that frame of mind, I may use one thing and it's Rolfing work; if I'm working from the Feldenkrais framework, something technique-wise might be exactly the same, but if I use it for the Feldenkrais Method, it's a different thing. So, it's nothing to do with technique, it's about the way of thinking and seeing.

I remember when I had my initial admission interview for Rolfing training. These interviews had a notorious reputation for students because the interviewers tried to ask difficult questions in order to see how students responded. I was practicing Aikido and karate then, and one of the interviewers (they were all Rolfers) asked me how I could do Aikido and karate without mixing them up. I said, "They are totally different." The interviewer kept asking, "But how can you be clear without getting mixed up," or something like that. I was a little hesitant, I didn't know what to say, but then the idea came and I said, "If you play baseball you swing and hit the ball. If you play golf you swing and hit the ball also. But you don't think you are playing golf if you are doing baseball." I thought I nicely escaped their challenge. This can apply to anything that we think is similar but has a different idea or point of view: we can stay with the commonality to make them the same, or make clear distinctions in their points of view to see them as different.

AH: That's a good differentiation. What kinds of clients come through your door these days?

YK: Well, most have some physical disturbances, but at the same time, there is wishing for some psychological change. Most people who are interested in Rolfing sessions, it's something like that.

AH: Your business name is Chronic Students. Tell us about that.

YK: When Jim Asher was coming to Japan regularly, he called us (including himself) "chronic students." That's kind of funny, but at the same time, there's some truth about it. So, I decided to name my

For me, Rolfing SI is not a technique, but a way of thinking and a way of seeing. So, if I have the way of seeing, and try to perceive, then how to do it comes of its own accord. But for that to happen, you have to have many different things. You have the idea of what to do, or how to do, but that doesn't become a technique. It's just a toolbox.

business Chronic Students. Under that, I organize many different workshops. It used to be that I would find whatever interested me and then try to contact the person to teach. Like I got information about Tom Shaver DO from Kevin Frank; I heard he was teaching at Kevin's place and I asked him to introduce us, and that's how it started.

AH: Your Chronic Students group seems to have a bit of a parallel to the Munich Group, where they organize different classes for people. Who comes to the classes, are they mostly Rolfers?

YK: Some Rolfers, some osteopaths, a lot of laypeople also. It depends on the type of workshop. If it's manipulation, a lot of manipulation people, and of course chiropractors, Rolfers. In terms of other workshops, like Continuum or meditation, it's just anybody.

AH: So, you're good at bringing people together?

YK: Well, I'm not really a good business person.

AH: But it sounds like you find the people whose hearts are in it.

YK: Yeah, that's true. All these things have some common elements. Some people are taking one thing, and not other things. Other people are taking all these classes, and those people are finding something similar to what I feel, the commonality of these different modalities.

AH: How would you describe the commonality between those things for you?

YK: Gosh. How do I describe the commonality? It's very difficult to speak to it . . . You know, it's spirituality. So everything is nothing, but nothing is everything. And then trying to find out what's my part within the whole. And recognizing me as a whole, and individuality is a part of it. And trying to lose as much individuality as possible. It's a different state of mind where my individuality and personality is smaller.

It's already there, it's already functioning that way, but I may not recognize it. All these things – biodynamics, esoteric healing, or meditation – are trying to bring us up . . . But up is not a direction necessarily, it's a bigger arena. It's like one cell of my body recognizing the whole of me. Wherever the cell is, it's always me, part of me, and this one cell's identification can be of 'me' or of the whole. But this whole me of my individuality is in the same way part of a bigger whole, which I may not identify with when I'm in my smaller identity. Reality is dependent on where you put your mind.

AH: When you're with a client, do you sense how the client is also part of the whole?

YK: That's a difficult thing, because I can be too busy trying to figure out what to do with the client. It's easier when I do biodynamic work and esoteric healing, because you don't do anything in particular, or you do not to do. Setting-wise, it's already there – to see others as the same as you, and not a singular you but part of a whole. But Rolfing work or Feldenkrais is much more to do with this person in front of you, how this person can live life better, which is more like insisting on this [individual] figure and how to use this. So it's there with a quite different way of seeing it.

AH: Just the format we have of visual analysis in Rolfing SI, you're separating into two people. I'm looking at you, and I'm going to work on this shape that you inhabit.

YK: Right.

AH: It sounds like you are expressing something about non-dualism, and an inspiration to work from a place of non-dualism.

YK: Yeah. One of the people I also organize classes for, he's a Course in Miracles teacher, Gary Renard. He's talking about that as a non-dualistic teaching.

AH: Earlier you spoke about the nothing, I forget what your other word was . . .

YK: Nothing is everything. Everything is nothing.

AH: That made me think of the famous line from the Heart Sutra, "Form is empty, emptiness is form."

YK: That's fair, yeah. Form is empty, that's how it's translated in English right? Well, before that, it says, "Form is not different from the emptiness" or "Emptiness is not different from the form." That's the non-dualistic idea.

AH: It's an interesting place to work from, when you're working with a body, because a body seems solid, it seems to be something.

YK: Yeah. So I don't think I can do Rolfing work from that standpoint. For me, biodynamic work is the closest way to be involved with the body to be like that.

AH: When I requested this interview, you wrote to me, "I'm a boring guy to talk with." I haven't found the conversation boring. I'm reminded a bit of what Kurosawa Akira said when he accepted an honorary Academy Award – that he was still working to learn and understand the essence of cinema. I hear a similar humility from you, that for all of the years you have put in, you are still inspired to move to some greater understanding that you can sense and are feeling your way toward.

YK: Now, in 2020, it's been a year since we did this interview, and I can see what I was thinking last year. It may have sounded like I could work from a nondualistic frame of mind, but by no means am I able to. I was just trying to explain the commonality for me within the quite different modalities I organize classes for as Chronic Students. It sounded like I was bluffing – ha ha. Thank you for interviewing me and not getting bored. I guess I didn't think I'd have much to say unless you asked.

Yoshitaka Koda became a Certified Rolfer in 1987 and a Certified Advanced Rolfer in 1997. He has practiced in Japan since 1990. He is also certified in Feldenkrais Method, Continuum Movement, and Esoteric Healing (from INEH). Through chronicstudents.com he organizes classes in bodywork, somatic arts, and spiritual methods.

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Contributions from Japan and the East-West Interplay

By Masahiko Kushizaki, Certified Rolfer™, Rolf Movement® Practitioner

Masahiko Kushizaki

ABSTRACT *The author discusses the history of the Japanese Rolfing® Association (JRA) and a vision for development of the Asia region and for increased East-West interchange whereby some of the unique developments from Asia can begin to have an interplay with Western Rolfing methods.*

JRA's Organizational History

In this article, I will discuss my perspectives and suggestions on how the Japanese Rolfing Association (JRA) and the Asia region can contribute to the global community of Rolfers and our profession. This has been one of the important questions for our membership for many years. Recent experiences of cultural interplay, East and West, suggest that we have unique perspectives to bring to the Rolfing® Structural Integration (SI) conversation, that will foster interchange in the global Rolfing community. I hope this article will deliver a voice representing not only Japan but the whole of Asia which encompasses ethnic backgrounds, living environments, customs, and cultures that are largely different from those of the West.

The JRA was licensed as a regional international organization (RIO) under the Rolf Institute® [now Dr. Ida Rolf Institute® (DIRI)] trademarks in December 2004, which authorized it to operate a membership and educational organization using DIRI curricula, methods, etc. In accordance with Ida Rolf's wish that Rolfing organizations be established as nonprofits, the JRA worked toward this and was awarded nonprofit status by the Japanese government in 2006. The antecedents of the JRA trace back further, however, some twenty years, and at the time of the JRA's launch, there were around twenty Japanese Rolfers who had been trained at the Rolf Institute. Support for the establishment of the JRA as one of the RIOs came particularly through the endorsement of Jim Asher and Cornelia Rossi, who wished to create a strong

Rolfing community in Japan and more opportunities for Rolfers in Japan.

A Vision for Asia as a Region

The JRA membership is dedicated to the development and sustenance of our organization. We have set up an educational division as well as a sufficiently functioning organizational structure. We have offered workshops, events, and other training and continuing education (CE) opportunities, all of which are an essential part of ensuring our financial stability. With this functional framework as an organization, I believe it is our responsibility now to start considering how to expand the Rolfing community in more regions of Asia, and to consider what the Asian countries and our perspective can contribute to the global Rolfing community.

Rolfing SI is not yet widely known in Japan, and hardly known in Asia as a whole, so we need to start with a clear vision. We must first gain recognition and trust for our work through the region. A good starting point would be the JRA building stronger relationships with Rolfers in neighboring countries so that we can share knowledge and information. In my opinion, this will require us to break free from the cultural restrictions and certain fixed ways of thinking that can easily be blind spots in more mono-cultural nations like Japan.

Rather than view the JRA as a uniquely Japanese entity, my view is that it would make sense to restructure our organization and our training programs to a more regional perspective to support the spread of Rolfing SI throughout Asia. Developing our Asian Rolfing community more broadly, then interacting with the RIOs and Rolfing communities in other areas of the world, will all be steps that will facilitate the integration of any uniquely Asian perspectives and contributions into our Rolfing practice.

Bridging from Experience

While many of the JRA's initial efforts were oriented toward developing and supporting Rolfing SI and Rolfers in Japan, there was awareness that we were the first Asian Rolfing organization, and that our work could be a template for further development in Asia. With this in mind, it's useful to reflect upon what we have developed and accomplished so far.

Every organization requires financial stability, and the JRA has supported itself through offering four Basic Trainings and a number of continuing education (CE) classes. These courses were initially developed to target Japanese students, and most of the participants have been Japanese. Before this, Japanese people who wanted to study Rolfing SI had to travel to the U.S. or Europe, often incurring additional costs to bring along a translator. Moreover, after becoming certified as Rolfers, it was a burden to have to travel overseas for CE. Although it is beneficial to offer trainings and CE classes locally in Japan, fees and tuition is typically higher than in the U.S. or Europe because of a lack of local instructors, the high cost of living, and the expense of bringing in instructors from overseas.

It is definitely desirable to modify our educational system towards a more regional perspective. Attracting more non-Japanese participants, especially students from other Asian countries, will bring in a wider variety of perspectives and add more depth to the courses. This was my experience when I participated in European trainings as part of my certification. I had the opportunity to study with a diverse group of students, and to learn from instructors of different nationalities, each of whom offered a truly creative learning space with their own unique personality and perspectives. This was not without a learning curve: since it was my first experience studying outside of Japan, it took me quite some time to get used to the new culture(s) and to feel part of the group.

From what I observed, classes in the West place much more emphasis on class discussion, allowing the instructor and students to create the learning process together. On the other hand, Japan education traditionally focuses more on students listening to the instructor to absorb knowledge. This conditioning, rooted in our culture and educational system, as well as students' English-language limitations, can affect how Western instructors perceive Japanese students. To a Westerner, we may seem passive. Our culture's view of what is considered acceptable leads to high value being placed on harmony and cooperation. While there is a beautiful side to this, it can also mean that people are sometimes pressured to accommodate others by suppressing oneself, which can lead to extreme altruism and habitual thinking.

Expanding our community into a larger community of Asian Rolfers will bring in both diverse, as well as, reinforcing perspectives. Japan and other Asian countries share much in common. There are similarities in educational styles, and for most Asians, English is a second language. These aspects may foster a regional unity for Asia within the global Rolfing community and support our intra-regional development and communication.

Even within Asia as a region, however, there are different cultural backgrounds, historical backgrounds, and economic conditions. Thus, there may well be cultural constraints that will interfere with the sort of pan-Asia Rolfing community that I envisage. In order to prevent such problems, I think it is desirable that we respect each other's cultures and styles. The JRA sharing its expertise may be merely a step to coming up with new concepts within a multinational organization for the Asian region. For example, it could be important to hold trainings elsewhere in the region. Someone organized a Basic Training in Indonesia in the past, and the draw of such a location that offers both a rich cultural and natural environment with lower local costs would surely also attract students from outside of Asia (e.g., Europe, North America).

Overall, the JRA expanding its activity as an organization would bring Rolfing training to a more diverse group of Asian students and

The creation and cultivation of Asian concepts and contributions will help our global community grow, adding new perspectives and more creativity in the field as a whole, just as we have seen with contributions from Brazil and Europe.

Figure 1: Participants at a JRA workshop, with the author on the far left in the front row, wearing a mask depicting Hyottoko (a traditional comic character in Japan; see https://en.wikipedia.org/wiki/Hyottoko), and then instructors Hiroyoshi Tahata and Nicola Carofiglio (front row, second and third from left) wearing traditional kimono attire.

create opportunities for cultural exchange and nurturing friendships. According to Marius Strydom, Rolfing trainings in South Africa have attracted an increasing number of students from Asia in recent years. Creating more opportunities for those who would like to study to be Rolfers and who would like to do CE closer to home in Asia would be a wonderful way to nurture a sense of regional community and rapport.

Figure 2: Rolf Movement Instructor Hiroyoshi Tahata giving a demonstration.

