Body Work

Cranial-Sacro

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Prof Emeritus of IMUNE
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Body Work intro

In the fifth grade we learned that our bodies are made of atoms. And atoms are made mostly of protons, neutrons and electrons. There are great spaces between these electrons and protons and other atoms. Here is a Hydrogen Atom.

**Protons, Neutrons, and Electrons**

Atoms are made up of protons, neutrons, and electrons. Protons and neutrons are found in the nucleus of the atom, while electrons orbit the nucleus. The number of protons in an atom determines what element it is. Hydrogen, for example, has one proton. The number of neutrons can vary, giving rise to isotopes of the same element.

**Electron Shells**

Electrons are arranged in shells around the nucleus. Each shell can hold a certain number of electrons. The first shell can hold up to 2 electrons, the second shell can hold up to 8, and so on. When two atoms approach each other, their electron shells can overlap, allowing them to share electrons and form a molecule.

**Repulsion and Attraction**

Despite the fact that each atom’s net charge is 0, the outer electrons repel each other. This is a very useful feature of nature. It makes our lives a lot easier. But why don’t they just go back and forth between the atoms? Things don’t fall through other things because they are levitating on an energetic electrostatic field. Remember that like charges repel each other. When two atoms approach each other, their electron shells push back at each other, despite the fact that each atom’s net charge is 0. This is a very useful feature of nature. It makes our lives a lot easier.

Now the question you should be asking is, if atoms push away from each other, why doesn’t the entire universe just blow away from itself? The answer is gravity is of course and actually most atoms’ quantum electron shells are not full. When two atoms come together and have empty spaces in their electron quantum shells, they will share electrons to fill in the spaces in both of their shells. Yes, the electrons really do go back and forth between atoms and they do so pretty fast. Outer Electrons tend to be kind of mobile, which is also a very nice feature of nature, since without it your walkman would not work or you would not be alive. It is the free electrons and protons in the body that allow life. Once both atoms’ outer shells are full due to this electron sharing, they go back to their usual repulsive behavior. This, by the way, is how we get molecules, hormones, enzymes and the secret to understanding Chemistry, Biology, Medicine, Physiology etc. It’s all about the electrons and protons, charged particles and vibration! How about a medical device to measure and correct electron disorders? We call it SCIO.

**Energetic Medicine**

Energetic medicine has made several scientific mistakes. First the hand delivered point probe was too sensitive to operator control and it was too slow to measure the body electric’s changing activity. The muscle testing was also found to be 100% under operator control in all tests and thus was not measuring the patient’s body but measuring the therapist’s intent. Many claims were not supported with research or with clinical evidence. There were many charlatans selling illegal even complete bogus fraudulent devices with exorbitant claims. Certain Russian devices and others were found to be completely deceptive shams and doctors have lost their license using them.

Recently the regulatory bodies have been mandated to make the energetic medicine people put up the evidence to support their claims. We at SCIO have done so. We now have a CE stamp of approval for our CE mark and this paper is about the claims we and you can make in print or elsewhere. Congratulations everyone, energetic medicine is saved. We have made the studies up the evidence to support their claims. We at SCIO have done so. We now have a CE stamp of approval for our CE mark and this paper is about the claims we and you can make in print or elsewhere. Congratulations everyone, energetic medicine is saved. We have made the studies up the evidence to support their claims. We at SCIO have done so. We now have a CE stamp of approval for our CE mark and this paper is about the claims we and you can make in print or elsewhere. Congratulations everyone, energetic medicine is saved.
There are about 100 trillion cells in the human body and another 50 trillion microorganisms in the gut. All of these cells are in communication with each other and the master regulator the Brain. The cells communicate via signals of
1. Electro-Magnetic Radiation EMR (that is Photons and only the photons touch things), this is mitogenic radiation and infrared body heat which also can transmit information
2. Electro-magnetic-static free electrons, or free protons (electricity)
3. Intra-cellular ionic charged particles, (sodium and potassium channel Pump of neurons)
4. Extra-cellular ionic charged particle, osmosis regulation, water circulation
5. Large molecular paramagnetic substance like enzymes and hormones
7. The vibrations or cycles of each of these transfers is the frequency of operation
A few stress-related diseases

1. Acid Peptic Disease
2. Alcoholism
3. Asthma
4. Fatigue
5. Tension Headache
6. Hypertension
7. Insomnia
8. Irritable Bowel Syndrome
9. Ischemic Heart Disease
10. Psychoneuroses
11. Sexual Dysfunction
12. Skin diseases like Psoriasis, Lichen planus, Urticaria, Pruritus, Neurodermatitis etc

(List incomplete)

In fact all disease is associated with or aggravated by stress. We now know that the electro-stress is increasing. The SCIO balances the body to better deal with Electro Smoke or Electro-Stress. See electro smoke paper

Ease of flow of information is health. Stressors deregulate the flow and produce Dis-Ease, Dys-Ease disease. Disease is problems with the flow of health. See the causes of disease in the IMUNE Literature.

The Brain receives Photonic, Electrical, and Chemical information from all of the cells of the body, to regulate all of the body processes.

With the DNA of 100 trillion (100,000,000,000,000) cells sending information to all of the Brain, it is an overwhelming task of the Body Electric

There are over 100 billion neurons in the Brain.

There are approximately 10,000 cellular Operations Happening every second. This means there is 10 to the 18th bits of information going to the brain every second, But the Reticular Activating System (RAS Word Brain) can only handle 1 million bits of Data a second or it is overloaded.

So the word area is getting one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of one percent of the information of life. We need to measure the body electric to determine health.

Verbal lack of symptoms is inadequate. You can be really sick and not know it verbally. But your body electric knows all of the processes right down to the electron.
The SCIO measure the Body Electric variables of voltage, amperage, resistance, hydration, oxidation, Ph and the oscillations of each of the electrical factors in the body. These oscillations make up some of the standard biofeedback measures.

The SCIO can measure the Brain wave (EEG), heart electric (ECG), muscles (EMG), Skin Resistance (GSR) and measure global and quadrant body voltage, amperage, resistance, hydration, oxidation, and Ph. EEG, EMG, ECG all involve oscillations. GSR or skin resistance does not involve oscillation. Resistance is measured without regular patterns of oscillation. This is one of the failures of the Voll and point probe devices.

The SCIO can treat Pain (MENS), Trauma (EWH), Emotions (MCES), and Reactivity (TVEP). So the SCIO becomes a valuable tool for a Body Work clinic.

Research has shown that when you apply an electrical impulses of a certain nature to tissue you can electrically treat pain, increase osmosis, speed up healing, measure reactivity, correct brain wave, treat emotional disturbances like addiction insomnia, anxiety, increase intellectual thinking and help learning disabilities. This and many more is shown in the literature and registered with the FDA as treatment devices.

When these therapies listed above are coupled with a cybernetic feedback loop where we can automatically adjust the pulses in strength, duration, speed, or wave form, we get a superior technology. The electrophysiological feedback Xrroid then results. A technology registered around the world for over two decades. Safe and effective energetic medicine now available.
Healing Injury and or Trauma

Simplified Body Work Physiology

So the body is extremely complex beyond our imagination and the body is extremely well organized beyond our imagination. To understand the body we must understand the structure. There are bones and the hard tissue and then there is soft tissue surrounding. There is thus a very very large amount of data to learn and a constant flow of updated literature to read. In America every state regulates Chiropractic, most massage and body work. This book is but an intro to the field. You need to learn hands on and not from a book. This book is but a study guide for learning about body work. So use this collection of material to see how you can help people with the art of simple massage to advanced chiropractic.

Soft tissue is a term that refers to structures of the body that connect, envelope, support and/or move the structures around it. Examples of soft tissue include:
• muscle, which supports and moves bones
• tendons, which connect muscles to bones
• ligaments, with connect bones to bones
• synovial tissue, which is the material that makes up joint capsules
• fascia, which surrounds the musculoskeletal components, giving upright integrity to the human form
• and other structures such as nerves, blood vessels and fat.

**Inflammation is a response to injury that is characterized by:**

• redness
• pain
• heat
• swelling
• loss of function (sometimes)

The inflammatory response is the body’s way to deal with infection or injury. It mobilizes chemicals that will deal with pain, ward off bacteria and begin the wound healing process.

Inflammation happens at the site of the injury or infection.

Spasticity is condition that results when the nervous system has lost control of the orchestration between contraction and relaxation of muscles. Spasticity causes much muscle stiffening. The opposite effect, flaccidity may also be present.

Spasticity occurs in persons with spinal cord injury and other conditions. Making a commitment to a sound flexibility routine is necessary to counteract the effects of spasticity. While strength training, avoid too much emphasis on muscle groups that tend to stiffen more. Spending time with the legs extended may also help. Also Known As: hypertonia

**Bones, Ligament and Tendons**

So the bones are the hard structure and they have joints at the bones ends. The bones are attached to other bones via ligaments which are semi-hard tissue acting like ropes to connect bones. There are muscles which are attached to the joints and or bones with tendons. These are like ligaments but connect muscles to bones. The famous Achilles’ tendon connects the calf muscle to the back of the ankle.

Achilles’ mother Thetis dipped him into the river Styx and he was invulnerable except for his heel. Everyone has a weak link we need to protect and we call often call it our Achilles’ heel. It is a weak link for many athletes.
Now the vast amount of electrons in the body is well organized. We need to intake energy and nutrients from food and to expel refuse. This is a cycle. We inhale air to get oxygen and the blood carries the oxygen and nutrients to the cells and the blood takes away the carbon dioxide and the refuse. Blood is key and everything is a cycle. There are countless cycles in the body that regulate the process of life.

When all of this is in balance and proceeding well we have EASE OF FLOW. The cycle flows easily when there is blockage of flow or acceleration of flow we get imbalance of flow and we call it DISEASE OF FLOW or simply DISEASE. To treat disease we must restore the balance of flow. Flow of air, flow of refuse, flow of thought, flow of nutrients, flow of energy, flow of prana, flow of nerv conductivity, simply restore flow.

A joint or connection of nerve blood and mechanics can be balanced and normal. The joint can be completely dislocated or the joint can be subluxated or partially out of balance. The art of Chiropractic and Osteopathy are designed to restore balance to subluxations.

Muscle tension, injury, blood too viscous, lack of nutrients, energy disturbance and else are the problem and others can cause a blockage of flow and disease results. This book is designed to start you to learn how to balance the body flow of energy and to correct subluxations.

This book is but a tool in the education of hands on experience of wonder and elation in helping others. As you learn more and more you will see how to help people and yourself to grow and find enlightenment and peace.
Management of Acute Inflammatory Lesions

By R. Vincent Davis, DC, PT, DNBPM

Acute inflammatory lesions should not be treated with heat producing agents. The cardinal clinical signs of an acute inflammatory lesion are swelling (tumor), redness (rubor), heat (calor), and pain (dolor).

The physiological response by body tissues to the application of heat is swelling (partially due to histamine release), redness (resulting from hyperemia), and heat (due to increased blood flow and cellular metabolic rate). Pain is commonly relieved by such a modality probably as a result of the gate control mechanism.

Because the heat producing modalities result physiologically in three of the four cardinal features of the acute inflammatory reaction, applying such an agent to acutely inflamed tissues would superimpose the elements of one acute inflammatory reaction upon another and would thereby enhance the pathological process.

Obviously, cryotherapy would be the initial modality of choice in lesions of traumatic origin, but this is the opposite of a thermal agent.

Heat producing agents are properly reserved for chronic inflammatory lesions.