Developing Teachers

A longer-term goal of regional training opportunities in Asia will be future teacher development. Currently, we have only one Japanese faculty member, Hiroyoshi Tahata, who is a Rolf Movement instructor. He conducts regular CE classes for Rolf Movement work, but other CE workshops require the JRA to invite instructors from other countries, as we have done for the four Basic Trainings held in Japan so far. (The only other Asian faculty member is Ashuan Seow, who lives in Australia.)

Future growth in the region may to some extent hinge on training experienced local practitioners as faculty, as a regional teaching pool to draw on would help reduce training costs.

Unique Developments and Perspectives

Just as Rolfers in the U.S., Brazil, and Europe have brought forth unique approaches and important developments in our work, we can expect the same from regional development in Asia. We are already seeing manifestations from this in Tahata's work, which has been profiled on various occasions in this Journal. Tahata devised a unique method called the Art of Yield (Agneesens & Tahata 2012, and Tahata 2012) or yielding that diverges from conventional Rolfing methods while working within the Principles of Intervention and achieving standard Rolfing goals. The method draws on his knowledge and experience as a cell researcher and was developed through comprehensive research and clinical experience. It also draws on Asian culture/ traditions, particularly how he has extended his work with yielding to include the Japanese concept of '*ma*' (Tahata 2018). His method, which many Rolfers in Japan integrate into their practices, can be considered a particularly Japanese approach to Rolf Movement.

Another Japanese Rolfer bringing in unique cultural influences is Tsuguo Hirata. He and other Japanese Rolfers have studied with a traditional ninja martial artist and are considering how those ideas can be brought into our work (Hirata 2019). He has also written for this Journal on other matters related to Japanese culture or his own unique perspective (Hoff & Hirata 2017, and his latest article on page 73).

Notably, Tahata and Hirata both are able to communicate their work in articles

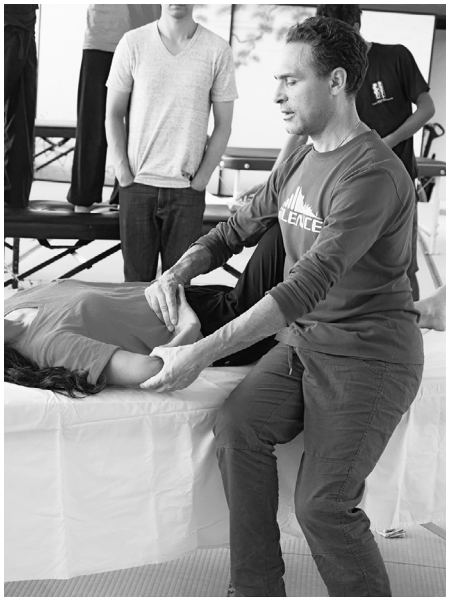

Figure 3: Rolf Movement Instructor Nicola Carofiglio giving a demonstration.

written in English. With resources to cover translation costs, we would no doubt have a larger pool of Japanese and other Asian practitioners who would have unique ideas and perspectives to share, both now and as the regional community grows.

A Unique East-West Interchange

Unconventional and unique methods like Tahata introduced with yielding and ma may take some time to be accepted in other cultures or into the standard Rolfing canon. The creation and cultivation of Asian concepts and contributions will help our global community grow, adding new perspectives and more creativity in the field as a whole, just as we have seen with contributions from Brazil and Europe.

As an interesting example of the cross-cultural interplay that is possible, I'd like to share the story of an educational project the JRA held last year – a workshop where two instructors who had never met offered an impromptu East-West collaboration based on a theme and keyword. Nicola Carofiglio, Rolf Movement instructor from Italy, had long been intrigued by Asian cultures and traditional ways of thinking. We invited Carofiglio, who was inspired by Tahata's Art of Yield approach, to teach two workshops with Tahata. The first was called Em-body Orient/Occident; the second was called Ultimately Rolfing Is for the Rolfer (based on a quote from Ida Rolf). Both classes had mixed groups of Japanese and European students. Workshop photos are shown in Figures 1, 2, and 3.

Carofiglio seemed to be aware that Japanese learners expect an instructor to teach, as he told us right away, "I'm not here to teach. I'm here to share with you what I know." He made sure to add that thoughts and suggestions were more than welcome, as they would be very useful reminders and inspirations for the instructors, as well as present different and valuable perspectives for collaboration. His words definitely helped all the students feel safe and comfortable. While I have experienced similar thoughtfulness from instructors in other courses, it felt especially meaningful as Carofiglio's clear intention was to create a safe space in line with the theme of the workshop, to offer a token of respect and appreciation to a culture where he was teaching for the first time. The groups seemed to appreciate the way of teaching: offering a space that focused on sharing thoughts, knowledge, and exploring together as a group.

Despite the fact that it was the first time for the two instructors to meet, let alone work together, the outcome was incredible. Presented with the theme Em-Body Orient/Occident, they generously and spontaneously shared the fruits of their research and experience as if in an improvisational play. It felt like witnessing life itself, everything coming together organically without a script. I wonder what impressions have been left on the bodies and minds of the others who were present in that special time and space. For me, every moment we shared is still vividly present, which I attribute to the sense of awe and fundamental oneness the two instructors held within themselves. While Tahata's approach focused on space, Carofiglio's emphasis was on the physical senses and how the body as a medium experiences oneness. It was a remarkable workshop where two teachings constantly echoed each other perfectly.

I was not alone in being inspired. Another participant, a Rolfer from the Netherlands, praised the way the two instructors inspired each other in their demonstrations, saying that he could find in their exchange the type of friendship that the Ancient Greeks considered most valuable – referencing Aristotle who wrote, "Perfect friendship is the friendship of men who are good and alike in virtue" (Book VIII, Nicomachean Ethics).

Looking Forward

These workshops with Carofiglio and Tahata certainly offered a new and unique experiment of demonstrating the importance of not only sharing knowledge, but also perceiving sensation through the body in order to be truly present as oneself, from the different perspectives of East and West. I felt we took a significant step toward the integration of Orient and Occident, East and West, and this inspires me in my thoughts of what the Asia region can contribute to global Rolfing SI, which has so far been more of a Western development.

Carofiglio has long been seeking to find a universal key for all human beings by integrating perspectives of Asian traditions and cultures into his practice. Since his visit, which prompted new insights, he continues his inquiry and speculation. We all look forward to his next visit and his new findings. We hope that other Westerners will also find that integrating unique perspectives and concepts from the East, whether traditional elements or new developments in our Rolfing community, will be helpful to further develop their practices.

The attendance by several other participants from Europe indicates increasing interest from Western Rolfers in Tahata's methods, which have already been gaining popularity in Japan. There was interest in bringing Tahata to Europe to teach, which would be another wonderful cross-cultural exchange. As the coordinator for this particular JRA workshop, I fully support any arrangements to nurture this budding trend. Interest in one of the methods developed in Japan is already a positive indicator for the Asian development proposals I make in this article.

The JRA recorded an interview with the two instructors, and published their feedback and comments in the Journal of The Japanese Rolfing® Association. While the article is in Japanese, and may not be accessible to most readers of this Journal, you can view some videos with English subtitles on YouTube at this link: http://www.nicolacarofiglio.it/mediateca.

Conclusion

Throughout human history and cultures, we see that people value their own traditions but also thrive when exposed to new perspectives from different cultures and their unique perspectives. Creativity is the driving force behind the development

of modern society as well as human evolution. Cross-cultural exchanges such as I describe have the potential to foster creative evolution in our Rolfing work. As we cooperate to turn those ideas into reality, we will nurture a sense of community and enable more possibilities to develop. We at the JRA hope to take part in creating a mature society, in both the Rolfing community and society at large, where everyone feels pride and respect for their own and others' identities, and where harmony and trust are valued.

Adopting a global perspective and staying up-to-date with changing circumstances will be essential for our profession. Closer collaboration of the JRA with Rolfers and prospective Rolfing students in other Asian countries has the potential to celebrate our diversity of cultures and share our experiences to build a stronger Rolfing community in Asia. With that development, we have a broader platform for regional contributions to the global Rolfing community. It is my hope that we will continue to learn and grow as part of the global community, and that someday this wonderful method/culture called Rolfing SI will reach throughout the gravity field on this planet.

Author's Note: I would like to thank Rolf Movement Instructor Hiroyoshi Tahata for encouraging me to write this article. I would also like to thank Anne Hoff for her editorial help in bringing the English manuscript to its final version.

Masahiko Kushizaki is a Rolfer and Rolf Movement practitioner living in Fukuoka, Japan. He has been certified for about three years, and incorporates in his work the yielding work developed by Hiroyoshi Tahata, as well as exploring the integration into Rolf Movement and Rolfing methods of Tahata's concept of spatial somatics employing the concept of ma. He fosters professional development by coordinating various workshops. He enjoys surfing and trail running in the mountains to pursue various states of physical sensation and perception.

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An Exploration of Bone and Brain, Tension and Gravity

By Tsuguo Hirata, Certified Advanced Rolfer™, Rolf Movement® Practitioner

Tsuguo Hirata

ABSTRACT *The author explores tension and the interface between tension in the mind/brain, muscles, and around bones. He introduces techniques of bone awareness and weight-transmission through bones as a means to retrain the brain and to allow deep tension to release and relates these to Dr. Rolf's maxim that gravity is the therapist.*

Introduction

Tensions limit movement of our bodies, but also our senses and motives, suppressing our potential. We hold tension at many levels, caused by many factors. One level of tension relates to the brain. Part of this is mental stress, ways that we use our minds to try to resolve difficult situations, generating both mental and muscle tension. When our energy goes into thought, the brain is focused there rather than on coordinating muscles. Another level of tension is in the muscles, which can be from physical activity, or from mental stress. There can also be tension held at deeper tissue layers close to the bone, such as shortened ligaments. This tension is often unconscious and may relate to old injuries, scars, etc. While not noticed, such rigidity around joints is likely an energy drain, impacting both movement and proprioception. These tensions all interrelate, of course. Particularly, when our body use is not optimal in relation to gravity, and when the transmission of weight is felt more in muscle than bone, it leads to deep patterns of body tension that also are conditioned in our perception and thus our brains.

It is my belief that muscle tension will often remain chronic unless the client employs both conscious physical methods as well

Figure 1: Hand Fan exercise.

as mental relaxation. What I'll call 'brain tension' we can alleviate by changing our views or attitude towards situations that cause distress, such as through Somatic Experiencing®, meditation, or a continual determination of will. Common muscle tension can be addressed through stretching, but the tension in the deeper layer around bones is best resolved through developing what I call bone awareness. We can learn to sense and direct weight transmission through bones, and also learn to touch in ways that access and hydrate/liberate tissue layers close to the bones. As we come to perceive these layers, we are giving new options for both movement and the brain.

Journey to the Bones

We are living in a three-layered body. The outermost layer includes skin, body contour, and our senses. We see and recognize each other by this outermost layer. The second layer is muscles, blood vessels, and nerves. Here we feel the power of movement, warmth, pain as proprioception, or liveliness in the body as a mixture of excitement and emotion. The innermost layer is bone and cartilage that gives structure, but we don't relate to this layer consciously in our daily lives. Rather, based on sensation we tend to think we 'live' in our muscles. Their contraction and extension gives tension feedback, for better or worse. It is my contention that releasing tension at this innermost layer, and learning to bring awareness to bone and what I call 'bone movement' revivifies our potentiality to manifest a lightness of body, open awareness and perception, open clarity of observation, unimpeded body movement, and the like. Also, this sensing of the deep layer of the body can be objectified so that we feel more vitality and well-being. I believe it will have a reciprocal effect on muscle and brain tension.

How do we leave the domain of muscle tension (the usual state in which we live) and move into the world of the bones? I believe we bring this deeper layer to consciousness by developing bone awareness and bone movement. Key to this is putting weight through the bone axis or bone midline. The next section will guide you in the practicalities of developing bone awareness. When that is established, you will be able to guide your clients.

We can learn to sense and direct weight transmission through bones, and also learn to touch in ways that access and hydrate/liberate tissue layers close to the bones. As we come to perceive these layers, we are giving new options for both movement and the brain.

Bone-Awareness Exercises

Hand Fan

We start with our own awareness. First, here is an exercise called Hand Fan to develop bone awareness from hand to radius, humerus, and scapula. This exercise originally was developed among practitioners of Daito-Ryu Aiki Jujitsu, the antecedent of Aikido.

Widen/open one of your hands by being aware of the metacarpal bones, not the fleshy fingers. First extend your little finger

Figure 2: Shifting Weight, Shifting Brain exercise, done in a chair.

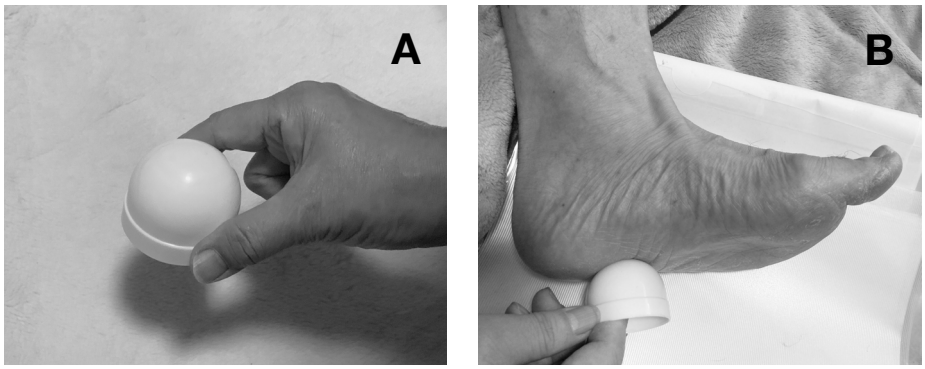


Figure 3: Preparation for Standing Bone Transmission exercise. Find a prop of the size and shape shown in (A). As you do the exercise, you will be standing with it placed in front of your heel in the location shown in (B).

backward and spread it wide. Then also extend your thumb towards you and wide. Then add in extending and spreading your index finger. Finally add in extension and spreading of the middle finger and ring finger so your hand is fanned open with fingers lengthened and extended as seen in Figure 1. Feel the sensation of all of the metacarpals extending and opening fully like a fan. Do this exercise as many times as you can in your spare time. This can help opening the interosseous membrane of forearm.

Shifting Weight, Shifting Brain

Our next exercise, Shifting Weight, Shifting Brain, works with weight transmission through the bones of the arms, which develops bone awareness and also challenges fixed patterning in the brain of how we get our support (in this way, addressing brain tension as well.) There are two variations for the starting position. One is to sit on the floor with your legs extended and spread wide, and to open both hands and place the carpal bones close together on the floor near your pubic bone. The alternative is to sit on a wide chair with your legs spread, here placing your hands on the edge of the chair in front of your pubic bone.

Then, from either starting position, extend your elbows and let your scapulae move forward to support your weight on the carpal bones through the radius, humerus, and scapulae. Your body, especially the ischia, should lift from the floor or chair just a bit as seen in Figure 2. This gives the experience of your whole body, including the pelvis, being supported by your hand/arm bones. This exercise requires more than your weight shifting to be supported by the arms (rather than by legs and hips); it also challenges your brain to adapt so as to accept this change from the usual support configuration. It means our weight support is changed to the new route of hands and arms instead of the old route in which our weight should be supported by feet, legs, and pelvis

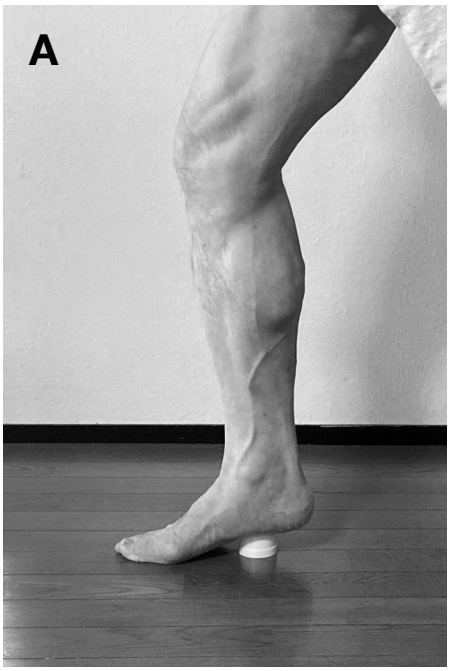
Standing Bone Transmission

Our next exercise requires a half-round item as a prop. Find something similar in size and shape to what is shown in Figure 3 (A), which is the plastic cap from a salad-dressing bottle commonly found in Japan. (Once you understand the exercise, you can be creative in coming up with something similar.) In the exercise, you will be standing on this prop with it placed in front of your heel in the location I show in Figure 3 (B).

Standing, with one foot forward, put your weight into your back leg so that you can place your prop in position ahead of the heel of the front foot as seen in Figure 4 (A). As you bring your weight to the front foot, checking that you are squarely over your prop and also that your femur, knee, and tibia are aligned over the foot as shown in Figure 4 (B). Feel your weight transmitting through the bones from femur to tibia to talus to foot arch. Now shift your weight between the back and front leg thirty times. As this will lengthen ligaments attaching to the calcaneus, the exercise may cause slight heel discomfort as you begin doing it, but over time this exercise will realign not only the ankle hinge but also the knee hinge.

Cartilage-Layer Access Touch

Our next exercise is to access the cartilage layer attaching to the closer end of a bone. The cartilage layer covering a bony surface should be active and elastic. Fibers extend from the cartilage and interweave with tendon attachments and ligaments. Over time, the functionality of cartilage can decrease as it loses fluid



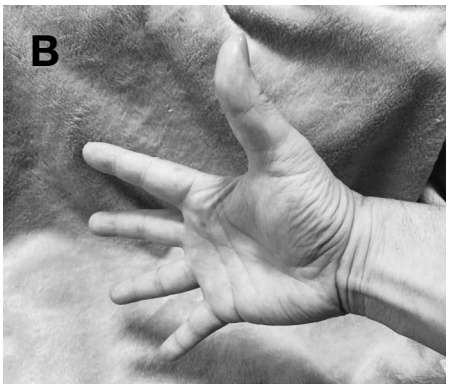


Figure 4: Standing Bone Transmission exercise. (A) side view. (B) front view showing correct alignment of femur over tibia, talus, foot.

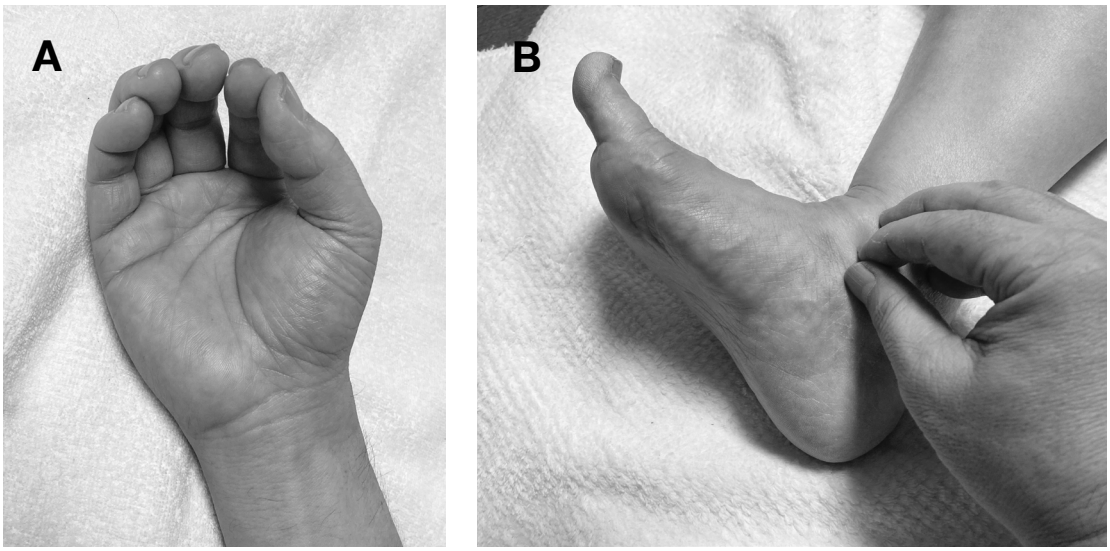


Figure 5: Cartilage-Layer Access Touch. (A) the 'claw' you use to direct pressure and palpate. (B) example of palpation at ankle.

content and becomes more fibrous. At the same time, tendons and ligaments it intermingles with may have shortened and become rigid.

The cartilage layer is below tendons/ligaments and relatively insensitive in comparison. To find this layer, you will use your hand like a five-finger 'claw' as shown in Figure 5 (A). In Figure 5 (B) I show how you can position this claw over rigid fibers of tendons or ligaments you find around a joint. Use the bones of your fingertips to direct pressure through the tendon/ligament layer to the cartilage layer (a very thin layer between the tendons/ligaments and the bone). Once you are at that layer, you won't feel the same intensity as you felt at the tendon/ligament layer. Hold twenty seconds and feel for the cartilage layer to expand and recover its elastic quality. This can be practiced at any joint as you practice to develop confidence in perceiving and palpating the cartilage layer.

We access the cartilage layer so that it can recover its elasticity. Also so that we can perceive this deep layer and access it in movement as part of our shift from muscle movement / muscle tension to bone awareness and bone transmission. My thinking about this layer was much inspired by Dr. Ida Rolf's book *Rolfing: Reestablishing the Natural Alignment and Structural Integration of the Human Body for Vitality and Well-Being* (Rolf, 1989). I encourage you to refer to her descriptions and explanations of the joints and bones in Chapter 11.

Gravity Is the Therapist

This article was originally slated for publication earlier in the year, but the publication schedule was disrupted, as was so much in our world, by the COVID-19 pandemic. As I had to close down my Rolfing® Structural Integration (SI) practice, in June I started a weekly study group to read and translate into Japanese Dr. Rolf's two books, the aforementioned *Rolfing: Reestablishing the Natural Alignment and Structural Integration of the Human Body for Vitality and Well-Being* and *Ida Rolf Talks About Rolfing and Physical Reality* (1978). Our purpose has been to find her intentions directly in her words and to understand deeply her message. For me it has been a great opportunity to unearth the treasures of Rolf's discoveries. As I go through the pages, I have been inspired to develop new movements and various types of touch. I first got these books nineteen years ago but did not go through them completely. Now, with nineteen years of experience and questions about Rolfing SI, I am finding even more trust in her ideas and learning deeply from re-reading them.

Moreover, I am inspired that we Rolfers and SI practitioners have a particular role to understand and share her vision with our societies in current times. Rolf proposed that our body structure and movement should be in accord with gravity, and that the result would be increased potential for vitality and well-being. This is not addressed in the medical field, nor in other forms bodyworker. Fascial work and muscle training alone are not a solution. Rather, it is by understanding the relation between tension and structure, as well as by acquiring a sense of weight-through-bone transmission, that we can find harmony between the human form and the gravitational field. That is a *real* balance I think. I hope many Rolfers will enjoy exploring my bone-awareness exercises and touch and use that to benefit others and enrich their Rolfing practices.

Author's Note: I'd like to thank Anne Hoff for her help in editing this article.

Tsuguo Hirata is a Certified Advanced Rolfer and Rolf Movement practitioner living in Yokohama and practicing in Tokyo, Japan. He incorporates ninja movements, yoga movements, and other martial arts into his Rolf Movement and Rolfing practice. In addition, Tsuguo's interests have led him to study osteopathic biodynamics, Somatic Experiencing®, and the Barral Institute's curriculum of visceral, cranial, peripheral nerve, and vascular articulation work, all of which he draws upon. Tsuguo's concern lies in how to explore and manifest our potentials and share those secrets with our society. He would like to continue to introduce other excellent Japanese-origin bodywork techniques and ideas to Rolfers worldwide.

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Evoking Embodiment Through SI

An Interview with Michael Polon

By Daniel Akins, BCSI, and Michael Polon, Rolfing® Instructor

Daniel Akins

Michael Polon

ABSTRACT *In this interview conducted in the autumn of 2019, Michael Polon, faculty with the Dr. Ida Rolf Institute®, discusses how current neuroscience can help structural integrators of all experience levels create more meaningful and effective clinical experiences for their clients, both within and outside of series work. He begins by describing various physiological mechanisms involved with the experience of touch from skin to brain and back again, then provides detailed examples of clinical application.*

Editor's Note: This article also appeared in the IASI 2020 Yearbook of Structural Integration*. We have made some modifications here for our journal style.*

Daniel Akins: In your presentation at the 2018 International Association of Structural Integrators (IASI) Symposium, you said that your curiosity as a student, a teacher, and a practitioner has become guided by questions about where our experience of what it's like to live in this body comes from and how the work of structural integration (SI) might affect, support, or change that. You spoke of how input to the brain from our physical form, memories, emotions, expectations, and beliefs interact in complex ways to result in our present-moment lived experience. How has your inquiry developed over the year-and-a-half since then?

Michael Polon: That's a long question with lots of factors. My inquiry is still very much alive in all of those aspects which we could bucket into the terms that the neurological world uses – including some in the [SI] world – which would be a 'bottom-up' set of interactions and a 'top-down' set of interactions. I think it's useful to explore those terms before we get to a big topic, a present moment lived experience, a salient unit of awareness, even in so far as what somebody bases their desires and goals off of, as in why to even pursue the work to begin with. I think it would be helpful to see what the work looks like from a bottom-up view, then from a top-down view, and then show how this experience of touch, of movement, of therapeutic presence changes the moment-to-moment experience.

Do we *have* to alter anything in the fascia to create meaningful change? *Can* we alter anything in the fascia that would support long-term change? And how does our work with *people*, as opposed to specific tissues, create short and long-term gains that are hopefully in accordance with what people's goals are?

DA: Let's start with the bottom-up view.