Chronic inflammation is commonly characterized by the presence of more cell proliferation and connective tissue than exudate with the presence of lymphocytes and plasma cells rather than polymorphonuclear leukocytes. Cicatricial tissue is more characteristic of chronic inflammation as well.

Cellular changes found in chronic inflammatory reactions commonly involve a reduction in local cellular function and/or replacement of typical cell types for the tissue in question with connective tissue (scar). The agents employed in the treatment of such lesions provide for physical and physiological improvement in such changes. Increased blood flow to the part enhances the bioavailability of intracellular nutrients, the drainage of waste products and transudates or exudates due to outflow, and the gradual replacement of more appropriate cell types being among these improvements. Collagen tissue may be replaced by areolar tissue in some cases, or fibrous connective tissue may be separated or reduced in length, thereby allowing for greater functional range of motion.

Heat producing agents are therefore contraindicated in the treatment of acute inflammatory lesions.

The Importance of the Thoracic Spine in Shoulder Mechanics

By Chris Feil, DC and William E. Morgan, DC

As discussed in previous articles in this series, cross-fitness programs tend to advocate exercises that require maximal shoulder end-range motions: pull-ups (often with a kip or a jerk motion at end range), handstand presses, press squats, push-presses, clean and presses, kettlebell overhead lifting, gymnastic ring work and other similar exercises.

To perform these motions without injury requires unfettered shoulder range of motion and optimum shoulder stability. While an argument may be made that these exercises help to create coordinated athletic patterns of strength, agility, and stamina, they still have a strong potential for causing shoulder injuries. Often not included in the explanation of the workout of the day in cross-fitness programs is the need for the participant to have flawless shoulder mechanics and strength.

Impingement of the rotator cuff muscle (supraspinatus) develops when the space between the rigid coracoacromial arch and the head of the humerus narrows. The muscles and tendons of the cuff that pass through this space begin to fray and eventually may tear because they are pinched between these hard surfaces. Why does this space narrow? Anatomically, it narrows due to bony spurs, degenerative changes, or soft-tissue thickening. Functionally, the space narrows due to dysfunctional synchronicity of the rotator cuff muscles, aberrant scapular-humeral rhythm, or faulty scapular positioning during overhead arm movements.

To maintain the subacromial space in an overhead arm movement, the scapula must retract and tilt posterior. A shortened pectoralis minor will cause the scapula to tilt anterior, contributing to a functional shoulder impingement. A study conducted at Ohio State University found that subjects with tight and short pectoralis minor muscles displayed similar scapular kinematics as individuals with shoulder impingements. Scapular retraction is affected by the mobility of the thoracic spine and rib cage upon which it glides.

Thoracic Spine Mechanics and Shoulder Pain
Normal scapular and thoracic spine motion allows optimal mechanics for athletic shoulder motions (left). Increased thoracic kyphosis, reduced thoracic mobility, or scapular protraction from pectoralis minor tautness can contribute to shoulder impairment and injury (right). The concept of scapulo-humeral rhythm is well-documented, and the rhythm is fundamental to maintaining the subacromial space. The long-accepted linear ratio of scapular rotation to arm motion in adduction is 1:2, 2 though the true interaction of the scapula and arm is not linear, but more curvilinear in nature.8 There is very little scapular rotation in the first 60 degrees of arm abduction, and then the scapula progressively begins to rotate as the arm travels to a full overhead position.4

Normal thoracic-humeral rhythm is important for injury prevention. Thoracic mobility becomes increasingly important in athletic overhead activities. The higher an athlete raises their arm, the more thoracic motion is needed from the thoracic spine to maintain the proper relative shoulder alignment. Individuals with a shoulder impingement have statistically less thoracic mobility and a more kyphotic thoracic spinal posture than individuals with healthy shoulders.3,6-7 A few weeks of cross-fitness training with a rigid thoracic spine could lead to injury and impairment of the rotator cuff.

Does T4 Syndrome Exist?

T4 syndrome has been accepted as fact by many clinicians over the past decade, in spite of a lack of evidence to support its existence. The theory of T4 syndrome attributes many of the problems seen in shoulders to a loss in the normal extension that takes place at the T4 vertebra.5 We should note that T4 syndrome has also been credited with causing diffuse arm, shoulder, and torso pain and sensory symptoms.

A review of the literature review did not find research substantiating association of the T4 syndrome to shoulder function. However, we did find a boastload of seminar notes elevating the “T4 syndrome” to a height not supported by the current body of research. T4 syndrome is based on clinical anecdotal experience rather than scientific evidence. While there is no substantial evidence that T4 syndrome directly relates to shoulder impingement, there is some current research pointing to the lower thoracic spine as being a fundamental component of shoulder motion.4

If accurate, this research suggests that the majority of thoracic extension occurs in the lower thoracic spine during overhead arm movement in asymptomatic shoulders, especially with both arms in an elevated position, as is seen in an overhead squat or overhead press. In the same study, upper thoracic extension was present in full overhead arm motion, but it was not deemed to be a significant variable in shoulder function.4 However, what the study did find statistically significant in the upper thoracic spine was lateral bending and ipsilateral rotation during single-arm elevation. Theodoridis and Ruston also found this repeatable relationship of overhead arm movement causing an ipsilateral coupling pattern between lateral flexion and rotation, which was repeatable and comparable for both arm elevation planes in healthy subjects.11

Thoracic Joint Manipulation

It appears that simply assessing T4 extension in a cross-fitness athlete may miss significant dysfunctions in the thoracic spine that affect the thoracic-humeral rhythm. For example, optimal shoulder function in a single-arm kettlebell swing may be improved by use of manual therapy when specifically addressing lateral bend and rotation components of the upper thoracic spine and any loss of extension in the lower mid-thoracic spine.

Thoracic joint manipulation might be the simplest answer to reducing pain in an impinged shoulder. In a 2009 study by Strunce and colleagues, a thoracic spinal manipulative thrust was performed on a sample of 56 individuals with symptomatic shoulders from impingement. After two days, there was a significant decrease in pain levels in over 50 percent of individuals.10

Before giving a list of boring rotator-cuff strengthening exercises to a cross-fitness athlete who is performing fun, dynamic exercises in their daily workouts, remember that a key component to overhead arm motion is thoracic mobility. When the alignment of the shoulder and the subacromial space is compromised from the loss of thoracic spine mobility and/or muscle tightness, it doesn’t matter what tension of rehab exercise band is used until the underlying cause of impingement is addressed. Evaluation and appropriate treatment of the spine should be considered when shoulder dysfunction is present.

The cross-fitness emphasis on pull-ups and overhead lifting may produce a glut of shoulder injuries from otherwise dormant thoracic and shoulder impairments. By recognizing the functional relationship between the thoracic spine and the shoulder joints, we can help athletes remain active and pain-free as they engage in their preferred activities.

References

2. Codman EA. The Shoulder; Rupture of the Supraspinatus Tendon and Other Lesions in or About the Subacromial Bursa. Thomas Todd, Boston, 1934.
Goodbye Tendonitis, Hello Tendinosis
By Warren Hammer, MS, DC, DABCO

Tendonitis is now considered a relatively rare condition. The good news is that with the diagnosis of tendonitis, patients were expected to get well in a short time, but with the realization that it is really tendinosis, more time is required (six weeks to six months, depending on the chronicity) for treatment and healing.

In many cases such as Achilles tendonitis, patellar tendonitis, lateral epicondylitis and rotator cuff tendonitis, a good percentage of cases do not get well as soon as we might desire. We do not have to blame ourselves. What we have to do is explain to the patient the underlying tissue damage that exists. Corticosteroid injections and NSAIDs cannot really heal a noninflammatory condition.

In my article “Is It Really Tendonitis?” which appeared in the January 12, 2000 issue of Dynamic Chiropractic, I quoted Boyer et al.2 who stated: “Signs of either acute or chronic inflammation have not been found in any surgical pathologic specimens in patients with clinically diagnosed lateral tennis elbow syndrome.” Maffulli3 states that “tendonitis” or “tendinosis” should only be used when the microscopic diagnosis of the condition has been confirmed.

Evidence is currently on the side of tendinosis over tendonitis. According to Bonar,4 tendonitis is symptomatic degeneration of the tendon with vascular disruption due to a partial rupture of the fibers. Most of the chronic conditions we see are not traumatic enough to cause a vascular disruption necessary for the creation of an inflammatory response. What we really are seeing is an intratendinous degeneration due to aging, and microtrauma where there is collagen disorientation, disorganization and fiber separation by increased mucoid ground substance. Tendinosis results from collagen degeneration and mechanical overload.1

Our treatment should emphasize the prevention of collagen breakdown, which requires rest and strengthening (especially the eccentric type). Elbow and ankle supports, for example, take on a new meaning. Warming up before activity and paying attention to correct biomechanics required for particular sports takes on a new emphasis. We must prevent collagen damage and, most importantly, stimulate collagen synthesis. Again, the knowledge that friction massage stimulates fibroblastic proliferation, which synthesizes new collagen, proves again why this method has proven so effective over the years.

Hypertonic Fascia
By John Lowe, MA, DC

Chiropractic’s myofascial pioneer, Dr. Raymond Nimmo wrote, in 1984, “Trigger points have become the glamour girl getting all the attention, while hypermyotonia, which spawns them, is ignored. Many chiropractors are victims of the illusion that clearing a patient of trigger points is all that needs to be done. But if you do not release the hypertonic muscles which produce them, they will redevelop.”1 He was right. But evidence today carries us beyond this bit of Nimmo’s wisdom: just as neutralizing trigger points may not be enough, relaxing excess muscle tone may also not be enough. Fascial tension must be reduced as well.

As a constricting entity, fascia can sabotage the best attempts to relieve pain that are directed only to trigger points and hypertonic muscles. A good example is pain from trigger points in the thoracic erector muscles. In many patients these muscles contain highly palpable ropy cords. Patients with hyperkyphosis, osteochondrosis, or spondylosis are especially prone to suffer from pain referred from trigger points in the matrix of these cords. The cords behave not as muscle, but as dense fibractic tissue. In my experience, the pain referred from trigger points in these cords can best be stopped with ultrasound or negative galvanism. But the relief is brief unless the erectors are stretched, which is cumbersome at best. So, I often use cross-friction technique -- although not atop trigger points -- to stretch and loosen these muscles.

Visualize a Steven Spielberg version of a human form, selectively stripped of skin, muscle, nerves, bones, and viscera -- every tissue except fascia. This form resembles a mummy wrapped in gauze, but more ghost-like; its substance somewhat translucent and iridescent when light strikes it at certain angles. Most of the body-form’s white substance is uniformly dense. But the fascia is thicker and more opaque at sites that have been subjected to stresses such as: 1) trauma, 2) intermittent biomechanical stress, or 3) immobility. The greater density at these sites is the fascia’s normal reaction to stressors, and it’s at these sites that fascial trigger points are likely to form.

When traumatized and inflamed, a fascial lesion heals by spider-webbing together with irregularly arranged collagen. Where fascia has been intermittently stressed (as when thoracic erectors support a forward-bobbing head), fibroblasts produce more linearly arranged collagen to reinforce the loaded myofascia.2 Injuries or sedentary life-styles limit body motions, leaving fascia chronically shortened and nestled closely to adjacent fascia. This immobility, and thus the lack of movement between adjacent fascial sheets, permits fascio’s collagen fibers to form intermolecular cross-bonds. In effect, the fascial sheets polymerize into a somewhat continuous, constraining straight-jacket of human flesh.