MP: Bottom-up – another way of saying that would be an 'outside-in' view – is how I learned the work initially. It's been my experience, in my early days as a student and a practitioner, that this is how the work was most commonly talked and written about. Bottom-up, in this case, refers to anything that the periphery of the body would deliver 'upstream' to the central nervous system, to the brain. Bottom-up is all about how to make impacts on peripheral receptors, peripheral tissues, in so far that that would turn into some kind of 'shift' for the client. The way I learned the work originally was almost exclusively bottom; there wasn't that much up. It was the tissue plasticity model where we looked at a body as a collection of tissue patterns – maybe they were considered flaws or faults – and we looked at making some kind of plastic or viscoelastic change to the fabric of that pattern.

DA: I often hear it assumed that freeing fascial restrictions is the primary thing we're doing, and then, secondarily, we educate the client to embody their altered form. Is that what you typically hear or have heard?

MP: I've heard something to that effect, for sure. My response to that assumption speaks to an overarching principle and an alternate, perhaps more science-supported view: Do we *have* to alter anything in the fascia to create meaningful change? *Can* we alter anything in the fascia that would support long-term change? And how does our work with *people*, as opposed to specific tissues, create short- and long-term gains that are hopefully in accordance with what people's goals are?

The bottom-up idea, going back to a fascial distortion model like when I first learned, was looking for deviations in posture, altered range of motion, or places where people hurt and assuming that that was a product of faulty fascia, typically in the terms of an 'adhesion'. The problem with that approach – which would be all-bottom since there's hardly any information needed, it's just a matter of manipulating the fabric – is that it assumes that what we think we're doing, we're actually doing. There's been some science in the last few decades and which continues to roll out that brings some serious questions to whether or not that's actually possible with the tools we have at our disposal – in our case, manual therapy.

Looking beyond a simple fascial distortion model – like we're just rolling lumps out of pizza dough or ironing creases out of clothing – what's been brought to light by the movement community, whether it's the movement community at the Dr. Ida Rolf Institute® or other movement practitioners in and outside of the SI world, their focus seems to have been much more of an *informational* model as opposed to a *deformational* model, deformation meaning all we have to do is deform and reshape the fabric. It almost invites a lack of care for the client's experience, which seems ridiculous to say. I don't think there are many practitioners out there that would suggest their clients' experience of the work doesn't matter to them, but *because* it matters to them it's obvious that there's more happening than just the fabric reshaping. With these insights from the movement side of the work and other significant inputs to the field of SI, we start to embrace the idea that it's the information that gets transmitted through a touch exchange that has a lot of potential gain for us to pay attention to so that we can make SI work better in specific ways that are aligned with our client's goals, like addressing some kind of injury, pain pattern, or something specific to the way that client experiences themselves which may be a little different than the next client that walks into your office.

When we look at touch as information it makes us do a little bit of homework in terms of physiology. We must ask, how does the myofascia or all of the tissues that are around and superficial to it – the skin, the hypodermis or superficial fascia, the adipose layer – how do they listen to touch? What do they experience in terms of neuron sensitivity – whether that's free nerve endings or mechanoreceptors – how does all that tissue peripheral to the myofascia pay attention to the touch information that we give during the session? What does the spinal cord, as the first stop for that information, choose to do with that? It either inhibits it right then and there or transmits it up to the brain, and then what does the brain do with it and the various locations to which it will deliver that information?

So that's the bottom-up view: touch as information creating impulses to carry towards the central nervous system that start to make shifts that actually change part of the experience of what it feels like to be us moment-by-moment, second-by-second – as opposed to the long duration that tissues would need to make a shift.

DA: Would you elaborate on some of those specific bottom-up factors that we might be influencing through our work?

MP: Yeah. The classic 'fascia is alive' idea that got popularized with Robert's Schleip's work, certainly in that 2003 article. I forget the exact title.

DA: The "new neurobiological explanation" articles (Schleip, 2003a, 2003b)?

MP: Yeah, those really opened the door to start looking beyond just mechanical deformation. He outlined a lot of different feedback loops that are affected by touch. The mechanoreceptors that he pointed us to in that article were the popular ones: the Ruffinis, the Pacinis, the Golgi tendon organs, but then he also made allusion to these free nerve endings, these unmyelinated C-fibers. This is a place I've actually studied quite a bit, and it seems like the world of affective neuroscience has a lot to teach structural integrators.

We know that the Ruffinis and the Pacinis are scanning for different types of feedback. The unmyelinated C-fibers have typically been classified as *nociceptors*, which aren't quite 'pain receptors', more like 'danger detectors'. Then the world of affective neuroscience has exposed this whole other big network, almost like a subsystem within the afferent nerves. They're also unmyelinated, they're also C-fibers (which just indicates the size and conduction velocity), but they're referred to as *C-tactile fibers*. When you look at this C-tactile subsystem, what you see is a vast network that outnumbers the rest of the proprioceptors on the order of about seven to one.

Why is this important? The classic network of touch detectors that Schleip pointed us to in 2003 tells us a lot of information in the realm of exteroception, i.e. what's touching us. It also helps us figure out where we are in space, i.e. proprioception.

What the world of affective neuroscience shows us from these C-tactile fibers – which, again, far outnumber the proprioceptive group – they inform us about *interoception*, which is a buzzword in the neuroscience community in the last five to ten years. Interoception is less about, "Where is my body and what is it doing?" It's more about, "How do I feel about what's happening?"

Clients, for the most part, seek SI because they're wanting to feel different. This interoceptive network is the gateway to modifying how it feels to be you on a second-by-second basis. So being aware that this system exists and what types of touch really excite it is a huge value gain for manual therapists and SI practitioners, for sure.

DA: This C-tactile fiber subsystem is located where? You're saying we directly interact with this network through touch?

MP: Yes. These fibers are there to code for how we feel about the touch that is being applied to us. They are for affective touch, meaning, "How does this touch affect us? How do we feel about things?" They code for what most of the literature calls *pleasant touch*, but pleasant is a subjective term: what feels pleasant to me may not feel pleasant to you; what feels pleasant to me on my hamstrings may be different on my quadriceps; it may be different from Monday to Tuesday; it may be different from practitioner to practitioner, client to client. So, "What does pleasant actually mean?" is a great question. Each client's experience receiving touch, how that fits into their goals, what they think they need, all of those questions go into whether something feels pleasant or not.

This is what ties into meaning. Pleasant, to me, might mean really strong, heavy-handed touch because that's what I think is good for me. Pleasant, to someone else, might be very light, just the weight of their hands, more of a cranial touch, because that's what their nervous system lights up to. It makes our work have to be meaningful to our clients if we want to create the most potential possible. Our clients' experience drives the meaning, not what we think we need to apply to deform the fabric.

DA: Could you help me understand these C-tactile fibers more clearly? My understanding of nociceptors is that they aren't receiving information about pain, per se; they're receiving information about temperature, degree of force, and other such factors, sending that information to the brain which then decides whether or not a threat is present.

You're talking about these C-tactile fibers coding for not threat, but for pleasant touch. What is the raw information that these C-tactile fibers are receiving? And is that encoding happening at the level of the periphery, or is it happening centrally?

MP: Great. The peripheral receptors are only specific to three types of detection: They can either detect chemical stimuli, thermal stimuli, or mechanical stimuli. Some of these receptors can be polymodal, meaning that they scan for more than one type of information. The key to answering the question you asked about where the encoding happens is to look at where the bottom goes to the up-structures. All the peripheral receptor can do is become excited. In this case, these C-tactile fibers are just excited by mechanical pressure. In our case, it's touch.

Touch travels along these unmyelinated nerves, they do their thing into the dorsal horn of the spinal cord. In the spinal cord, some very complex immune / endocrine-system factors then decide to either inhibit or facilitate the next neuron in the chain, and that goes up to the brain. The big difference between nociceptors and these interoceptive nerve endings is the delivery site in the brain. The C-tactile fibers end up having synapses in an area in the brain called the *insular cortex*. The insular cortex is not concerned with proprioception, like the *somatosensory cortex*.

The insular cortex is involved with creating the experience of *how* we feel in this moment – not necessarily where we feel or if we're moving, like the proprioceptive networks are trying to code for – the insular cortex has everything to do with how you feel. So if you want to create an experience of feeling different, this network of neurons is a great pathway to shifting that. This is stuff we've been doing for sixty years. Now that we know we're doing it, we can do what we do a little better, more efficiently, in ways that are more client-specific.

DA: Could you give an example of how this might show up in practice, how we might affect the insular cortex of our clients through these C-tactile fibers?

MP: We're doing this all the time, whether we know it or not. Even if you're doing a classic myofascial technique you're still affecting this highly complex set of neurons, all the way from the mechanoreceptors that Schleip mostly talked about to this subset of C-tactile afferents; any time a body gets touched, all of these neurons are active. The thing I'm most excited about is educating practitioners that there's this huge window of opportunity beyond the viewpoint of just reshaping fabric. If you do a forearm stroke up somebody's hamstrings you're stimulating the Ruffinis, the Pacinis, the free nerve endings that have classically been categorized as nociceptive, but you're also stimulating these tactile nerve endings. The more pleasant (think meaningful or useful) the touch feels, the more it's going to light up in the insular cortex – again, that's the spot that changes how it feels to be me, how it feels to be you, in the moment.

One way to elicit more of a top-down response, to prime the insula to be more interactive with the information it's receiving, is to ask the client, "What does this feel like?" and to be curious about their moment-to-moment experience. Some schools of thought, in terms of SI education, really focus on this part; other schools don't. This is a major opportunity for the practitioner to evoke more meaning out of every intervention by being curious about what's going on in somebody's world of experience. That may include using something like imagery, an inner vision of what's happening under the skin, or even just some descriptors or adjectives about what the touch feels like. Whenever we ask clients to 'come to the touch' by qualifying how it feels, we start to prime the insular cortex so that *they* have to 'ping' the insular cortex, and then they start to assemble

more meaning out of the information that had been going there the whole time.

DA: You're saying that it's essential to the quality of our work with clients that we are attentive to and prioritize their present-moment experience. Are there any other bottom-up factors that you find important?

MP: Yes, there are several other bottom-up responses that are often at play in bodywork. It's important to take note of a couple of very convenient and, at times, confusing touch feedback loops – confusing because they are often times effective yet short lasting in response to classic SI-style touch. The ones that come to mind both revolve around something that doesn't feel good, like tension or pain. If somebody says they feel tight, or they feel pain somewhere, there are a couple of feedback loops along this bottom-up style of thinking that can trick a practitioner into thinking that they have resolved an adhesion.

When something is hurting or feeling tight, if we stimulate those Pacinis or Ruffinis with either our classic style of SI touch or with some of the faster-moving massage techniques like effleurage or petrissage, or even rubbing a boo-boo on a kid's knee after he or she falls off the slide on the playground – stimulating these mechanoreceptors will inhibit the nociceptors from being able to propagate their signal from bottom to top. It's why we tend to rub things when we hurt them: If we slam our shin into the coffee table, we rub it; if we smack our hands onto the countertop, we shake it so that we inhibit these nociceptive mechanoreceptors. This will commonly shut down something acute or maybe even a persistent pain, giving the practitioner and client the experience that whatever was driving that pain has just resolved. The problem with this feedback loop – which is called *ascending inhibition* and is featured in Melzack and Wall's *gate theory of pain* – is that it's short acting. Sometimes a short-acting response of quieting the pain system down does the trick; other times it just isn't enough of a change. This is why we probably don't have to worry about all of these new massager guns putting us out of business any time soon.

Another feedback loop that we can use, especially with heavy-handed touch, can be simply described as *counterirritation*. The neuroscience world likes to refer to this one as *diffuse noxious inhibitory control*, which seems to be changing to *conditioned pain modulation*. What this means is that if you create more pain temporarily you can evoke an experience out of the brain where it will buffer pain globally in the short term. This gives practitioners an opportunity to flood somebody's nervous system with a lot of discomfort and the aches and pains our client walked into the office with are no longer present. When this happens, it's easy to assume that their change in experience is because we changed their fascia.

Between the ascending inhibition of moving the mechanoreceptors around along with counterirritating by creating a lot of discomfort resulting in a descending response to buffer pain, both of those feedback loops make it seem like we could address whatever was driving the discomfort rather quickly. Without knowing any of this neurology, if you had to answer, "What tissue changed as a result of the touch," answering that question with "the fascia either melted, re-sculpted, or somehow let go of an adhesion" would be a logical answer, especially if you're only looking at what changed in the tissue. If you're looking at what changed in the nervous system you have a lot more plausible answers to choose from and they seem to match the client's experience that these changes can be short-lived.

DA: Do you think fascia has any relevance to our work?

MP: People who study fascia know a whole lot more about that question than I do. I like to study how the nervous system – and by that I don't just mean nerves, I mean the nervous system, which would be inclusive of what is it like to be you – how that whole system is modified through SI.

DA: Do you think that the surrounding tissues of the peripheral nervous system might play some part in the information exchange of touch? For example, if force is carried through tissues to the neurofascial interface.

MP: This is a good place for histology, i.e. the study of tissue, to show up. I think one of the aspects that is confusing for new students, which is who I usually hang out with in the Rolfing classes that I teach, is: What is the difference between fascia and connective tissue? And which fasciae are we talking about when we say *myofascia*?

If you look at cross-sections of fascia, skin, or those first few layers of tissue transitions that most texts show, they usually show a very similar thing: the outside of the skin is mostly made up of epithelial tissues, and as you drop down a layer or two just below that you see a mix of epithelial and connective tissue – not quite the myofascia just yet. In that 'soup' of the superficial connective tissue, which is just under the skin, is where you see these mechanoreceptors living. As you get lower and lower, you see fewer and fewer mechanoreceptors. When we look at the myofascia, which would be the white stuff on the surface of the red muscles, that stuff seems to have less density of neurons and mechanoreceptors than the layers that are closer to the skin.

The question of what's happening at the neurofascial interface begs another question: Which fascia are we talking about? The terms *connective tissue* and *fascia* are not the same. It seems like the world of fascia research is trying to get unified definitions of what fascia is, what fascia isn't, what this layer of fascia is called versus that layer. From the surface fascia just under the skin, to the adipose layer just under that, to the myofascia, these are all different tissues with different densities of mechanoreceptive nerve endings.

DA: So your main concern is with the client's experience. You aren't saying that fascia does this or does not do that – you're saying that whatever fascia does, these exteroceptive and interoceptive factors are highly relevant to the client's experience whether we intend to affect those factors or not.

MP: Correct. We know that from modalities like craniosacral work, like movement, even something outside of our scope like kinesiology taping. We know that there are lots of ways to influence the different nerve endings that lay in the superficial tissues. We know there are ways of influencing "what does it feel like to be me?" even when someone doesn't touch me but I just explore my body in different ways, like through movement work. So a good question to ask is, "How does movement work impact fascia?" versus "How does movement work impact what it's like to be you in this moment?" It's questions like that that generated my curiosity into pursuing this stuff further.

DA: We could get into how you came to this, but we haven't gotten into top-down yet.

MP: The top-down conversation would start with questions like, where do these neural circuits end up in the brain? Where do the nociceptive neurons wind up delivering their information? Where do the proprioceptive neurons wind up delivering their information? Where does this whole interoception thing happen?

Proprioception, which is going to be stimulated every time we move and certainly when people touch us in an SI-style of touch, projects into an area of our brain called the somatosensory cortex. The somatosensory cortex is involved with mapping where we experience our bodies to be and how they seem to be moving or not, moment-to-moment. This is a lot about spatial data; it has very little to do with how we feel and more about what the body is doing in terms of movement.

DA: But earlier you seemed to downplay the significance of proprioception.

MP: Proprioception is a critical capacity of a brain, whether it's helping us not fall down, or coordinating a dance move, or a golf swing, or how to sprint off the starting blocks. It's critical to all aspects of human movement, and its involvement in things like posture and pain seem to be less of a focal point.

DA: So proprioception may not be as relevant to the touch experience, but it's relevant to the client's movement. This might show up more when you stand your client off the table and what they do with that information.

MP: Yeah, so proprioception is always happening and it's always going to be bouncing off of what we're feeling about what's happening, i.e. interoception. Proprioception is critical for things like performance, fall prevention in the elderly, for coordination and learning. When I watched my fourteen-month-old daughter learn to walk her proprioception was firing off like fireworks; it's easy for us to walk once we've mastered how to do it. In terms of touch, the quality as opposed to the quantity, the *quality* of the touch, that seems to be what's more responsible for making these big shifts in what it's like to be us. Some of the stories we've seen over the decades about major life transitions with SI – major experiences of maybe what we could call healing and really opening up a new potential of growth for our clients – would have to include more than just proprioception.

DA: Any specifics you'd like to speak to?

MP: Again, if we define proprioception as this awareness of where we are in space and how that's changing, it's critical to things like coordination, stabilization, or learning new movements. But this other aspect of anything emotive, anything that has some kind of meaning or valence to us, exists outside of the proprioceptive system.

I like to study how the nervous system – and by that I don't just mean nerves, I mean the nervous system, which would be inclusive of what is it like to be you – how that whole system is modified through SI.

DA: You're saying that accessing that sense of meaning, through interoception, is critical to how our clients end up processing their proprioception.

MP: It's critical, and I imagine a good term for it would be *interdependent*. Shifts in proprioception – especially for someone for whom proprioception has major consequences, like an athlete, dancer, or performer – have a big emotional meaning. They have some big risk or reward payoff, but it's not the proprioceptive system that's tracking that. The proprioceptive system is just tracking spatial data. It's void of emotion.

The bigger shifts that I hear about in clients, that I heard about through the decades that got me excited to do the work, were more about life-potential opening in new ways as a result of this structural integration process. That's what never made sense to me: If we're just changing proprioception, where does all this other stuff happen? If we're just changing the tension on the fabric network, why does this work mean so much to people?

DA: Have you found some ways to bring a sense of risk and reward to your clients to enhance this interoceptive-proprioceptive interdependence?

MP: I think this has been happening the whole time, for as long as practitioners have been doing SI. This network of nerves, this C-tactile subsystem, the process of interoception have been around for much longer than we've known about them, which is why really explosive results were happening from the work, even in the 1950s and 1960s before we knew why they were happening, which brings us to a 'side road'. Let's come back to the main road, but I want to take a little tour down a side road for a second.

In speaking with some of the first generation Rolfers™, in the times of the 1950s and 1960s classes before these neural networks were really understood, it was easy to attribute what we were seeing happen to what we knew to be the most connective of all of the tissues in the body. So if we're looking for a tissue that goes from one foot to the opposite SI joint to the opposite shoulder again, that is the connective tissue.

Recent studies on how far those tissues actually transmit force and what they do in the presence of 'SI amounts' of touch offer some interesting dialogues which we can refrain from here. But as we got into the 'decade of the brain' and neurology started becoming more a part of what was included in SI trainings, what we see now is a network of connective relationships that aren't in the connective tissue. They're actually in the neural tissue, and information from one foot to the other SI joint to the opposite shoulder again travels at lightning speed and is capable of making radical shifts of experience in terms of embodiment, of movement, of pain, of what it's like to be you, all without any fascia needing to change. Now that we, in 2019, know that this stuff is there we can start exploring how our touch, movement work, even just our therapeutic presence changes that 'informational connective tissue' as opposed to the fibers of the fascia system.

Since we only had fascia as an answer, then of course we used fascia to explain why we saw such radical shifts in behavior, but now that we have neurology it actually gives us more insight and provides a better understanding as to not only what has been happening, but what is possible with the work. That's where I'm really excited.

DA: Has your sense of possibility for the work changed?

MP: My sense of possibility for the work has burst open into what seems almost boundless, limitless. Whether we are addressing something as simple as postural shape, a pain pattern, a limitation

My sense of possibility for the work has burst open into what seems almost boundless, limitless. Whether we are addressing something as simple as postural shape, a pain pattern, a limitation to performance, or some fixation of self-identity, all of those experiences are now well within what's possible to shift . . . but we need to look to neurology to figure out why that is so.

to performance, or some fixation of self-identity, all of those experiences are now well within what's possible to shift in a meaningful relationship, especially throughout a series of work with a present, patient, empathic, and attuned practitioner – but we need to look to neurology to figure out why that is so.

Any time we are working through touch, we're working with parts of this interoceptive system that reach into past experience, into relational presence, and include major developmental experiences like attachment style. This is why we've seen such success in supporting people who have experienced trauma, because touch is so informational at this emotional level and it has much more to do with this moment-to-moment attuned, relational presence as it does some kind of technical accuracy to target one tissue over another tissue. As soon as we use touch and evoke some kind of meaning from the client's perspective, even if it's just curiosity and bringing them to the experience of what it feels like to be receiving the touch in the moment, we start to light up the neurology of what may have been limiting these pain patterns, these postural patterns, even these emotive patterns of perhaps not wanting to be seen, or not feeling proud and elegant, or not allowing oneself to take up space. All of those aspects seem to be more of what changes posture than just simply a tight muscle.

DA: A fear I often hear when about relating science to SI is that it will lead to us limiting our work to symptom amelioration, or we'll become over-focused on 'fixing'. But it sounds to me like you're just using modern neurobiological insights to bring us back to a more holistic take on the work, a more transformative approach.

MP: That is very well said. Having a focus on just one tissue over another tissue, whether that's nerves, viscera, cranial fluids, or fascia seems to be at odds with the idea of holism. Part of what I love about this neurocentric approach to structural integration is that we look at what makes somebody whole. It's not just their nerves, that's not what this is about.

This is not about neural manipulation versus fascial manipulation. This is about working with a broad system of experience which is mitigated through lots of different tissues and brain regions to create the experience of what's happening in the moment for the client. To truly take a holistic approach, we wouldn't favor one tissue over another tissue. We wouldn't favor this technique over that technique; we would favor what means the most to the client, and that might take a little detective work or homework to realize what is motivating someone to come to us.

Why is standing taller important to them? Why is not having back pain important to them, or whatever the presenting goal or desire is on first glance? That's a way we can evoke meaning and bring our clients more to each session and every series, as opposed to us implying or imposing our own ideas about what we think someone else should have more or less of.

DA: To bring us back to the 'main road', you're saying that tuning into the client's sense of meaning, what they're coming to us for, allows us to leverage their own sense of risk and reward to help them embody their desired outcome?

MP: Yeah. I think what it does is reveal how much of a person's experience is modifiable. It shows us how big the menu is in terms of what is possible with the work; we aren't limited to loosening this muscle, re-sculpting that piece of fascia, or determining that one posture is better for this other person and a different posture is for someone else, or that everybody should be in the same posture – there's lots of research that would challenge all of those ideas. If we come to our work humbled, in a position of humility and in true service of what a client really wants – not just what they say they want, but what might be under why they want it – then we can start to tailor our work with much more meaning, knowing that there is this network of nerves and brain responses that are working for us to make these goals happen.

DA: Suppose a client comes to you saying they want their fascia realigned; you wouldn't necessarily try to convince them whether or not that's important. You would be more interested in what they imagine fascial manipulation or alignment would do for them, and then you'd go from there. Is that correct?

MP: Absolutely. The truth is, I have no idea what's happening to their fascia when I work on them. When I'm working with someone, the only way I can really know what they're experiencing is to ask. I'm also aware that what they tell me will be filtered through their personality, language, beliefs, culture, and other factors that shape their inner world rather than just the biology of what's happening in their tissue. The best I can do is just be humble and curious.

If somebody comes in with a goal, whether they want to deadlift better, warrior pose better, ski better, stop their back pain, or have their fascia realigned, I still ask why those things are important. There's usually some value that those things are in service of. Whether it's feeling free, feeling strong, having their bodies experience some enjoyment in their activities – that's the stuff I build sessions and series in service of: the deeper values. Now that I know that there is a system of nerves scanning for my touch input that deliver right into the meaning-making structures of what it's

like to be my client, all of those goals are much more reachable and I don't have to manipulate through one tissue or another to get there.

DA: Since you're guided by the client's experience you can just be with the complexity; you don't have to figure it all out or pretend to.

MP: Knowing the client's experience and how their experience is or isn't in service of their goals gives me so much more insight than the strategies, techniques, or goals of the letter of the 'Recipe' ever did.

DA: Do you still do series-based work? If so, are you able to use your current understandings to evoke more meaning out of series work?

MP: Do I do series work? All the time. Not exclusively, but still all the time. Do I think this approach evokes more meaning in series work? Absolutely. I think this is something that even new practitioners could include. It's hard in the beginning if you're under an imperative to do every technique to every part of the body that you've seen every one of your teachers ever do. To work in a way that is attuned with what that client is wanting out of their session with you in the moment, prioritizing what would be most helpful is actually a lot simpler than trying to go through every technique hoping that a few of them land.

DA: Are you saying that by prioritizing the client's experience we can still proceed through the series, making more relevant choices for the client in every session throughout?

MP: Right. What this is not, is every client gets every session exactly how they want it. This is not, "Tell me how to work on you in the way that's the most pleasurable." This is using their experience of what it's like to receive the work in service of the themes or goals of the session, which may or may not be a Ten Series, a twelve-series, a whatever series. Maybe you only get three or five sessions with someone.

How do you prioritize? While this may sound like an advanced concept to someone who's coming from the ABCs of the original series, I don't think it's that far off base. The students that I mentor in my private practice, I see a lot of ways of applying these ideas even if we follow the letter of the Recipe, how to evoke more meaning each step of the way, stroke-by-stroke, intervention-by-intervention, and how to anchor it into an 'integratable' experience – if that's a word.

DA: Making the experience integratable. I think that's a useful concept.

MP: My sense of evoking the client's present experience throughout each moment of the session has been that the results of the work integrate on the fly. We don't do an hour's worth of work and then try to integrate it all at the end; if we bring the nervous system along with us frame-by-frame, it's really quite easy to learn along the way as opposed to trying to figure out why I feel so disorganized all at the end.

DA: We're always integrating.