Fascia, as well as tendons, capsulaes, and ligaments, may polymerize and lose its flexibility after only three weeks of inhibited motion.3,4 Fascia adheres to fascia, with collagen fibers coiling in on themselves and shortening over time.5 This leads to a hyperfasciotonia that seriously compounds any hypermyotonia. Hypertonic fascial layers trap and squeeze nerve receptors, along with blood and lymph vessels. This creates and activates trigger points.

Muscle and its fascia can’t be separated in that they function and dysfunction together.6 Where there is tight muscle, there is usually tight fascia. Fascia can become hypertonic and produce the same pathophysiological phenomena as tensed muscle. Fascial-release techniques, then, are as important in myofascial therapy as are muscle-relaxing techniques; both are critical to giving patients enduring relief from pain. Myofascial therapy is exactly that -- in name, in theory, and in practice.

Chronic inflammation & tissue degeneration in orthopaedic surgery

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<thead>
<tr>
<th>Project title</th>
<th>Chronic inflammation &amp; tissue degeneration in orthopaedic surgery</th>
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<tbody>
<tr>
<td>Project owner / contact</td>
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Chronic inflammation and tissue degeneration are hallmarks of many patients undergoing orthopaedic surgery. The focus of the research in my laboratory is to identify and characterize factors important for the sustenance and perpetuation of the inflammatory reaction in diseases like osteoarthritis (OA), rheumatoid arthritis (RA) and bone and soft tissue injuries. The aim is to find novel therapeutic targets in these devastating diseases. In collaboration with other academic laboratories and pharmaceutical companies, novel factors important for resolution of the late inflammatory reaction are also studied in functional translational assays using human cells.

Publications


Arm and hand pain causes: Tissue degeneration and atrophy (incl. enthesopathy and Trigger Points)

by Christina Abbott on November 23, 2009

This is a series on arm and hand pain causes. If you missed the beginning, go back to the Checklist.

"Use it or lose it," the saying goes, and with muscles, there’s a lot of truth to that. If you’ve ever seen the before and after view of someone who has had a cast for a broken limb, you’ve probably seen how much the muscles can shrink. It only takes two weeks to lose immobilized muscle tissue and much longer than that to build it back up.
Craniosacral therapy

Dr Desi Says
Learn Cranial Sacral Therapy and it is more than just Good Posture
Craniosacral therapy (also called CST, also spelled CranioSacral bodywork or therapy) is an alternative medicine therapy used by osteopaths, physical therapists, massage therapists, naturopaths, chiropractors, and occupational therapists. A craniosacral therapy session involves the therapist placing their hands on the patient, which allows them to tune into what they call the craniosacral rhythm. The practitioner claims to gently work with the spine and the skull and its cranial sutures, diaphragms, and fascia. In this way, the restrictions of nerve passages are said to be eased, the movement of cerebrospinal fluid through the spinal cord is said to be optimized, and misaligned bones are said to be restored to their proper position. Craniosacral therapists use the therapy to treat mental stress, neck and back pain, migraines, TMJ Syndrome, and for chronic pain conditions such as fibromyalgia.

Several studies have reported that there is little scientific support for the underlying theoretical model for which no properly randomized, blinded, and placebo-controlled outcome studies have ever been published. Also, craniosacral therapy and Cranial Osteopathy are two different professions in both training and practice. Though they are based on the same principles, Craniosacral Therapists are an unlicensed group, not doctors. Cranial Osteopaths are fully licensed doctors of osteopathic medicine (medical physicians), having gone to medical school, passed medical boards and as such have a deeper and broader knowledge of the human body than a Craniosacral Therapist.

History
Cranial Osteopathy was originated by physician William Sutherland, DO (1873-1954) in 1898-1900. While looking at a disarticulated skull, Sutherland was struck by the idea that the cranial sutures of the temporal bones where they meet the parietal bones were "beveled, like the gills of a fish, indicating articular mobility for a respiratory mechanism." The idea that the bones of the skull can move in this manner is contrary to anatomical facts.

Sutherland stated the dural membranes act as 'guy-wires' for the movement of the cranial bones, holding tension for the opposite motion. He used the term reciprocal tension membrane system (RTM) to describe the three Cartesian axes held in reciprocal tension, or tensegrity, creating the cyclic movement of inhalation and exhalation of the cranium. The RTM as described by Sutherland includes the spinal dura, with an attachment to the sacrum. After his observation of the cranial mechanism, Sutherland stated that the sacrum moves synchronously with the cranial bones. Sutherland began to teach this work to other osteopaths from about the 1930s, and continued to do so until his death. His work was at first largely rejected by the mainstream osteopathic profession as it challenged some of the closely held beliefs among practitioners of the time.

In the 1940s the American School of Osteopathy started a post-graduate course called 'Osteopathy in the Cranial Field' directed by Sutherland, and was followed by other schools. This new branch of practice became known as "cranial osteopathy". As knowledge of this form of treatment began to spread, Sutherland trained more teachers to meet the demand, notably Drs Viola Frymann, Edna Lay, Howard Lippincott, Anne Wales, Chester Handy and Rollin Becker.

The Cranial Academy was established in the US in 1947, and continues to teach DOs, MDs, and Dentists "an expansion of the general principles of osteopathy" including a special understanding of the central nervous system and primary respiration.

Towards the end of his life Sutherland believed that he began to sense a "power" which generated corrections from inside his clients' bodies without the influence of external forces applied by him as the therapist. Similar to Qi and Prana, this contact with, what he perceived to be the Breath of Life changed his entire treatment focus to one of spiritual reverence and subtle touch. This spiritual approach to the work has come to be known as both 'biodynamic' craniosacral therapy and 'biodynamic' osteopathy, and has had further contributions from practitioners such as Becker and James Jealous (biodynamic osteopathy), and Franklyn Sills (biodynamic craniosacral therapy). The biodynamic approach recognizes that embryological forces direct the embryonic cells to create the shape of the body, and places importance on recognition of these formative patterns for maximum therapeutic benefit, as this enhances the ability of the patient to access their health as an expression of the original intention of their existence.

From 1975 to 1983, osteopathic physician John E. Upledger and neurophysiologist and histologist Ernest W. Retzlaff worked at Michigan State University as clinical researchers and professors. They set up a team of anatomists, physiologists, biophysicists, and bioengineers to investigate the pulse he had observed and study further Sutherland's theory of cranial bone movement. Upledger and Retzlaff went on to publish their results, which they interpreted as support for both the concept of cranial bone movement and the concept of a cranial rhythm. Later reviews of these studies have concluded that their research is of insufficient quality to provide conclusive proof for the effectiveness of craniosacral therapy and the existence of cranial bone movement.
Upledger developed his own treatment style, and when he started to teach his work to a group of students who were not osteopaths he generated the term 'CranioSacral therapy', based on the corresponding movement between cranium and sacrum. Craniosacral therapists often (although not exclusively) work more directly with the emotional and psychological aspects of the patient than osteopaths working in the cranial field (citation needed). Craniosacral Therapy Associations have been formed in the UK, North America, and Australia.

The primary respiratory mechanism

The Primary Respiratory Mechanism (PRM) has been summarized in five ideas.

Inherent motility of the central nervous system

Still described the inherent motion of the brain as a “dynamo,” beginning with the cerebellum. The postulated intracranial fluid fluctuation can be described as an interaction between four main components: arterial blood, capillary blood (brain volume), venous blood and cerebrospinal fluid (CSF). The function of such a mechanism is postulated by Lee as being based on a fulcrum created by the root of the cerebellum and its hemispheres moving in opposite directions, resulting in an increase in pressure which squeezes the third ventricle. The pulsation is described as essentially a recurrent expression of the embryological development of the brain.

Fluctuation of the cerebrospinal fluid

Sutherland used the term "Tide" to describe the inherent fluctuation of fluids in the Primary Respiratory Mechanism. Tide alludes to the concept of ebbing and flowing, but also the contrast between waves on the shore having one rhythm, with the longer rate of lunar tides below. The Tide incorporates not only fluctuation of the CSF, but of a slow oscillation in all the tissues of the body, including the skull.

Practitioners work with cycles of various rates:

- 10-14 cycles per minute - the original "Cranial Rhythmic Impulse" (CRI) (also described as 6-14 times per minute)
- 2-3 cycles per minute - the "mid-Tide"
- 6 cycles every 10 minutes - the "long Tide"

There is sufficient scientific evidence to conclude that fluctuations in cerebrospinal fluid do exist. In a previously cited article by the British Columbia office of health and technology states, “Eleven studies reported primary data on the motion of cerebrospinal fluid (O’Connell ’43; Du Boulay et al. ’72; Cardoso et al. ’83; Takizawa et al. ’83; Avezaat & van Eijndhoven ’86; Enzmann et al. ’86; Feindberg and Mark ’87; Urisno ’88 & 2; Zabolotny et al. ’95; Li et al. ’96.) None of these studies was undertaken to contribute to the knowledge of craniosacral therapy. Rather, this set of studies represents research carried out to provide neurosurgeons with data on the pathophysiologic mechanisms pertaining to CSF motion for diagnosis, treatment and monitoring of brain injury and other neurological disorders.” Most of the studies were undertaken in subjects with neurological disorders, or in small populations that are poorly described. The flow patterns observed, therefore, may not be representative of individuals undergoing craniosacral therapy. The retrieved studies verify that CSF movement and pulsation is a clearly observable phenomena measurable by encephalogram, myelogram, magnetic resonance imaging and intracranial and intraspinal pressure monitoring. Furthermore, the research evidence supports the contention there is a cranial "pulse" or "rhythm" distinct from cardiac or respiratory activity. However, changes in CSF due primarily to brain injury are not linked to health outcomes.

In 1960 Lundberg made a continuous recording of intracranial activities of traumatised patients, finding three waves, one of which Lee believes resembles the CRI. There is research which demonstrates examiners are unable to measure craniosacral motion reliably, as indicated by a lack of interrater agreement among examiners. The authors of this research conclude this "measurement error may be sufficiently large to render many clinical decisions potentially erroneous". Alternative medicine practitioners have interpreted this result as a product of entrainment between patient and practitioner, a principle which lacks scientific support. Another study reports craniosacral motion cannot be reliably palpated.

Mobility of the intracranial and intraspinal dural membranes

In 1970, Upledger observed during a surgical procedure on the neck what he described as a slow pulsating movement within the spinal meninges. He attempted to hold the membrane still and found that he could not due to the strength of the action behind the movement.

It has been theorized that during cranial-sacral treatment the membranes act as a fulcrum for fascial restrictions throughout the body, and craniosacral therapists may perceive a change in quality as a result of disturbance such as infection or allergic irritation.

Mobility of the cranial bones

Cranial sutures are almost immobile after fusion, inhibiting movement between cranial bones. According to Lee (2005), this understanding arose in the mid-1900s and was misinterpreted from the work of authors hoping to correlate suture closure with the chronological age of a skull in archaeological specimens. Lee suggests the authors found there was no correlation between suture closure and the chronological age of the individual, and also most skulls demonstrated no suture closure at all except as structural evidence of pathological physical trauma. Lee cites many references giving evidence for mobility in human skulls, and modern anatomy books suggest incomplete fusion of some sutures. According to Gray’s Anatomy, “[w]hen such sutures are tied down by sutural ligament and periosteum, almost complete immobility results.”

Cranial textbooks propose that motion of the skull is possible during flexion and extension because the sutures are mobile. The sphenobasilar synchondrosis (SBS) - the junction between the base of the sphenoid and the occiput - is thought to fuse by the mid- to late twenties, but still retain incomplete fusion of some sutures. According to Gray’s Anatomy, “[w]hen such sutures are tied down by sutural ligament and periosteum, almost complete immobility results.”