MP: I think we can be. If we bring our clients along, we can be. If we leave them in a more passive state, I think the work can be confusing when the volume of work adds up. When the volume of work adds up before there are enough check-ins, pauses, and digesting points, the work feels like a flooding of information, as opposed to bringing someone on a journey with checkpoints of salience and integration along the way.

DA: What if your client has had a long day and they don't want to stay engaged? How do you reconcile their present-moment experience with their big-picture goals?

MP: I might ask them what feels more important to them in the moment and why, and then maybe even set a context around, "Well, for the next hour," or whatever amount of time, "we're here to do this, and the best way I know to lead us through this process would be to include your awareness of what's happening, so if you're up for it, I think we would get a lot more value out of staying engaged throughout the process." And then, of course, it's up to them.

DA: Is there anything else top-down you want to speak to?

MP: Our work is never not top-down; we are always creating top down experiences. When you follow the bottom-up to top-down metaphor far enough it becomes confusing where the line is when bottom-up becomes top-down. To keep it simple-ish, I think a worthwhile distinction is that, at some point, this information is coming upstream into various parts of the central nervous system and then the spinal cord or brain does something about that. There's all this *affect* coming in from our work, and then there's an *effect*, a response.

If we take a tissue-centric view of the effects of our work there seems to be some temporary hydration in the extracellular matrix; that comes from the Stecco group in Europe. That's worth studying, and there's so much more to it. We know that some of the effects of our work are going to be a temporary modulation of pain – again, back to the idea of why we rub on things. Another effect of our work is that we are going to elicit a sharper sense of proprioception: The more input we get into our proprioceptive neurons, the more our mapping systems light up different parts of the brain and we start to see ourselves, feel ourselves, where we are, how we move more clearly. That has some interesting ramifications for the persistent-pain population.

The next piece of the top-down part – the part that I'm most excited about – is the effect response about what it's like to be us in this moment: The top-down expression

I think this is something that even new practitioners could include . . . To work in a way that is attuned with what that client is wanting out of their session with you in the moment, prioritizing what would be most helpful is actually a lot simpler than trying to go through every technique hoping that a few of them land.

of interoception. This is a big component of the work. We can see it any time we take a break from our hands-on work, any time we're asking someone how something feels or what they're noticing in response to our touch or movement, and definitely, like you asked about, what's happening at the end of a session. The way in which people report feeling is very filtered through this interoception, this "How do I feel?" Even when somebody says, "I feel good. I feel better. I feel lighter. I feel less pain." All of those qualities of lighter, better, good, less pain are coming through a very heavily interoceptive influence. That's all interoceptive output.

DA: Is all interoceptive output equally useful to the client? For example, if a client says, "I feel good," every time they stand up. Are you satisfied with that? Do you think there's more possible for them? Do you push them to inquire further?

MP: I always think there's more possible. I also try to be humble enough to know that I don't know what "good" means. I imagine good means pleasant, or more pleasant than before. Maybe they're just being polite? I always want to know, if somebody says they feel good, "What's good? How do you feel good? What's good about the way you feel?" For a client to answer that question they have to ask themselves, and in doing so they ping their interoceptive feed to get more in tune with what feels good, why they feel good, why they said that, and that highlights the circuitry that anchors their integration of the changes they get.

This all circles back to, "How could we be as interactive as possible?" Interactive, in certain phases of my practice, just meant I'd ask the client to move all the time while I'm doing work – that's one way of recruiting some interaction. The way I find to be more meaningful is to go for this experience of what it's like to be them. It's less about doing a pelvic rock, or a knee forward or back, and more about, "What are you noticing as I work here?" When I ask that question, people usually don't say "good." Asking a more open-ended question oftentimes will lead to a more qualitative answer, and if it doesn't then there's a way to ask follow-up questions about what the experience is like to unpack it further.

When I can get into an interaction where we're unpacking what something feels like, how it feels, then there's an easy way to relate it to what the client's individual goals are. "How does this sensation, how does this awareness relate to whatever goal you came in with?" Because I don't know the answer. That's one way to evoke meaning.

DA: Say someone came in with persistent low back pain, you have them supine, you're working near their ASIS, and you ask them what they're noticing and they say, "It hurts." How might you relate that to their goal of resolving low back pain?

MP: That's a couple steps down the line. First I may say something like, "Does it hurt right where I'm pushing? Does it hurt where the back pain is that you're coming in with?" I want to know more about what hurt feels like to them. How does it hurt? Does it hurt like, burn, ache, or something else? Maybe it even hurts like it's scary and they want me to stop. How would I know? I want to unpack their immediate experience of what is hurting and how that feels.

The point is just to bring them into the experience. I think bringing them into the experience does a couple things. One is, it helps them see that there are other ways of experiencing the immediate hurt. It also shows that their practitioner cares, which is a huge element of our work. If you imagine a bodyworker who isn't interested in their clients' experience of the work versus one who is, I think it's an easy assumption to make as to which practitioner will get better results, regardless of technical skill.

A question I've asked in classes I've taught at the Dr. Ida Rolf Institute® over the years is, "What were the most important or impactful qualities of your practitioners?" Students all answered in terms that indicated how much their practitioners cared about them. Just knowing that somebody cares, that the touch is in service of extending care and support actually hacks into this interoceptive network via the attachment system. Touch means different things to different people; to have it mean, "I care about what's happening for you in service of you getting what you want out of these sessions" goes a huge way into setting the stage for not only a noticeable shift in experience, but a long-lasting impression of how okay they are in the world.

DA: Besides pain, another common reason people seek out structural integration is concerns about posture. They might think their posture results in certain symptoms. They might have aesthetic concerns about their posture or want to appear a certain way in the world. How do you relate with those clients?

MP: I think there's a lot of confusion over what Dr. Rolf may have meant or what some of the first- or second-generation teachers took from what she said. Posture shares some etymology with *position*, which might imply this sort of "you put it there and leave it there" idea. That isn't what posture is; it's way more dynamic than that. Maybe it's an artifact of our classroom teaching, this before-and-after picture model.

It turns out posture is way more context dependent. That's the big key here. Is there a perfect posture for everybody? No. The saying we're hearing now is "the best posture is the next posture" because we're not meant to be in any one posture for very long at all. So to answer your question about what I do with clients who want something to change in their posture, again I go back to why. Why do they want that? If they say, "My neck always hurts because I have terrible posture," then I say, "There are definitely things we can do to change both your neck hurting and your posture but they might not be related as much as we thought, so let's see if we can get your neck to stop hurting and maybe we'll change your posture, too." And then I would ask how that sounds. If people are rigid with what they want me to do, I ultimately am in service of what they're wanting and why they're wanting it, so I may find another route in.

Things like normal anatomical variation, cultural norms, gender norms, injury history, all kinds of factors modify why someone would choose this posture over that posture. This biopsychosocial idea of posture helps us see it as a biologically-driven event, psychologically-driven, and it's even driven through the social system. The shapes of your bones, the length of your muscles, your tibia-to-femur ratio, things like that are going to help determine your posture. It's also determined in the psychological domain: how your nervous system interprets signals and when it chooses to act on them, what it chooses to suppress. Some of it may be genetic, some of it may be learned, and some of it may just be the state of arousal you're in that day. The social aspect shows up in, "My posture's different when I'm with my family, or when I'm with my boss, or when I'm playing ultimate frisbee versus when I'm trying to sit in an airplane and get work done for three hours."

Is a change in posture the only goal of SI? I imagine most SI practitioners would say "no," yet so much of what we measure as results, certainly in terms of before-and-after, does seem to be in postural achievements . . . What are we really wanting to see and then how do we know when it happens? What are clients coming in with and how do we determine when we've been successful?

Posture is biologically mediated, it's psychologically mediated, it's even mediated through what environmental context we're in at that moment and who else is around in that social domain. So to think that one posture is going to work for everyone, that every individual has their ideal posture is a bit unreasonable. We have lots of information from the world of sports performance, strength and conditioning coaching, all of the pain-science literature that suggests posture is best when it's dynamic, when it's adaptable to different conditions for different purposes. Thinking that SI is designed to instill an ideal posture is, I think, a big miss of some of this potential we referenced earlier.

DA: We could think of posture as an expression of adaptability. How rigid are we, or how adaptable are we?

MP: I think all of this points back to, is a change in posture the only goal of SI? I imagine most SI practitioners would say "no," yet so much of what we measure as results, certainly in terms of before-and-after, does seem to be in postural achievements. That in and of itself makes me question, what are we really wanting to see and then how do we know when it happens? What are clients coming in with and how do we determine when we've been successful? That information seems like it would not exist on a series of before-and-after postural assessment photos. I have thought for a long time that it would be fun to do a series of before-and-after pictures to see how various experiences may modify posture: photos before and after a yoga class, or three sets of kettlebell swings, a nap, or some time in meditation.

DA: Couldn't changes in posture over time just be an indication that change of some kind has occurred? I mean, it doesn't necessarily indicate that pain has changed, for example, but it does show change in general.

MP: Sure. I think a lot of the information exchange that happens during an SI session has the potential to modify posture, but the world of science has and will always disregard before-and-after pictures as evidence of any kind of meaningful outcome, and there are good reasons for that.

DA: Sure, because there could be many factors that contribute to long-term posture change and actual experiences may vary. But with so many practitioners over the decades showing photos of significant posture change correlating with SI series work, even though that evidence may not be the most scientifically valid that's still a large volume of low-quality evidence indicating some kind of change.

MP: Yeah, that's a game that I don't like to play, but I know in terms of advertising, marketing, or Instagramming, having a lot of visual evidence is important for some people. I don't know how to talk about that because posture is not that important for me. I like qualitative evidence, testimonials, word-of-mouth – I think it's a better transformation metric than position difference. After many years of study I still don't really know when, how, for whom, and why posture matters or not. Sometimes posture gets "worse," whatever that means, but what if that shift was in service of a client becoming more authentically themselves?

DA: What assessments do you use these days to guide your work? Do you do any visual assessment? Palpation?

MP: I do both, and I love that you asked that question. Certainly the visual and movement assessments are pretty standard pre-session routine; it's more a matter of why I do them. I'm less interested in looking at things like scapular mechanics, pelvic motion with knee bends, stork tests, or anything like that. I'm more interested in using these pre-session assessments to set a baseline of experience for clients: "What's it like when you bring your arms up over your head in this jumping-jack motion? What does it feel like through your low back when you do these knee bends?" That way we have a metric on what it feels like now, after. I'm aware that my eyes and hands are only so sensitive – maybe these are my shortcomings as a practitioner – but there is a lot of research out there that challenges the reliability of both visual and palpatory assessment amongst even experienced manual therapists. And still, meaningful change to the lived experience could happen radically and I wouldn't be able to see it at all.

My interest has moved away from what I think I see and feel to what I can know about what someone feels like on the inside. So I use those assessments pre- and post-session to set baselines. What's it like at the beginning, and what does it feel like now? It's more about qualitative inner experience, less about me trying to figure out if my client got a couple of degrees more motion. We've got good research that says maybe that's not so meaningful anyway, in terms of pain or injury risk. My hands are probably not sensitive enough to feel a millimeter or two more motion here or there, but I'm very interested in what it feels like for someone to live in that body.

DA: So for example, if you're doing a classical first session [of the Ten Series], I imagine you might start by inviting the client to experience their breath and elaborate on what they notice. Then you get them on the table to do some work guided by their values and their experience, inviting them to go deeper into their felt sense as you're

working, and then you stand them back up and ask them what they feel. Does that sound something like how you might work? Would you add or change anything to that?

MP: I'm sure I could add or tweak a couple things, but in general that's the approach. I want my clients to be active in the assessment. It's almost like *they* are going to do the assessment. I set up the, you know, "face this way and do that thing," or "feel your breath here," or "what's it like in this direction?" But I'm always inviting them to assess themselves, not in terms of proper or improper or how much is the right amount of motion, but about what's the quality, so that they have their attention placed on some aspect of meaning that we can revisit an hour or so later and ask "what does that do?" It shows them that something has changed, that their experience is modifiable, that they're capable of much more change than they may have originally thought, and it opens the door into what is possible with a little bit of touch and awareness. So I care more about what my clients are doing in terms of assessing themselves; I'm just there to set up the mechanics of it.

DA: Do you do frequent assessments throughout your sessions?

MP: The way I work these days, it's almost an ongoing dialogue. Every few minutes is a check in around what's it like now? What are you noticing now? How was that different from before? I've noticed that the longer I practice, the less need for certainty I have. I'm much more willing to go along with my clients' inner world of experience and not have the mechanics of the session lined out in protocol heading into it. I have themes on my radar of what's important in terms of whichever session we're on. I have the meta-themes of why they're coming to me, what their goals are for the work, and that keeps us tethered to something that looks like the Recipe, but it's much more easily tailored to individual clients' inner worlds than me just applying the same thing to everybody.

DA: Would you encourage practitioners to invest less time in studying technique and spend more time developing their interpersonal skills?

MP: Far be it from me to tell anyone how they should do their practice. All I can really report on fairly is what's made the most difference for me. During the first few years of my practice I was on a continuing education tear, I wanted every technique from every modality possible, but I can tell you that the results of really changing people's worlds with this work came about not so much through the addition of techniques but more through learning how to relate with people. Everybody's needs and interests are different when they first start off with the work, but in terms of this interoceptive network and this neurocentric approach to SI as a field of study, all of that would indicate it's probably less about what we do and more about how we do it, and most importantly, why does this matter to our clients' goals? If techniques can help with that, then great. In my experience, techniques are a lot about *what* to do and less about *why* this ties into the individual client's needs or wishes. Why not set the bar high?

DA: The relational aspects of our work preclude our effectiveness no matter what techniques we're using, however highly-refined touch skills might allow us more options that speak to specific client concerns. Would you agree?

MP: Sure. While these specialized techniques or approaches from different modalities probably have some efficacy for different conditions, what they all have in common – whether it's cranial touch or visceral touch or any of the things that SI students typically look towards for more training – they all make us more confident practitioners. In so far as techniques help us show up with a sense of confidence, we can articulate why we're doing what we're doing with some kind of value for our clients. Different techniques are still going to have similar effects on the interoceptive experience of our clients. Being technically sound in terms of touch skills is great, but having these 'soft skills' of how to relate to people via these heavily technical touch skills, that's the high fruit on the tree in my book. For every idea that this is the one technique that addresses this condition the best, there will probably be a whole lot of research that would refute that. I like to think of having lots of techniques as having lots of ways to skillfully induce new sensations and experiences.

DA: Well, then what differentiates the touch of an SI practitioner from, say, the hug of a loving spouse?

MP: Great question. Our highly-refined touch skills in the context of a therapeutic relationship have contextually different meaning than the touch of a lover. The metrics of the touch – depth, speed, direction, etc. – are only a small component of how the touch impacts the nervous system. The exact same touch in two different contexts can have radically different outcomes. What differentiates a slow caress on your neck from your lover versus one from the creep behind you at the grocery store? It's the context, the meaning. That's a great example of how bottom-up and top-down are different.

Given our progression through the themes of the series, whether it's ten, twelve, thirteen or however many sessions you work under, there are a couple of factors that are in favor of an SI series of touch over other forms of bodywork. One is that we get all over the terrain of somebody's physical structure throughout the course of the series. We have multiple passes through to help somebody re-map and re-associate experience, whether it's in their shoulders, hips, or feet, we revisit things. The other factor is that it takes time to build a therapeutic alliance, which we know is one of the best predictors of outcome across any modality. Getting ten, eleven, twelve, thirteen sessions with someone is always going to outpace benefits from one or two treatments, regardless of technical factors like skill or precision. Having the repetition to build trust, safety, and rapport, we know that's tremendously impactful for clients.

I think there's a ritualistic aspect to healthcare, and to human interaction in general, that has gone away as our culture has become more isolated from one another in this digital age. The presence of ritual and this sacredness of opening into being impacted, I think you can piggyback on the assessment piece.

The act of being assessed sets up in the client the capacity to be impacted, for whatever's being assessed to be changed. It focuses our salience, it focuses what we're paying attention to. The skillful presence – whether it's through touch, movement, imagery, cranial work, or spinal mechanics – the careful and sacred attention of an SI practitioner across a series of sessions is precious.

That's very much not a hug from a loving spouse. A hug from a loving spouse may help with back pain, a headache, a stressful day at the office, or things like that, but what's on the table with a repeated series of sessions – this ritualized progression through themes and anatomical terrain, this rich relationship that develops within the client and between the client and practitioner – that's the beauty of the work, to me. Unveiling the neurology

that allows this to take shape over a series of sessions makes it much more reachable and exciting in terms of what's possible with the work as opposed to just reshaping fabric.

DA: Completion of a series might fulfill another missing aspect from our culture: rites of passage.

MP: Sure. Yeah. I think in many ways, at the end of every session there's a mini rite of passage, whether it's how individual practitioners close their work, whether it's a classic neck / pelvic lift / back work kind of thing or even if it's just a reassessment of, "What's it like now? How are you going to allow this to shape your life moving forward in the next week (or two, or month, or whatever time you plan between sessions)?" That in-between-session integration is part of those mini rites of passage along the way. But I think you're right on, that having gone through a series of sessions that has a distinct start, middle, and finish, can offer something that is often missing in our culture.

DA: Is there anything else you'd like to add?

MP: Oh, man. There's so much. What's most important for me to include in the classes I teach is that I strongly believe this is a way to evolve Dr. Rolf 's work. It was mentioned to me by one of my mentors and it's something that I've always held onto tight, is that Dr. Rolf left the community a baby on a doorstep, and it was up to the succeeding generations of instructors to continue to learn and evolve what's possible within this framework. That's where my excitement has been, in the service of evolving Dr. Rolf's work, vision, and the power and potential of this work. It can be challenging to reconcile what was originally taught with all this good information that says maybe what we're doing really isn't what we think we're doing, or maybe there's more to it, and maybe understanding that is going to involve challenging your assumptions even if you've been at this for ten, twenty, or thirty years.

At twenty years in, I just taught a class that had a practitioner in it who's been at it for fifty years. We both sat there side-by-side with students who had recently graduated. We all came to a similar conclusion: that we probably will never know how SI works for sure, but it's exciting to know what's possible and to keep learning. I love learning; it's what I do in a lot of my free time. That may mean I'm kind of dorky and need some different hobbies, but the way I stand with this work is that I'll probably never be done learning about it. I would encourage students and practitioners that, if they want to learn and grow, to do that in ways that make them a little uncomfortable, not just confirming their own biases because we know the traps that are involved with cherry-picking or echo-chambering information, but to learn outside of their inherent biases.

That's where my excitement has been, in the service of evolving Dr. Rolf's work, vision, and the power and potential of this work . . . If the work is about helping people grow and evolve, then the work needs to grow and evolve, as well.

All perspectives, mine included, are limited. They're always partial, but they all have value. For me, bringing value back to the community is always supercharged by evidence. I have a bias towards what can be reproduced and validated by the rigors of the scientific method as being more valuable than my own ideas and opinions. The research around manual therapy, movement, and embodiment has gone through the roof in the last twenty, thirty years; there's so much more information available than there was sixty, seventy years ago when Dr. Rolf was developing this stuff. Why would we not include all of the evidence that we can get our hands on – not just the evidence that fits in with what we already believe?

Continuing to learn and be open to new ideas from different fields of study puts us in a seat of humility which allows for growth and expansion of the field. This is what I believe we're doing, or at least it's what I want to do in individual sessions, which is to put myself in a position of humility and honor the growth and potential in front of me in my clients – it's the same thing that I want to do as a practitioner, as a teacher, and it's a value that I have for this work. If the work is about helping people grow and evolve, then the work needs to grow and evolve, as well.

DA: Michael, thank you for sharing your time and insight.

MP: Well, I hope it's insightful.

Michael Polon has been practicing as a Rolfer since 1999. That same year he was invited to re-enter the classroom as a teaching assistant and has taught Rolfing® SI and continuing education classes ever since. After almost twenty years of study, Michael still has the same beginner's excitement when it comes to exploring the art, science, theory, and practice of Rolfing SI and related disciplines.

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Pro Levitatem

An Appeal to Rolfers™ to Re-Introduce the Concept of Levity to Our Paradigm

By Max Leyf Treinen, PhD, Certified Rolfer

Max Leyf Treinen

ABSTRACT *This article is an appeal to the Rolfing® Structural Integration (SI) community to consider how an introduction to our way of thinking of the concept of levity as a polar and commensurate principle to gravity could benefit our work.*

> *Take the very top and centre of scientific interpretation by the greatest of its masters: Newton explained to you—or at least was once supposed to explain, why an apple fell; but he never thought of explaining the exact correlative but infinitely more difficult question, how the apple got up there.*
>
> John Ruskin in *The Storm-Cloud of the Nineteenth Century*

In the mid-seventeeth century, a group of natural philosophers from the Florentine Accademia del Cimento (Academy of Experiment) published a treatise called *Contra Levitatem*. In this short work, they argued that there was no reason to appeal to any force other than *gravity* to explain the motion of physical objects. Dante had affirmed in the *Divine Comedy*, some four odd centuries prior, that the *earth* and all the nested planetary spheres are turned in perfect harmony by 'the *love* that moves the sun and the other stars' (*l'amor che move il sole e l'altre stelle*). In a similar manner, the Florentine thinkers set for *gravity* in contrast to *love* as the real *primum mobile* (prime mover). Newton's publication of *Principia Mathematica* near the end of the century appeared to validate the Florentines' initiative and serve to establish the *contra levitatem* doctrine as incontrovertible fact.

That living sap rises against the gradient of gravity in the spring is another very expressive demonstration of levity in action.

As a result, it became the tacit paradigm to explain celestial and terrestrial motion and, for just that reason, it has hardly been noted since. Indeed, the notion of *levity* as a quality of buoyancy polar to the centripetal pull of *gravity*, if it is mentioned at all, is usually being employed as an analogy to describe a psychological disposition and never uttered in a univocal scientific sense.

If science were the same thing as truth, then the rejection of *levity* by the Florentine academicians would be grounds for the same dismissal of it by everyone to follow. But, obviously, the relationship between science and truth is more complicated than simple identity. In fact, dialectical refutation of erstwhile theories is the engine as scientific progress as such. For this reason, the affirmation that science is the same thing final truth – truth come to rest – would be tantamount to the simultaneous rejection of science as we know it. Science, by nature, is restive; always striving beyond itself. All of this by way of preface to justify the proposition that *levity* be reintegrated into our paradigm of physics. Readers are encouraged neither to accept nor reject these propositions, but rather to try them out for size, as it were, to discover if they fit the keyhole of experience and unlock new dimensions of vision. Naturally, I believe that experience will ratify them, or else I would not have written this piece.

Many objections may immediately be raised to the prospect of reintroducing the notion of levity to our conception of the physical universe. I will address a few of them and I hope this will be sufficient to show that *levity* deserves real consideration in our community. Among the first objection that is likely to occur to Rolfers is that Dr. Rolf never mentioned *levity*. To my knowledge, this is true as far as it goes. Nevertheless, Rolf revealed an intuition of this quality on many occasions without invoking it explicitly by this name. Most commonly, the unspoken notion of levity appears when she attempted to articulate the fundamental manner in which structure and anatomy are to be conceived. Rolf's view of anatomy that affirms the primacy of fascia and that interprets the function of the bones not as *support structures* but as *spanners for the fascia* is essentially a description of *levity*. More specifically, it is an example of how the conditions of *levity* may be described in the language of *gravity*.

Why do we need the notion of *levity*, then, if whatever it is and whatever it does can be described just fine with familiar gravitational terms? In answer, consider the analogy of warmth. It is not assumed that because temperature can be reduced to energy or motion that the concept of heat can be done away with. Quite the contrary, it is only the immediate perception of heat as a qualitative reality that its atomic underpinnings can be coherently understood and conceptualized as such. In a similar manner, I believe Rolf could never have articulated her theory of tensegrity in terms of *gravity* were it not for an immediate perception of the body's lift.[1] This can only be perceived directly in the mode of *levity*. Moreover, to grant such original recognition to the force of gravity without simultaneously recognizing a force that is polar to it both flouts the principle of *polarity*[2] and remains conceptually incomplete because it fails to account for phenomena that do not uniformly follow the gravitational gradient.

I hope this brief discussion and treatment of objections has served to establish a legitimate foundation for the *contra levitatem* maxim to be reappraised and perhaps rejected. Before I conclude this article, I wish to offer a brief characterization of *levity* from a philosophical standpoint. I hope this will also suggest why its acceptance may benefit the Rolfing community.

In principle, *gravity* is understood to be the force that accounts for how two objects are drawn towards one another. In most day-to-day contexts, this is tantamount to describing *gravity* as the force that accounts for the weight of an object. *Levity*, on the other hand, can be conceived as the inverse of this.[3] *Levity*, therefore, is the principle of lift in spite of the tendency of matter to follow the gravitational gradient. Observation of nature will reveal that these counter-gravitational influences bear a relation to warmth and light. The fact that the sunlight draws a crocus from the dark earth in spring is a quintessential expression of *levity* in action. If we do not perceive it as such, I believe it is because we have no suitable concept at hand that can disclose it in this way. Newton's apple, to which Ruskin alluded in the epigraph to this article, is another example: that it could fall in the first place implies that it has risen and this is a fact that gravitational physics may offer at most an oblique and circuitous description, as by appeal to osmotic pressure. In a general sense, life itself bears an essential relation to *levity*. At the same time, inert, lifeless matter is bound to the influence of *gravity*.

That living sap rises against the gradient of *gravity* in the spring is another very expressive demonstration of *levity* in action. Inversely, in autumn, the erstwhile living sap falls in the form of withered leaves. This is the consequence of the leavening, counter-gravitational principle of life having withdrawn and relinquished the leaf to *gravity* and the latter's endless hunger for what lies below. When it is said that 'only dead fish go with the flow', the same relationship between the withdrawal of life and the exclusive capitulation to the gravitational influence is being indicated. In essence, therefore, *gravity* is a contractile and centripetal force while *levity* is the inverse. This is to say, *levity* is buoyant, suctional, and expansive. It may even be stipulated, in articulating a definition for this term, that *levity* is the principle that accounts for that the cosmos does not collapse on itself.