Cranial-sacral treatment

A typical cranio-sacral therapy session is performed with the client fully clothed, in a supine position, and usually lasts about one hour. In the Upledger method of craniosacral therapy, a ten-step protocol serves as a general guideline, which includes (1) analyzing the base (existing) cranial rhythm, (2) creating a still point in that rhythm at the base of the skull, (3) rocking the sacrum,
public and professional liability insurance and annual continuing professional development is a 
standards of competence required for registration are craniosacral therapy techniques plus hands 
by the Complementary and Natural Healthcare Council (CNHC) from late 2009 onwards. The 
Foundation for Integrated Health, craniosacral therapy is to be regulated on a voluntary basis 
In the United Kingdom, resulting from a regulation programme facilitated by The Prince’s 
Regulation 
professions as to the validity and efficacy of Cranial Type techniques and principles.

Criticisms
There are extensive criticisms of cranial-sacral therapy from the scientific and health care 
treatment was 5% and no significant risks were shown.

There are few reports of Adverse side effects from CST treatment. In one study of craniosa-

the Body Work with increases in endorphins, but research shows the effects may actually be brought about by 
endocannabinoid system.

There are few reports of Adverse side effects from CST treatment. In one study of craniosacra-

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CranioSacral Therapy (CST) has been shown to help the autistic individual find greater ease, both within themselves and in the world around them, by decreasing structural stress and strain on their central nervous system.

Autism spectrum disorder (ASD) is estimated to affect one child in every 150 births. Autism is the fastest growing developmental disability, with a diagnosis rate rising 10 to 17 percent each year. ASD is considered to be a result of biological and/or neurological disorders that affect the functioning of the brain. To date, there is no known single cause of ASD.

The CST Model of ASD

Dr. Upledger’s recent model of autism is based on his hands-on experience with autistic children and their responses to therapy. It’s supported by research at Johns Hopkins University showing “increased levels of proinflammatory cytokines, neuroglial activation and inflammatory changes” in the cerebrospinal fluid of the autistic patients studied.1 Simply stated, ASD is partially caused by a loss of flexibility and probable inflammation of the membrane layers surrounding the brain.

This compromise can create restrictive force on the brain tissue leading to adverse strain on the internal body-regulating components of the hypothalamus, the reticular activating system and the autonomic nervous system; irritation and hypersensitivity of neurons, glial cells and neurological pathways; abnormal pressure change within the brain tissue; adverse affect on the limbic (emotional) system; over-heightened central nervous system immune response; brain tissue congestion and toxicity; and endocrine system compromise.

What is observed as typical ASD behavioral impairment in social relationships, social communication and imaginative thought might be the effects of inner chaos created by the abnormal grasp, squeeze and irritation of the membrane on the brain. Combining the extreme tension caused by an abnormally inflexible brain container with inflammation can lead to a brain confined within biomechanical and biochemical turmoil.

The CST Approach to ASD

The focus of CranioSacral Therapy is to enhance the balanced motion of:

• The membrane layers surrounding the brain;

• The fluid (blood and cerebrospinal fluid) moving into the cranium, out of the cranium, and throughout the brain tissue; and

• The areas of the body that do not show normal response to the craniosacral rhythm, which might be straining the craniosacral system and the brain.

When working with an ASD individual, the initial focus often is on the cranium to locate an area that has the greatest motion response to the craniosacral rhythm. Delicate release and pumping techniques are used to create more motion in that area.

The increased motion is used as a dynamic biomechanical tool - one hand is used to continue to increase motion and direct fluid flow, while the other hand is used to encourage motion in non-moving areas. Little by little, small changes create larger changes that enhance the mobility of the brain’s container (the craniosacral system).

Increased balanced motion of the membrane surrounding the brain helps flush toxins and inflammation out of the brain tissue. As this occurs, it naturally can elevate biochemical processing, which increases the function of neurons and neurological pathways.

Newfound motion of the brain tissue and fluid helps decrease the abnormal and often enormous strain the brain has been under. This allows the brain cells a greater ability to process and react to information of all sorts. As Donna Williams states in her book, Autism: An Inside-Out Approach, “When I was an infant, my senses didn’t work right and my response to light and sound and touch were not just meaningless, but too acute. I could not only, not understand the world, but I also could not stand it.”2 CST gently can help the ASD person come to newfound levels of tolerance, understanding and response within themselves and with the world around them.

While this article has been focusing on the brain, CranioSacral Therapy also is directed to the whole body, since tissue restrictions anywhere can adversely affect the membrane surrounding the brain. CST helps elevate the body’s natural healing and compensatory mechanisms by facilitating neurological function. This, in turn, can elevate the structure and function of the body as a whole, thereby aiding the correction of dysfunctional systems such as the digestive and immune systems that seem to often be involved in ASD.

CranioSacral Therapy also combines well with and can enhance other forms of therapy the ASD person might be using, such as sensory integration therapy, neurodevelopmental therapy, speech therapy, occupational therapy, physical therapy, diet programs, detoxification programs and homeopathy. When working with a child, it’s helpful to maintain a program of consistent CST, since there is a tendency for the membrane of an ASD child to tighten as growth spurts occur.

CST Is a Sensitive Pathway to Nervous System Correction

CranioSacral Therapy gently and fully embraces each individual as unique. Through this type of acceptance, sensitive touch and delicate application of technique, pathways of change can form. CST can help the brain decrease levels of abnormal inflammation, sensation, tension, toxicity and chaos. This can lead to greater ease and efficiency of nervous system processing, which often manifests as a reduction of ASD symptoms.

References
**Cranial Sacral Test**

The Basics of the Cranial Sacral Test is developing a soft yet firm intimate touch contact with the patient’s spine and emotional neuro-muscular system. This step by step system will guide you to a basic Cranial Sacral evaluation. To hear is to think to see is to believe to do is to know.

**Steps 1 and 2 - occiput, right and left**

With the patient comfortably supine and the examiner comfortably seated at the table, the examiner’s hands were laid palms up on the table so that the ulnar sides of the two hands approximated each other. The fingers were flexed between 60 and 90 degrees. The fingertips were placed in contact with the patient’s occipital region in a (nearly) symmetrical fashion immediately caudal to the superior nuchal line. The examiner’s fingertip contact was allowed to remain passive until the soft tissues relaxed and the examiner could sense the firmness of the deeper bony structures. Once this relaxation of soft tissue occurred, gentle traction was applied in a postero-cephalad direction. As the occiput moved in compliance with this traction, a gentle laterally directed force was added to the traction by each of the examiner’s hands. The resistances of the two sides of the occiput to this examiner-induced passive motion were then rated individually on the 1 to 3 scale.

**RESULTS:**

<table>
<thead>
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<th>RIGHT</th>
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Name___________________________ Date_________

Comment___________________________________________
Steps 3 and 4 - temporal bones, right and left

For testing of restriction to motion of the temporal bones, the examiner and the patient remained in the same relative positions as aforementioned. The patient’s occiput was gently cradled in the examiner’s interlaced fingers (hands palms up). The examiner’s thumbs were positioned so that they were in contact with the temporal mastoid processes and tips.

First, a side-to-side motion was gently induced so that when one mastoid tip was pressed medially, the opposite tip was allowed to move freely in a lateral direction and vice versa. The motions were tested in rhythm with the cranial rhythmic impulse (CR1). Several excursions were monitored. Then, resistance to a very minute circular motion of the temporal bones was tested. The axis of this motion can be conceptualized as running through the external auditory canal and through the petrous portion of the temporal bone. Resistance to these examiner-induced motions was rated on each side in terms of its severity. Before terminating this temporal bone testing, symmetry of motion was restored by the examiner.

RESULTS: RIGHT _______________ LEFT _______________
Name __________________________ Date ___________
Comment ________________________________________

Steps 5 through 15 - sphenobasilar joint

These STEPs were all tested using the “vault hold.” The positions of the subject and the examiner were unchanged except for the application of the examiner’s hands to the subject’s head. The “vault hold” is the descriptor for the method of application of the examiner’s hands to the subject’s head. This application was for the evaluation of the interosseous motions which are conceptualized to occur between the bones of the cranial vault. The index fingers of each hand were applied gently to the area overlying the external surfaces of the great wings of the sphenoid. The fifth fingers of each hand rested in contact with the occipital squama approximately one-half inch medio-posterior to the occipito-mastoid suture above the superior nuchal line. Some slight differences in the placement of these fingers may result if examiners have small hands, or if a head is relatively large in size, but this does not interfere with the proprioceptive cues that can be perceived.

The third and fourth fingers of each hand were not used in the motion-testing process during sphenobasilar evaluation. The thumbs did not contact the subject’s head but did contact each other. They served to provide the examiner with proprioceptive and kinesthetic cues about the equality of motion when movements in one direction were compared with reciprocal movements in the opposite direction.

The types of cranial motion tested using the vault hold were:

- STEPs 5 and 6—Flexion-extension.
- STEPs 7 and 8—Right and left side bending with a degree of rotation.
• STEPs 9 and 10-- Right and left torsion.
• STEP 11-- Compression-decompression.
• STEPs 12 and 13-- Right and left lateral strain.
• STEPs 14 and 15-- Vertical strain in superior and inferior directions.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________

Steps 5 and 6 - flexion extension

Using the vault hold, the examiner exerted a gentle force over the occipital squama and great wings of the sphenoid concurrently. This force was directed caudad and was applied by his paired index and fifth fingers. The thumbs were in contact with each other and furnished proprioceptive and kinesthetic cues so that the examiner's force was applied as symmetrically equal as possible.

After the cranium responded to the initiating force (of approximately 5.0 grams or less), the examiner became passive and followed the cranial motion to its restricted end point. This was the test for flexion. Restriction against this examiner-induced motion was then rated and reported after comparison with restriction encountered when testing for extension, next. To test for extension, a similar bilaterally equal force was applied by the examiner in a cephalad direction. The testing was then repeated until the examiner gained a reliable impression as to the relative ease/restriction of these reciprocal motions.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________

Steps 7 and 8 - side bending-rotation restriction toward right and left, respectively

The vault hold was applied as afore-mentioned. In order to test for restriction toward side bending-rotation toward the right, the examiner's left index and fifth fingers were gently moved cephalad and medialward while slightly approximating each other. Resistance (restriction) to this examiner-induced passive motion was compared with side bending-rotation motion testing toward the left. In order to test for restriction toward the patient's left, the examiner repeated the same procedure using his right hand. Restrictions were rated on the 3 point scale, each side individually.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________

Steps 9 and 10 - torsion restriction toward the right and left, respectively

Using the vault hold, the examiner applied a gentle force with the index finger of one hand and the fifth finger of the other hand simultaneously in a superior (cephalad) direction. First, testing was completed for torsion on one side and, then, after allowing the motion to return to a position of easy neutrality, testing was completed on the opposite sides. The forces were extremely gentle. Following the initiation of motion by the examiner, the motion was monitored to its restricted end point. The restriction was rated for the side on which the great wing of the sphenoid bone resisted superior motion; if the left great sphenoid wing and the right occipital squamous moved easily in a superior direction, but the right great wing and the left squamous moved superior (cephalad) with difficulty, the restriction was rated as a 2 or 3 on the right side in reference to the right wing of the sphenoid bone offering resistance to the superior motion.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________

Step 11 - compression-decompression restriction

Using the vault hold, the examiner exerted a force over the great wings of the sphenoid bone with his index fingers. This force was in a frontal direction away from the fifth fingers which were gently immobilizing the areas over the occipital squama. It is essential that this force be applied as bilaterally equally as possible. The examiner's thumbs in contact with each other furnish valuable kinesthetic and proprioceptive cues during this testing procedure. Following the initiation of the motion, it was monitored to the restricted end point and rated on the 3 point scale (ease/restriction in response to the initiating force). A free anterior-posterior expansion motion (indicated by ease of motion in a frontal direction) suggested the absence of compression.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________

Steps 12 and 13 - lateral strains-restriction toward right and left, respectively

Using the vault hold, the occiput was gently held immovable by the examiner's fifth fingers. The index fingers were then used to induce motion and test restriction bilaterally on a horizontal plane in a direction at approximate right angles to the median sagittal plane of the subject's head. Restrictions toward this induced motion were rated and recorded toward the right and toward the left of the examiner.

RESULTS: RIGHT__________ LEFT__________
Name_________________________ Date_________
Comment__________________________________________
Steps 14 and 15 - vertical strain-restriction of superior motion and inferior motion, respectively

Using the vault hold, the occiput was gently held immovable by the examiner’s fifth fingers while his index fingers (overlaying the great wings of the sphenoid bone) exerted a gentle symmetric force on a frontal plane first in a superior (or cephalad) direction, and then in an inferior (caudad) direction. As the vertical motion carries to its end point, it can be perceived that it possesses an arcing component which is directed posteriorly. Restrictions were rated as they limited the superior and/or inferior response to motion testing in those directions.

RESULTS: RIGHT_____ LEFT_____
Name___________________________Date_________
Comment___________________________________________

Steps 16, 17, 18, and 19 - sacrum

All four of these STEPs were tested with the patient supine upon the upturned palm of the examiner’s right hand. The spine of the sacrum rested in the space between the examiner’s third and fourth fingers. The sacral apex and coccyx rested in the examiner’s upturned palm. The tips of the examiner’s third and fourth fingers were just lateral to the spinous processes of the fourth or fifth lumbar vertebra (depending on the patient’s size). The distal aspects of the examiner’s index and fifth fingers were in contact with the superior lateral aspects of the sacrum.

RESULTS: RIGHT_____ LEFT_____
Name___________________________Date_________
Comment___________________________________________

STEP 16

The test for restriction toward sacral flexion was performed by using the examiner’s palm to gently induce an anterior motion of the sacral apex.

STEP 17

The test for restriction toward sacral extension was performed by inducing an anterior motion of the sacral base. Both of these motions were tested through several cycles of the CRI and the restrictions to examiner-induced motion toward both flexion and

RESULTS: RIGHT______ LEFT______
Name___________________________Date_________
Comment___________________________________________

One of the easiest ways to learn about the gentle modification of craniosacral system motion begins with the feet. As you cradle the heels in your hands, “tune in” to the external rotation (the flexion phase of craniosacral motion), the return to neutral, the excursion into internal rotation
(craniosacral extension) and so on, as the rhythm repeats itself.

As you discover this motion, answer these questions. Does the motion seem symmetrical? Do the feet rotate externally or internally with more facility? As an example, assume that the left foot rotates externally further than the right, and that neither foot rotates internally as easily or as far as it does externally.

In order to change this less-than-perfect situation, follow each foot to the extreme range of motion to which it moves with the greatest ease. In our example, this would mean that you follow both feet into external rotation. When each foot has moved as far into external rotation as it will go (in this case, the left foot rotates externally further than the right), resist the return to neutral by making your hands immovable. Do not push further into external rotation; simply resist the return to neutral by the feet from their extreme positions of external rotation. As the return to neutral is resisted or prevented by applying gentle force at the subject's feet, another examiner monitoring the head will feel a subtle resistance to the cranial bones' attempted return to neutral, and thence into the extension phase of craniosacral motion. The return to neutral and the move into extension will occur on the head, but with less facility. This perceptible change at the head is due to the resistance you have caused by manipulating the subject's feet. As the craniosacral system again returns to its flexion phase, you will notice further movement into external rotation at either one or both feet. Follow this external rotation closely. Carefully take up the slack, just as you would keep a fishing line slightly taut when reeling in a fish, or as you would keep the front bumper of your automobile snug against the rear bumper of a car you are pushing. When the external rotation reaches the limit of its new range of motion and attempts to return to a neutral position, the hands of the therapist again become immovable. The rest of the craniosacral system will reluctantly return to neutral. Then, against the new and increased resistance, it will proceed into its extension phase.

This occurrence can be witnessed by an examiner monitoring the activity at the subject's head. Each time the feet rotate externally a little further, carefully take up the slack and resist internal rotation. After some repetition (the number will differ, usually between 5 and 20), the total craniosacral system motion will "shut down," i.e., become perfectly still. This is called the still point.

The still point has been induced by the therapist's resistance to the physiological motion at the subject's feet. It is usually heralded by gross irregularities of the craniosacral motion which become manifest throughout the whole system. The craniosacral system may shudder, pulsate or wobble. As the therapist persists in resisting the return to the neutral position of the physiological motion at the feet, the craniosacral system's activity will ultimately shut down.

**INTRACRANIAL FLUID CONGESTION**

Congestion of fluids within the cranial vault may be secondary to an obstruction to outflow at the cranial foramina that causes low-grade increases in back pressure. The most common areas for tissue contractures that increase back pressure are probably at the jugular foramina. These foramina are located just lateral to the occipital condyles. A somatic dysfunction in the occipitoatlantal relationship will very likely result in tissue contracture, which will increase the back pressure to cranial-vault venous outflow via these (jugular) foramina.

The jugular foramina also afford passage to the ninth, 10th, and 11th nerves. Disturbances of these nerves may result in clinical symptoms related to cardiac rhythm, digestion, bowel function, swallowing, etc. The spinal accessory portions of the 11th cranial nerve arise from the upper five or six cervical segments. They pass cephalad through the foramen magnum into the cranial vault. They exit from the vault via the jugular foramina and provide motor fibers to the sternocleidomastoid and trapezius muscles.

On the basis of these anatomic relationships, it can be seen that tissue changes in the vicinity of the occipital condyles and jugular foramina may result in varied pain and autonomic syndromes.
An effective therapeutic approach must deal with all the soft-tissue disorders that may cause obstruction to fluid outflow from the cranial vault.

**First-Rib Restriction**

Remaining restrictions of the first rib are then easily corrected by bending to the side of the restriction so that maximal tissue relaxation is obtained. With the thumb and index finger grasping the tissues in the region of the first-rib head, mobilization can usually be accomplished by the use of direct gentle pressure. If further mobilization is required, respiratory assistance (as above) may be quite helpful.

**Release of Upper Cervical and Suboccipital Tissues**

The patient and physician remain in the same position except for the physician’s hands. These hands are approximated palms up, with the fingers flexed so that the distal phalanges are oriented at approximately 90 degrees to the longitudinal plane of the patient’s cervical spine. The fingertips apply deep pressure in the suboccipital region bilaterally. The physician’s fingertips are also used to support the patient so that the occipital region is initially suspended above the physician’s palms. Finger pad contact should be maintained with the inferior aspect of the patient’s occiput.

As the suboccipital tissues relax, the occiput will gently settle into the physician’s upturned palms. The firmness of bone (the atlas) will be apparent at the fingertips on completion of this technique. This is a passive and waiting technique on the part of the physician. Respiratory assistance (as above) by the patient may be employed to facilitate tissue relaxation.

As the tissues relax, a discrete area of tissue contracture may be discovered. This may be a key trigger to the pain syndrome. It should be specifically treated with further deep pressure until it is perceived to relax. This technique is aimed at releasing all tissue hypertonus that may influence outflow from the jugular foramina.
Parietal Lift

The physician should be seated above the patient’s head. The physician’s fingertips are placed gently in contact with the lateral aspects of the patient’s parietal bones bilaterally. The fifth finger pads are in contact with asterion, anterior to the lambdoid sutures and just above the temporoparietal sutures. The other three fingers of each hand are placed about 1 cm. apart and must be above the patient’s temporoparietal sutures. The physician’s thumbs are now crossed upon each other above the patient’s head. (They do not touch the patient’s scalp.) Next, after finger placement is rechecked, gentle pressure is exerted to compress the lateral aspects of the parietal bones medially. If the temporal bones are pressured, the technique will not work and may, in fact, worsen the clinical symptoms. The amount of pressure exerted on the parietal bones is on the order of 5-10 gm. The thumbs, in contact with each other, are used to steady the physician’s hands. This gentle pressure on only the parietal bones as held constant for several minutes. (Usually three to five minutes will suffice.) As the temporoparietal sutures disengage, it will feel to the physician as though the parietal bones are moving superiorly and spreading very slightly. Do not release your parietal pressure suddenly. Do it gradually, otherwise you may worsen the symptoms. Usually when this release is felt, the patient will remark that “pressure” within the head has been relieved.

1. On the midline of the body— at the juncture of the sagittal and lambdoid sutures on the scalp, between the occiput and the atlas, between C2 and C3 (spinous processes), and between C7 and T1 (spinous processes).

2. At the juncture of the metacarpal bones of the thumb and index finger on the distal aspect of that joint capsule, about midway between its palmar and dorsal surfaces (Hoku). This locus is very reactive to needling and deep pressure.

3. At the midpoint of the popliteal crease bilaterally (B54). The best effect is obtained by transcutaneous needling.

4. Immediately inferior to and directly over the mastoid tips bilaterally. The best effect is obtained by transcutaneous needling or by gentle pressure and circular massage. Do not use even moderate pressure on this area, or you may induce a variety of autonomic responses. If your pressure worsens the head pain, it is too firm.

5. At the inferior aspect of the occiput on the lateral aspect of the trapezius, bilaterally. These loci are very effectively treated by needling or deep pressure.

6. About 1 inch inferior to the superior border of the trapezius, midway between the deltoid origin on top of the shoulder and the vertebral articulation of the first rib. These areas are well known to many patients as effective for the use of relaxing massage. They are very effective loci for needling to achieve cervical relaxation and to reduce intracranial fluid back pressure. (Look for discrete areas of acute tenderness.)

7. The medial aspects of the scapular spines (bilaterally) frequently present effective peripheral stimulation loci, as do the medial borders of the scapulae superior to their spines. Peripheral stimulation therapy loci, which are very useful in the reduction of intracranial fluid pressure, are known in acupuncture as K1, GV24.5, and GV26. K1 is located bilaterally on the soles of the feet just proximal to the prominence of the metatarsophalangeal joints between the second and third metatarsals. These loci are very responsive to needling or deep pressure. The other
two loci (GV24.5 and GV26) are found, respectively, on the midline between the medial aspects of the eyebrows (over the glabella) and above the mucocutaneous junction of the upper lip a third of the way towards the base of the nose. These loci are very responsive to needling or to the application of locally applied heat by contact with a warm metallic object.