More than to agitate for any evolutions or revolutions in contemporary scientific paradigms, however, I have written this apologia of *levity* because of my excitement at what it may offer to our work. Specifically, the notion of *levity* can assist the conceptual coherence of Rolfing SI. Some may cast aspersions on the importance of such coherence and affirm instead that it is preferable to go by feel.[4] Of course, they are correct insofar as they are already intuitively working with the principle that I have chosen to designate by the term *levity*. But I believe that neglecting to seek clear conceptual underpinnings to understand our work is akin to attempting to circumnavigate the globe but at the same time refusing to consult a map. Granted that the map cannot substitute

In essence, therefore, gravity is a contractile and centripetal force while levity is the inverse. This is to say, levity is buoyant, suctional, and expansive. It may even be stipulated, in articulating a definition for this term, that levity is the principle that accounts for that the cosmos does not collapse on itself.

for the territory. And yet, neither can the territory be a map of itself.[5] If it could, no map needs ever have been drawn in the first place. If we affirm the utility of a map, then we must at the same time affirm the benefit of improving it.

I have argued that the addition of the principle of *levity* in polar relation to that of *gravity* can benefit our work in just this way. Aside from this proposal, the purpose of this article has been to pose questions, which I hope may serve to promote further inquiry and discussion of this issue, and not to provide answers to them.

Max Leyf Treinen has had a Rolfing SI practice called The Way of the Elbow since 2013 in Anchorage, Alaska, where he also teaches courses in ethics and critical thinking at a university. He recently earned his doctorate in philosophy from the California Institute of Integral Studies after successfully defending a dissertation on the epistemological foundations of Goethe's scientific method and the manner in which Rudolf Steiner helped to carry it forward in his own work.

Footnotes

1. Gravity itself has, since Newton's first mathematical formulations of its effects some three hundred years ago, now been reinterpreted as an emergent phenomenon that is the result of warped spacetime in the vicinity of massive bodies following Einstein's theories.

2. As articulated by Jeff Maitland, Jan Sultan, and Michael Salveson.

3. I hesitate to describe it as a force because this seems already to begin a conceptualization of *levity* in terms of gravitational physics that are, in some manner, contrary to it.

4. Of course, they are correct insofar as feeling is a *sine qua non* for effective work. But if they mean to discount the significance of achieving conceptual clarity as to the principles and aims of our work, then they cannot really assert this position without affirming in practice what they are ostensibly denying in principle. In other words, the position that conceptual clarity of the nature of our work is unnecessary is a position that must be articulated conceptually or not at all.

5. See "On Exactitude in Science" by Jorge Luis Borges (from *Collected Fictions*) for a philosophical exploration of this relation in the form of a short story.

Review

SourcePoint Therapy: Exploring the Blueprint of Health by Donna Thomson with Bob Schrei

Reviewed by Duffy Allen, Certified Advanced Rolfer™, Rolf Movement® Practitioner, and Kara B. Imle, Certified Rolfer

> *The path of energy work involves a lot of personal transformation. It's not just a collection of techniques, it's not a quick zap. It's a path into and through the unknown, the possible, the dream. It requires a commitment to exploring a world beyond the ordinary, beyond the limits of your current thinking.*
>
> Donna Thomson and Bob Schrei

Since its introduction to the Rolfing® Structural Integration (SI) community in a weekend workshop in 2004, SourcePoint Therapy® (SPT) has had a consistent allure to Rolfers and structural integration practitioners. One of its co-founders, Bob Schrei, is himself a Certified Advanced Rolfer. The other founder, Donna Thomson, is an intuitive and meditation guide with a master's degree in social work, and the primary author of *SourcePoint Therapy: Exploring the Blueprint of Health* (Merlinwood Books, 2015). This book's appeal to practitioners of SPT is that all the basic principles and practices of SPT are included. It also holds some real gems for Rolfers and other bodywork professionals.

SourcePoint Therapy came out in 2015 and I've been practicing the work since 2006, but I keep coming back to the book for clarification and for the meditation exercises. These are not only written into the text but are also available on-line. The book is an overview of the perspective of SPT, but not a how-to manual. The authors are very clear that learning the work requires a personal introduction, which is offered through their international workshops, found on their website, www.sourcepointtherapy.com. The website also contains audio meditations from the book. These short experiences (usually around ten minutes) are helpful to SPT practitioners as well as those who seek a supported contemplative practice. Author Donna Thomson produced these, and they make either a vital addition to one's existing meditation practice, or a point from which to begin down the path of mindfulness.

SourcePoint Therapy, like Rolfing SI, revolves around the information of the 'blueprint'. Dr. Rolf talks about a blueprint in her book, *Rolfing: The Integration of Human Structures* (1977). She is never quite explicit about defining the blueprint but does mention it in the preface: "A joyous radiance of health is attained only as the body conforms more nearly to its inherent pattern. This pattern, this form, this Platonic idea, is the blueprint for structure" (Rolf, 1977, pg. 16).

The blueprint in SPT is defined in the book as "a specific, ordering, organizing energy field within this universal energy field [the matrix] that contains the information that gives rise to the human body and maintains its health" (pg. 3). The hallmarks of the blueprint are order, balance, harmony, and flow. In the practice of SPT, the practitioner connects with the information of the blueprint, him or herself, and the client in a triad formation. (The book has a beautiful drawing of this on page 62.) The triad, the means by which the information is conveyed, is a central feature of the work, and underscores one of its most prominent principles, getting out of the way.

Getting out of the way is one of those general terms that we often hear when we are learning a skill. It is that discipline of allowing things to unfold even as we work within given parameters. Anyone who has studied music can identify with this quality. Musicians can have lovely technique, but will not truly master the instrument until there is sufficient musicality to their playing. Musicality could be thought of as the quality that arises when technique is in the background and the inherent order, balance, harmony, and flow of the music are in the forefront. In doing Rolfing SI or any other bodywork modality, we also strive to get out of the way. This phenomenon becomes evident when a session simply unfolds; when the work guides itself; when, at the end of the session, both client and practitioner are able to integrate the work and feel as though the sum of the session was greater than the parts.

The triad also makes explicit the relationship of the practitioner and the client in a way that Rolfers who seek to work transformatively need to cultivate. It keeps us out of the realm of projection by moving though the layer of our own or our client's story as well as any mechanical rationale for where and how to treat. In fact, SPT also provides some tidy answers to the question posed by Jeff Maitland: "Where do I start and what do I do next?" It does this via a system of scanning the client's body. These scans are discussed, but again, not taught, in the book. Scanning for the location of blockages to the flow of the information of the blueprint is central to the practice of SPT. The practice parallels Rolf's adage, "Where you think it is, it ain't," as the blockage may be anywhere in the system, likewise the effects of moving through or around these blockages.

Perhaps the most salient touchstone between SPT and the practice of Rolfing SI is the sacrum. The book discusses at length the structure of the human system in both geometric and energetic terms, describing the body and its surrounding matrix not only as muscle, nerve, bone, and organs, but as a series of ellipses, rectangles, spheres, and triangles. It is organic architecture and sacred geometry all at once. It finds its physical manifestation in that 'sacred bone', that upside-down triangle, the sacrum. In the Rolfian universe, the sacrum is both key and doorway to freedom of movement. We hold it at the end of every session to free the breath, for, as Rolf said, "The body is solid material wrapped around the breath." In SPT, too, "The sacrum is the gateway between the energetic domain and the physical structure of the human body" (pg. 40).

SourcePoint Therapy is recommended reading for any practitioner who seeks to deepen the integrative component of Rolfing SI, or for SPT practitioners who want to affirm their own practice.

Reference

Rolf, I.P. 1977. *Rolfing: The Integration of Human Structures*. New York: Harper & Row.

Institute News

Welcome Message from Our New Board Chair, Libby Eason

Dear Colleagues,

The Dr. Ida Rolf Institute® Board of Directors is looking forward to upcoming opportunities in 2021. We will be focused on strategic planning and reaching out to our members, faculty, and staff to contribute to the process. Look for the invitation to participate in a membership survey crafted by new Board Member Dan Somers, and follow-up focus groups. Other projects will include planning for the DIRI fiftieth Anniversary celebration, and continuing outreach to members through ConnectMembership meetings. If you have not joined the ConnectMembership Zoom meetings yet, please do – this is your invitation for direct interaction with the DIRI Board and our Executive Director.

I am honored to be able to serve as Board Chair, following the very capable Rich Ennis. It is my goal to continue building connections with the board, staff, members, and with the community at large. Please give me a call or send an email any time. I look forward to being in touch. You can reach me via libbyeason@gmail.com or 404-315-0099.

Reflection and Thanks to Previous Board Chair, Rich Ennis

Rich Ennis joined the board in 2014, and became Board Chair in 2015. Rich and the Board hired Christina Howe as Executive Director and Chief Academic Officer. Together they brought DIRI and school infrastructure into the current century – website, learning management system and membership system, as well as accounting system that allows up-to-the-minute, accurate reporting. Curricula and teacher-in-training programs were updated, raising the DIRI standards higher, and they also coordinated with the Regional International Organizations (RIOs) on training and current contracts.

A major investigation by the U.S. Department of Education found nineteen issues that had to be remedied. This was accomplished, and Title IV student loan funding continues to be available for students. COMTA accreditation was renewed as well, which is part of what makes federal student loan funding available for DIRI students. A new assessment program was also developed, and teaching the teachers as well as students has been better coordinated, and assurance of curriculum delivery meeting those standards has been achieved.

Bylaws and Ethics were updated. Regional training programs were launched, with one completed in the Midwest.

In 2018, new branding was launched, and followed with a marketing campaign that has been successful in increasing public awareness of Rolfing® Structural Integration (SI) and bringing in more students.

In 2020, a PPP loan was obtained, allowing DIRI to continue operations for six months through the pandemic shutdown, and the building lease was renegotiated to reduce rent payments during that time.

A diversity and anti-racism committee was convened in 2020, and continues to provide input into Board and school policy.

Thank you, Rich, for your four years as Board Chair, and able leadership that promoted DIRI's position as a leader in the field of SI, and the only SI school to be accredited by COMTA and able to receive Title IV student loan funding. Best wishes in your continued Rolfing practice and other work.

Structure, Function, Integration.

We are delighted to officially announce the development of a new website dedicated to serving readers of the Journal and expanding readership. It will feature monthly articles from previous issues, links to purchase current and past issues on Amazon Print and Kindle, plus a Q&A section that fosters connection and the sharing of knowledge among SI professionals and all interested individuals. Stay tuned for updates on our April 2021 launch!

Institute News

Upcoming ConnectMembership Meetings for DIRI Alumni & Faculty

Below is a list of our first two events for 2021. DIRI members can find a full list of scheduled monthly events in the ConnectMembership section of the website when they are logged in. Additionally, reminder newsletters and emails will be sent to members ahead of each meeting. We look forward to connecting and empowering Rolfers™ globally.

Thursday, January 21st 2021 6:00 PM MST

ConnectMembership - Veterans: Preparing to meet the needs of Vets and the VA Whole Health Initiative

Presenters: Larry Koliha and others who serve or are veterans

Learn more about how the Institute is engaging with Veterans both as clients and as potential students. Hear about the VA's Whole Health Initiative and how our work is situated to be part of this new focus.

Thursday, February 25th, 2021 6:00 PM MST

ConnectMembership - Learning the Ten Series

Presenters: Guest faculty TBA

How has teaching and learning the ten series evolved over the years? Are we ready for a program redesign now? Share your perspective on the next steps for preparing the best Rolfers possible.

Upcoming USA Classes 2021

2021-2023* Rolfing® SI Basic Training Boulder, CO Campus

Program	Start Date
P1.21	1 February 2021
P1.21	1 March 2021
P3.21	7 June 2021
P3.21	5 July 2021
P4.21	4 October 2021
P4.21	1 November 2021
P1.22	1 May 2023

Regional Training in Atlanta, Georgia please refer to the Rolf.org website

2021 Rolf Movement® Integration Certification (Intensive)** Boulder, CO Campus**

Program	Start
RMI2.20	1 March 2021
RMI3.20	24 May 2021
RMI1.21	12 April 2021
RMI2.21	12 July 2021
RMI3.21	20 September 2021

*All classes including CE can be found at rolf.org
**The RMI classes listed are for our 30 Day Intensive Program and include three parts. We also offer a Workshop Format that can be completed over time for added flexibility from various USA locations.

Upcoming CE Courses

The Dr. Ida Rolf Institute® is committed to cultivating academic growth and therapeutic skills in all of its graduates. Continuing education studies can cover a broad range of relevant subjects. Certified Rolfers may take workshops in specific manipulative techniques or may explore other related subjects such as craniosacral therapy or visceral manipulation. Classes are continually being added - please visit www.rolf.org/courses for the most recent updates, or to register.

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