**Scapula therapy**

**Parietal lift**

**SPINAL DURAL STRESS**

The dural tube is a relatively inelastic and tough membrane. It attaches firmly at the foramen magnum to the posterior bodies of C2 and C3 but not again within the spinal canal until it reaches the level of S2. It becomes the filum terminale externus, passes out the sacral hiatus, and attaches to the coccyx as its periosteum. Considering the anatomic relations of the dura below the foramen magnum and the fact that it forms the endosteum of the cranial-vault bones, it becomes apparent that any continuing stress on the dura mater is capable of producing head pain. A common situation, often ignored, is the anterior flexion of the coccyx due to trauma. The patient seldom perceives the relationship between a fall on the "posterior" and the subsequent onset of persistent head pain. Consideration of the dural osseous attachments readily illuminates a mechanism of dural stress transmission from the anteriorly flexed coccyx to the foramen magnum of the occiput. This stress, though of low grade, is continuous and may cause recurrent occipitointal somatic dysfunction, which in turn causes fluid outflow obstruction at the jugular foramina and intracranial fluid congestion. The cervical musculature becomes hypertonic in response to irritation of the motor nerves. Visceral autonomic syndromes frequently occur. These syndromes eventually resemble each other and become autogenically perpetuated. All the techniques described above may be instituted; however, permanent results will not be obtained until the coccyx is mobilized.
Direct Technique

With the patient comfortably flexed in the lateral recumbent position, the physician’s gloved index finger is inserted into the anus. The coccyx is grasped between the index finger (in the rectum) and the thumb (external). Anterior flexion and posterior extension motion testing is gently carried out. Very often the patient will comment that anterior flexion increases or causes head pain and posterior extension motion relieves it somewhat. These observations by the patient confirm your diagnosis. The correction is achieved by the application of gentle direct technique against the pathologic motion barrier with respiratory assistance until a relaxation is felt. This simple treatment is very effective. It has solved some very severe and persistent headache problems.

Sutherland’s Technique-- "Directing Fluid"

This technique makes use of a mechanism that is not yet scientifically understood but produces predictably favorable clinical results. It is not necessary to be an experienced cranial manipulator in order to successfully employ this very effective therapeutic approach. Place the pads of one or two fingers gently on the scalp directly over the painful suture area. Now, imagine a line or vector from the painful area through the center of the skull (using a globe as the ideational model) and out the other side of the patient’s head so that an imaginary diameter has been formed. With the other hand, very gently palpate for a pulsation of the scalp at the region where the vector (diameter) would emerge from the patient’s skull. The exact location can easily be determined in a few seconds with an extremely light palpatory touch.

Once the area of pulsation has been located, apply two or three finger pads to the area while the fingers of the opposite hand (in contact with the painful suture) are gently laid upon the scalp so that the length of two of these fingers parallel the painful suture about 0.5-1.0 cm. on either side of it. The painful suture will seem to begin pulsating. This pulsating will continue for a matter of minutes. As the pulsation gradually subsides, so will the pain. A very gentle spreading action by the fingers paralleling the painful suture will speed the therapeutic effect, but it is not mandatory.
Remember that gentleness is absolutely necessary for the success of this technique.

Cranial Base

The muscles and fasciae which attach to the cranial base are extremely numerous and can cause marked interference with cranio-sacral system function when abnormal tension, hypertonus or contracture is present. The cranial base is released to improve the free mobility of the occiput and the temporals in response to hydraulic system activities inside the cranial vault and vertebral canal. It should be release after the therapist has balanced and released the thoracic inlet. The fluid release from the cranium, often obtained by the successful treatment of cranial base restrictions, must have an outlet. A congested thoracic inlet creates venous back pressure which interferes with fluid drainage from the cranial vault. This condition, if present, should be remedied prior to releasing cranial base restrictions and balancing its motion. The technique for release of the cranial base makes use of deep pressure into the tissues of the suboccipital region of the neck. Place your fingers vertically so that the tips act as a fulcrum upon which the supine patient’s upper cervical region is balanced.

The pads of your fingers should maintain contact with the occiput. The head of the patient should be poised above the palms of your hands. The therapeutic force is supplied only by the weight of the patient’s head. As the tissues of the suboccipital region begin to relax due to fingertip pressure, the patient’s head will begin to settle into the palms of your hands. Continue the pressure at the suboccipital region in a straight anterior direction. Maintain fingerpad contact with the occiput. Don’t let the tissues move your fingers in an inferior or caudal direction. Ultimately, as the tissues relax, you will feel the firmness of the posterior arch of the atlas. Slowly the atlas will begin to disengage from the occiput. This occurrence is signaled by a “floating” sensation. As it floats, follow and “balance” it. Once it seems free from the occiput, support the atlas anteriorly with the tips of your ring fingers. Move the occiput gently and minutely in a posterior direction with the tips of your middle fingers. This procedure further disengages the occiput from the atlas and decompresses the occipital condylar region.

This technique not only mobilizes the cranial base but also releases the tissues around the jugular foramina. This enhances fluid drainage via the jugular veins from the cranial vault, thus reducing intracranial fluid congestion. The reduction of intracranial fluid congestion will further contribute to cranio-sacral system mobility.

The glossopharyngeal, the vagus, and the accessory cranial nerves pass through the jugular foramina. Release of any compromise of these foramena often has a beneficial effect on the function of these nerves.

THE CV-4 TECHNIQUE

The still point achieved by application of the technique to the subject’s occiput is traditionally called a “CV-4” technique. CV-4 means compression of the 4th ventricle. In this case, 4th ventricle refers to the ventricle of the brain. Dr. Sutherland, the originator of this technique, believed that he was compressing the 4th ventricle of the brain and thus affecting all of the vital nerve centers located in and about the walls of this ventricle. The occipital squama provide an accommodation to changing intracranial fluid pressures. The CV-4 technique significantly reduces the ability of these squama to accommodate. The intracranial hydraulic fluid pressure is therefore increased and redirected along all other available pathways when the motion of the occipital squama is extrinsically restricted. Thus, the CV-4 technique promotes fluid movement and hence, exchange.
The enhancement of fluid movement is always beneficial except in cases of intracranial hemorrhage when clot formation is enhanced by stasis, and in cases of cerebral aneurysm where changing intracranial pressures could produce leaking or rupture.

The CV-4 technique affects diaphragm activity and autonomic control of respiration, and seems to relax the sympathetic nervous system tonus to a significant in stressed patients. Autonomic functional improvement is always expected as a result of still point induction.

Clinically, this technique is beneficial in cases where a lymphatic pump technique is indicated. It has significantly lowered fever by as much as 4 degrees F in 30-60 minutes. It relaxes all connective tissues of the body and therefore benefits acute and chronic musculoskeletal lesions. It is effective in degenerative arthritic processes, in both cerebral and pulmonary congestion, in regulating labor and as a means of reducing dependent edema.

The CV-4 technique is, quite simply, an excellent “shotgun” technique for a multitude of problems in that it enhances tissue and fluid motion and restores flexibility of autonomic response.

As the therapist, cup your hands so that the thumbs make a "V". The apex of the "V", formed by the thumbs, should be level with the spines of the second or third cervical vertebra. The thenar eminences are applied to the occipital squama medial to, and totally avoiding the occipitomastoid sutures. As the subject’s occiput narrows in the extension phase of the craniosacral system cycle, this movement is followed by the thenar eminences, take up the slack by following the narrowing of the subject’s occiput. The occipital broadening of the flexion phase of craniosacral system motion is again resisted.

This procedure is repeated until the cranial rhythm becomes reduced and disorganized, then ultimately stops, temporarily but completely.

When this stop occurs in the cranial rhythm, the still point has been induced. The still point will continue for a variable number of seconds or minutes. The subject’s respiration will change, and light perspiration will often appear on the forehead. A noticeable relaxation of the body will occur.

Within a few minutes, you will notice that the subject’s occiput once again attempts to broaden into the flexion phase of the craniosacral system’s rhythmic cycle. When you feel a concerted strong motion bilateral, stop your resistance. Follow this broadening and evaluate for amplitude and symmetry of craniosacral motion.

A still point can also be induced anywhere on the subject’s head by applying the same principles of following the motion to its extreme extension and resisting the return to neutral until the rhythmic activity temporarily ceases.

**The technique of somatoemotional recall and release**

The technique of somatoemotional recall and release (also known as “unwinding”) begins quite simply and the patient takes over very quickly. You must stay with it until the release occurs. This may take five minutes or it may take an hour. If your schedule is tight and you believe your patient may benefit from this technique, reschedule an appointment for when you have adequate time.

With the patient seated, we usually begin with one hand on the parietal region of the head and the other on the upper thoracic region posteriorly. A slight, inferiorly-directed compressive force is exerted upon the parietals so that the cervical and upper thoracic vertebrae are gently compressed caudally. When the effect of the pressure on top of the head is felt by your other hand in the upper thoracic region, maintain that amount of pressure and allow the patient’s body to do whatever it seems to want to do. The only limit which you place on the body is to prevent it from retracting its steps. That is, once it has made a particular movement it may do anything it wants except to go back the way it has come. If it tries, you gently resist. The body may assume various positions of flexion, extension, side bending, rotation or any combination of these positions. It is very important that the patient be relaxed throughout the procedure. If not, it is extremely difficult to follow the body’s inherent direction as the willed motion or resistance of the muscles will interfere. To attain this state of relaxation, not only must the patient be in an appropriate frame of mind, but the body must be properly supported so that no fear of falling is generated. Sometimes more than one therapist is necessary to properly support the body. The releases will be multiple, and can be monitored on the parietals. As you reach a position in which an injury occurred, the parietal bone movement will reduce. As the body works the injury pattern loose, the parietals will move into a free and easy motion pattern. If an emotional component is involved with the somatic problems it will appear before the parietal release is perceived. Try to follow wherever the patient’s body leads you.

As releases occur, new balance points will present themselves. Each release seems to facilitate the next; things move more and more rapidly. Be alert. Do not inhibit your patient by dragging on their body movements. The only exception to this rule is when the body gets into a rut of continually repeating a pattern of movement, usually circular. This repetition may continue for an interminably long time. A very slight, nonspecific drag placed on the motion by the therapist will reveal an exit point where the motion will take a new direction. From this point, the motion is followed again without external drag. This is a dynamic process, and the movement to movement events and changes are unpredictable. What is predictable is the benefit your patient will experience.

When the treatment session is over the patient will relax significantly. No further autonomous body movements will occur when you attempt to resume the session. But if an arm goes up into the air during the session, gently grasp it and follow. Significant restriction may be localized in the
extremities, as the first example below demonstrates.

Another method we frequently use is to gently touch the anterior ilia of the standing patient and compress slightly medially until the patient's own body movements begin. Then follow through, release after release. The process can also be started with the patient lying supine. In this case, the ankles are grasped and a slight traction or compressive force introduced to start the release process. Each release which occurs during any of these techniques is like another layer of an onion you are peeling away to discover what is in the center.

Remember, the patient will finally assume the body posture in which the injury occurred. You will know when this posture is correct because the craniosacral system will shut down. Often the patient will spontaneously comment that “this is exactly the position I was in when a specific accident occurred.” All you have to do then is to hold that posture and wait until the complete release has occurred. Remember, release is a process which requires time to complete. Completion is signaled by the patient’s body relaxation, breathing change, cessation of emotional outpouring, patient awareness of completion of the release process and a smoother, more even and higher-amplitude craniosacral system rhythmic motion.

The CranioSacral Rhythmical Impulse ("C.R.I.") DEVICE

Two tennis balls (or racquet balls) are tethered in tandem so that they are touching one another. This can be done by putting holes through the balls on a straight line and tying them together with heavy string or leather ties. Alternatively, the two balls can be placed in the toe of a sock which is then knotted tightly. In order to assure that the balls stay in contact with each other, place the first sock inside another sock which is also tied tightly.

INSTRUCTIONS

Recline on your back, on the floor or upon a sofa or bed. Place the device under your head so that the entire weight of your head rests on the two balls. They should be symmetrical with respect to the midline. They are placed about midway “up” the back of the head in the following location: At the top of the occipital bone (but below the lambdoidal suture). This is in a slight depression in the skull just above the slight bony prominence, which is in turn just above the attachment of the main neck muscles. The level is slightly above that of the ear openings. Allow the weight of your head to rest flexibly upon the device for 15 minutes. Relax comfortably. You may shift position slightly in order to maintain symmetry and comfort, but do so gently and gradually. Repeat daily.

THEORY

The craniosacral rhythmical impulse ("C.R.I.") is the rhythmical mobile activity of the craniosacral physiological system. The structures of the craniosacral system are organized around the meningeal membranes, and the craniosacral system is intimately related to the function of the nervous system (most directly the brain and spinal cord), the musculoskeletal system (most directly the cranium, spine, and pelvis), related fascia, and other systems. Induction of momentary “still points” in the craniosacral rhythmical impulses is an effective technique for mobilizing the craniosacral system’s inherent self-correcting abilities, which in turn can have profound beneficial effects throughout the body.

INDICATIONS

This is a good “shotgun” technique for enhancing tissue and fluid motion, especially relaxing connective tissues throughout the body, and for restoring flexibility of autonomic nervous system response. It is beneficial for acute and chronic musculoskeletal lesions, including degenerative arthritis. It can lower fever as much as 4 degrees F. It can reduce cerebral or pulmonary congestion, or dependent edema. It has been used to improve auto-immune disease, autistic behavior of children, and anxiety. This technique can benefit most individuals to some degree, and is rarely harmful.

CONTRAINDICATIONS

The only contraindications are in situations in which even slight and transient increases in intracranial pressure are to be avoided: impending cerebrovascular aneurism or hemorrhage-- as in acute stage of stroke or cranial trauma.
The technique for releasing the pelvic diaphragms

The technique for releasing the pelvic diaphragms is quite similar to the technique used for releasing abnormal tonus of the respiratory diaphragm. The position of the therapist’s hands is, of course, different. Place one of your hands under the supine patient and hold the sacral body so that the spine runs across your palm. Your hand acts as a foundation which offers firm resistance once you begin the anterior-posterior compression.

Place your other hand upon the patient so that the hypothenar eminence covers the pubes and the rest of the hand covers the suprapubic region. Begin to apply a compressive force with the anteriorly placed hand against the patient’s pubes and suprapubic area. The hand under the patient offers firm resistance. As the compressive force is gradually increased, it will reach an effective level at which point a normally symmetrical pelvic diaphragm will allow a laterally symmetrical spread of the tissues. If abnormal tonus of the pelvic tissues exists, an inherent motion between your hands will begin to show as a shear, torsion or rotation. All of these motions should be followed without resistance, but the therapist should maintain the minimal compressive force required to continue the self-correcting activity of the patient’s pelvis. When the softening sensation of release of abnormal tonus is perceived, the treatment is finished. If in doubt, repeat the technique to determine the normalcy of response to the anterior posterior compressive force which you have induced. This technique can be repeated as often as necessary to obtain the desired result.

The diaphragm

When the muscle of the respiratory diaphragm contracts, it pulls the central tendon downward, thus reducing the intrathoracic pressure and increasing intra-abdominal volume. At the same time it increases intra-abdominal pressure and reduces intra-thoracic volume. A contraction of the respiratory diaphragm also exerts an inferiorly directed traction upon the pericardium which is transmitted via fascial continuity through the carotid sheath to the base of the skull. Hence, patients with chronic diaphragmatic hypertonicity frequently manifest less than optimal craniosacral system mobility.

The diaphragm is innervated by branches of the ventral primary divisions of thoracic nerves 9 through 12 and by the phrenic nerve, which arises primarily from the 4th cervical nerve but which may also receive contributions from the 3rd and 5th cervical nerves. An abnormal state of hypertonus or contracture of the respiratory diaphragm may occur unilaterally or bilaterally. It may occur from problems associated with any one or all of the lower four thoracic nerves on one or both sides. It may occur as a result of problems along the course of one or both of the phrenic nerves or from one or both sides of the cervical region at the levels of the 3rd, 4th and/or 5th segments. It may occur from inflammation of the pleura which spreads to the diaphragm, from pericarditis and from inflammation of the hepato-biliary system and other related abdominal viscera.

Dysfunction of the diaphragm may also occur secondary to somatic dysfunction which involves the lower six ribs, the sternum and xiphoid process, the upper three lumbar vertebrae, the psoas major muscle, the quadratus lumborum and/or the fasciae related to any of the structures named above. It may also occur secondary to inflammation of any of the structures which pass through it, such as the aorta, the esophagus or the vena cava.

The significant point is that abnormal hypertonus of the diaphragm is a common secondary finding in a vast number of conditions. Frequently, after the primary condition is cleared, the diaphragm autonomously maintains and continues the asymmetrical tension patterns and abnormal hypertonus created within it. The dysfunctioning diaphragm then interferes not only with proper breathing activity but also with craniosacral system function and freedom of fascial mobility. The patient is thus somewhat devitalized. This reduced level of health sets the scene for recurrent illnesses, vague complaints of fatigue, migratory pains, the accumulation of toxic wastes due to reduced fluid mobility and gaseous exchanges, depression and general malaise.

The above scenario provides some of the basis for our contention that with all craniosacral system dysfunctions, special diagnostic and therapeutic attention should be paid to the naturally occurring cross-restrictions of the human body. The technique for releasing abnormal tension in the respiratory diaphragm is quite simple. The patient lies supine upon the treatment table. The therapist sits comfortably next to the patient. Place one of your hands under the thoracolumbar region of the patient so that the spinous of the 12th thoracic and the upper three lumbar vertebrae are in the palm of your hand.

Your other hand, placed anteriorly, should cover the epigastrum, the xiphoid process and the anterior inferior costal margins. While using one hand under the patient as a rather firm and immovable foundation, apply pressure from anterior to posterior with the anteriorly placed hand. Begin the pressure very lightly, then slowly increase it until you feel a motion within the patient.
When you perceive this motion, follow it in any direction which it tends to go. Maintain the anterior-posterior compression with just enough force to cause this inherent motion to occur and continue.

The inherent motion which you perceive may be predominant in either the posterior or the anterior regions of the patient’s body, or it may appear to be uniform throughout the body. You may palpate it as a shear, a torsion, a rotation or any combination of these. Any other possibilities which represent the releasing of hypertonic tissues may occur.

When you consider the directional orientation of the muscle fibers of the diaphragm, it becomes apparent how various restrictions and distortions of tissue motion can occur. Not only are all transverse angles represented by these fibers, but the variation of angle from almost longitudinal to transverse is great.

This circumstance provides a three-dimensional potential for the restriction of normal mobility. Additionally, these angles change as respiratory effort and other variables change the level of the diaphragm between the thoracic and abdominal cavities.

As the tissues between your hands begin to relax, a new balance will be achieved within the patient’s body. This new condition will be heralded by a softening of the tissues which is readily perceptible. Once that softening occurs, the anterior-posterior compression is gradually released and the diaphragm is considered to be freed and balanced.

If you are in doubt, remove your hand, wait 1 to 2 minutes and repeat the procedure. If the diaphragm is free of abnormal hypertonus, a symmetrical spread will be perceived as the anterior-posterior compression is reintroduced into the patient’s body. If the diaphragm could benefit from further treatment, an asymmetrical, inherent motion will be felt as the appropriate amount of pressure is applied. The procedure can be repeated as often as is necessary to obtain a symmetrical balance.

**Motion testing for classical sphenobasilar joint dysfunctions**

In testing the types of motion described below, the therapist initiates the gentle movements of the cranial vault bones in the desired direction, then monitors the resulting motion until it reaches a restricted end point. You evaluate range of motion, symmetry of movement and ease or restriction of motion.

The force applied to the patient’s head is exceedingly light, 5-10 grams in most instances. (For those of you who are not metrically oriented, that is about one-sixth to one-third of an ounce.) Greater force interferes with inherent cranial motion. Remember, you are trying to evaluate what this craniosacral system does under normal circumstances, not how it responds to outside interference. Most biological systems respond to outside threats such as heavy touch, traction or pain, by contracting. You should work with your patients at a level of touch which is beneath the stimulus threshold so as to avoid causing the contraction-self-protective response from the organism you are attempting to observe.

The motions which you will test using the vault hold, and which Sutherland attributed to the sphenobasilar joint or synchondrosis are:

1. Flexion-extension.
2. Sidebending with convexity to the left or to the right.
3. Torsion with the great wing of the sphenoid high on the left or the right.
4. Vertical strain with the posterior sphenoid body either superior or inferior to the anterior occipital base.
5. Lateral strain with the posterior sphenoid body either left or right of the anterior basiocciput.
6. Compression or impaction of the sphenobasilar joint/synchondrosis.

Among the first five of these six sphenobasilar joint motions, the reciprocal motions are compared to determine the presence of “lesion” or motion dysfunction, i.e., the range of flexion motion is compared with the range of extension motion. Traditional cranial concept as originated by Dr. Sutherland states that when the sphenobasilar joint moves more readily into flexion and is more resistant to extension, it is called a “flexion lesion.” When the sphenobasilar joint moves further into left lateral strain than into right lateral strain, it is called a “left lateral strain lesion.” The lesion is named for the direction toward which the cranial base moves with the greatest facility.

When the sphenobasilar joint is compressed or impacted, examination will reveal that the joint is resistant to anterior-posterior expansion or disimpaction. There is thus no real reciprocal motion for use as a comparison. The diagnosis must be made on the basis of the therapist’s experience with compressed and noncompressed patients. As your experience grows, you will gain confidence and sharpen your diagnostic acumen.

When testing for flexion or extension, the therapist should always first lay hands on, tune in and join the inherent motion of the patient. Testing for flexion or extension phase, respectively. Do not attempt to initiate a flexion movement while the patient is moving into flexion.

There is a neutral or relaxed period of time between each reciprocal movement of a brief time of relaxed neutrality following the return from the extension phase of motion, and vice versa. It is the excrusion from neutrality to the end of the range of boost as the patient’s craniosacral system moves from neutral into one or the other of the active ranges of motion. You then evaluate the response to the push or boost. In the perfectly functioning craniosacral system, flexion and extension are the only normal sphenobasilar joint motions which are occurring where that subject is in a relaxed, supine position.

However, the sphenobasilar joint-cranial base will allow for a little gently-induced, extrinsically-originated torsion, sidebending, vertical strain, lateral strain and compression-decompression. It is how much of each of these motions the craniosacral base will permit which is of interest to the therapist and which is, therefore, the subject of the testing procedures described below.

Cranial base motion patterns are positionally inducible. While you are monitoring the cranial motion, ask another person to raise or rotate one of your subject’s extremities (either upper or lower), Observe what changes occur in cranial motion. A little experimentation in this manner will be to afford the therapist an appreciation of the delicate integrity of the human body and of the significance of connective tissue tonus and tension.

**Sphenobasilar/Cranial Base Flexion-Extension**

Using one of the vault holds described above, exert a gentle force over the occipital/squama and great wings of the sphenoid concurrently. This force is directed toward the patient’s feet. When
you use the first vault hold, the third and fourth fingers are not in use; the thumbs are in contact with each other and furnish proprioceptive and kinesthetic cues so that your force will be applied as equally and symmetrically as possible. After the cranium has responded to the initiating force (on the order of 5 grams), you become passive and follow the cranial motion to its restricted end point. Flexion at the sphenobasilar union is the postulated motion which is being tested. That is, the angle formed by the basiocciput and the sphenoid body becomes more acute. After reaching the end point of the flexion motion, passively follow the sphenoid wings and occipital squama back to a position of neutral balanced ease.

To rest the reciprocal motion (extension) of the sphenobasilar joint/cranial base, you apply a similar, bilaterally equal force in a superior cephalad direction toward yourself. Once the motion is initiated, your force is terminated and the motion is passively followed to its restricted end point. This motion implies a lessening of the acuteness of the angle at the sphenobasilar union.

Once again, the therapist passively follows the cranial bone motion to a point of neutral balanced ease. The testing may be repeated several times until you are satisfied that your impression is reliable with respect to the relative ease or restriction of the reciprocal motions. The direction toward which the motion is restricted is noted; e.g., restriction against the induction of flexion is called an “extension lesion” and vice versa. Always begin your testing force at the onset of the physiological flexion or extension motion, and compare the result with normal tension. Sutherland postulated, and both the Sutherland Cranial Teaching Foundation and the Cranial Academy have traditionally taught, that the palpable, rhythmic activity perceived on the skull of the subject is the result of changes in the angle formed between the sphenoid body and the occipital bone.

The normal rhythmic flexion and extension motions are proceeding as usual, but the cranial base is operating from a torsioned orientation. This lesion is named either right or left for the side on which the great wing of the sphenoid bone moves more easily. All crania should exhibit some torsion in response to extrinsically applied initiating forces. You are interested in the symmetry of the torsion motion in response to your test. Lack of symmetry means that a lesion pattern is present in the cranial base.

To better understand torsion motion, simply imagine an axis running through the patient’s head between the posterior occipital protuberance (where the straight venous sinus ends) and glabella anteriorly. Then imagine that the sphenoid is tilted slightly to one side upon this axis, and the occiput is tilted slightly in the opposite direction upon the same axis.

The normal rhythmic flexion and extension motions are proceeding as usual, but the cranial base is operating from a torsioned orientation.

SPHENOBASILAR/CRANIAL BASE SIDEBENDING

Sidebending distortions of cranial base motion, we believe, are maintained by an imbalance of tension placed upon the bones of the sphenobasilar joint by one or a combination of factors. The result is that the anterior-posterior distance between the sphenoid great wing and its paired occipital squamous bone on the same side is shorter than on the opposite side. This means that the median sagittal plane through the head is angulated slightly at the sphenobasilar joint.

The normal flexion and extension phases of craniosacral system motion continue, but from a sidebent orientation. When this lesion pattern is discovered, it is called sidebending with convexity either left or right. The test for sidebending lesion patterns is performed by the application of one of the vault holds described above, but with palm contact on one side to perceive convexity bulging. At the beginning of a flexion phase of the craniosacral motion, the therapist should attempt to gently approximate the occipital squamous and the ipsilateral great wing of the sphenoid. As this gentle approximation is performed, a bulging of the convexity on the opposite side is perceived with the palm of your other hand. The extent of this bulging should be mentally noted. The cranial motion is passively monitored back to neutral, then through the extension phase, and back to neutral again. As the next flexion phase begins, repeat the test on the opposite side. The amount of approximation and convexity bulging at each side of the head is compared. The lesion is named for the side at which the greater bulging convexity is perceived.

We repeat: the force applied by the therapist during this test is small (5-10 grams) and initiatory only. Once the sidebending has begun in response to the induced force, you become a passive monitor observing how far it will go. This is not a test to see how far you can push it. The sidebending force is induced during the natural origin of the flexion phase of craniosacral motion only. Essentially, you are inducing an exaggerated flexion of the sphenobasilar joint, unilaterally. Normally, during the flexion phase of motion the occipital squama and the great wings of the sphenoid move closer as the angle at the inferior sphenosacral surface decreases slightly.

SPHENOBASILAR/CRANIAL BASE TORSION

This lesion is named either right or left for the side on which the great wing of the sphenoid bone moves cephalad with the most ease and excursion. A “right torsion lesion” simply means that the orientation of the sphenoid is such that the right great wing elevates more easily. All crania should exhibit some torsion in response to extrinsically applied initiatory forces. You are interested in the symmetry of the torsion motion in response to your test. Lack of symmetry means that a lesion pattern is present in the cranial base.

To test for torsion, the vault hold is applied. A gentle torsional motion is induced at the great wings of the sphenoid, while the occiput is stabilized relative to any torsional movement. The motion test can be initiated at the beginning of either a flexion or extension phase of craniosacral motion. If your testing force is focused more upon the wing of the sphenoid which is rising cephalad, initiation of the test should be made during the beginning of the extension phase. If you are concentrating more upon the great wing of the sphenoid moving inferiorly, then start the test at the beginning of the flexion phase. You are simply testing to determine the direction of ease toward which cranial base torsion can be induced.

CLINICAL SIGNIFICANCE AND TREATMENT OF FLEXION, SIDEBENDING AND TORSIONAL DISTORTIONS OF CRANIOSACRAL SYSTEM MOTION

The clinical significance and correction of flexion, extension, sidebending and torsional lesions of the cranial base are all discussed together for several reasons:

1. In our experience these lesions are usually secondary to some somatic dysfunction or imbalance which is extrinsic to the craniosacral system. Frequently, flexion, extension, sidebending and torsion dysfunctions of the cranial base are correctable by cranial treatment, but will often return unless the extracraniosacral system problem is itself identified and treated. These cranial base dysfunctions are often self-correcting when the primary dysfunction is
remedied. We use the "spontaneous" correction of abnormal flexion-extension, sidebending and torsion patterns as indicators of the therapeutic effect on the primary, extracraniosacral system problems. Strain and compression of the cranial base often have their origin within the craniosacral system.

2. Craniosacral motion pattern abnormalities are often transient. This is not true of the more severe cranial base strain and compression problems, which are discussed further on. The transient nature of many of these problems may be due to the fact that they are often secondary to temporary changes in the neuromusculoskeletal system. These changes are usually the result of traumas and everyday stresses.

3. Although the dysfunctions of flexion-extension, sidebending and torsion of the cranial base may be symptomatic, they are seldom seriously incapacitating and/or debilitating as may be the case with cranial base strains and compression problems.

4. The correction (at least, the temporary correction) of these lesions can usually be effected by the application of indirect technique without much difficulty. The correction of cranial base strain and compression problems is frequently more difficult and may sometimes require the use of direct techniques with more individual modification in order to achieve success.

Flexion-lesion heads, in general, belong to externally rotated bodies. That is, the extremities will usually be more externally rotated. The walk will often have a slight "waddling" quality, and the head will tend to be transversely wider and proportionately shorter in its anterior-posterior dimension.

The complaints of such flexed-externally rotated patients will often be related to pelvic and lumbosacral instability; annoying but seldom severe headaches; transient and numerous musculoskeletal system problems. They will frequently have endocrine dysfunction, recurrent sinusitis and nasal allergies. This type of cranial lesion is often temporarily correctable by the use of indirect technique. That is, after it has been determined that flexion is the dysfunction, follow the motion into its extreme range of flexion, and hold against that barrier very gently. When the craniosacral system attempts to return to the neutral position, the therapist becomes immovable. Do not push against the indirect barrier; just prevent the cranium from returning to neutral. If it begins to exhibit torsion or sidebend, or proceeds into any other motion pattern, you allow that to happen. These are lesions which you have not diagnosed and which will probably correct as you prevent the return of the craniosacral system to its neutral position. You are a passive barricade.

Ultimately the cranium will get further into the flexion range of motion. When this occurs, you have achieved at least a partial release of the flexion lesion pattern. As this movement into further flexion occurs, you follow, staying against the barrier but not pushing it. This may occur once or several times. Finally, one of these movements of the flexion range of motion will be accompanied by a sense that the patient's head has "softened."
**WHAT ARE THE SYMPTOMS OF TMJ/TMD?**

**TMJ Temporal-Mandibular-Joint**

The technique for evaluation and treatment of the temporomandibular joint is performed with the patient lying supine. Seat yourself superior to the patient’s head. Comfortably rest your arms and hands upon the table next to, and extending above the patient’s head. Lay your hands gently over the sides of the patient’s head so that the ears and temporal regions are covered by the base of the fingers. We like to hook our middle fingertips under the angle of the mandible so that they fit into the notch.

A gentle cephalad or superiorly directed traction is then exerted on both sides of the mandible as equally as possible. The force is gently and slowly increased until you perceive action or change at the temporomandibular joints as those joints are impacted by the traction. Usually, the mandible will then tend to swing back-and-forth or from side-to-side. Follow this motion without offering any resistance. At the same time, continue your superiorly directed traction. Lateral or anterior-posterior motions of the mandible reflect the inherent balancing process induced by your traction. Once this balancing process is completed, the lateral or anterior-posterior motions will stop.

If you continue traction in a cephalad direction, you will feel activity in the temporal bones. We do not believe you can have temporomandibular joint dysfunction without temporal bone dysfunction. The mandible will exert a force in the mandibular fossae of the temporal bones. This cephalad-directed force causes the temporal bones to move cephalad and begins to disengage the temporoparietal sutures, as described previously.

Since the level of these sutures is angled superiorly and externally, and since it is at an acute angle, the temporal squama are forced to move laterally by the cephalad traction. This phenomenon can easily be felt at the palms of your hands. It causes a shear at the suture as the lateral borders of the parietal bones also attempt to move cephalad. The parietals are restricted in their cephalad movement by the falx cerebri and are forced into external rotation by your traction.

During this time the temporal bones, through their petrous ridges, are stretching the tentorium cerebelli, which is now acting as a diaphragm. This changes the fluid pressure inside the cranial vault. You will feel a considerable amount of fluid motion, membranous change and balancing in the course of the procedure.

The temporal bone will move and balance in many directions. Let this happen; simply continue your cephalad traction. Finally, all the activity will stop and you will perceive a balance. The point of balance is the end of this part of the technique.

The next step is to apply caudally directed traction to the mandible. Apply enough pressure with your hands against the mandibular rami to exert this caudad force. Because the skin is attached indirectly on its deep side to the bone of the mandible, by simply taking the slack out of the skin...
and then continuing to apply traction, the force will thereby be transferred to the mandible. Do not try to actually grasp the mandible.

During your caudally directed traction, the temporomandibular joints will disengage and balance. Then the temporal bones will move inferiorly in response to mandibular traction. This will again activate the dural membranous diaphragm and cause a movement of cerebrospinal fluid inside the cranial vault. The temporoparietal sutures will disengage and shear in the opposite direction, and the parietals will move from external to internal rotation. Continue the caudally directed traction until all this activity has quieted down and a balance has been achieved.

When completed, you have not only effectively treated the temporomandibular joints, but you have also corrected the temporal bone involvement, mobilized the temporoparietal sutures, partially mobilized the parietal bones, caused fluid exchange in the cranial vault and balanced the dural membranes. This is truly an excellent "holistic technique" for the craniosacral system and all that it affects.

Stress Reduction and Body Work

Stress is the most incipient killer of people today. Stress is responsible for 70 to 80 percent of the disease in America. Stress reduction is a must in today's society for longevity, health and happiness. Below are some simple rules for fighting this unseen killer.

1. Stress awareness begins with recognition or awareness. Our stress inventory provides insight into the amount of stress in our lives. As we become aware of stress, we can begin to deal with it. The "ostrich" technique of stress reduction never works.

2. Humans resist change. Whether change occurs in the body, mind, social, spirit or environment, most humans will resist. To learn to relax, we must learn to break our old habits of stress reaction and substitute more productive reactions such as clear thinking, calm headed and relaxed understanding. To change requires perseverance, positivity, proper goals and beneficial rewards. Whether changing eating habits, exercise routines, stress reactions or social skills, change requires work, but the rewards of a healthy body and mind for you and your family are worth it.

3. Stop addictive behavior. Whether it is coffee, soda, sugar, heroin, cocaine, alcohol, etc. an addiction is an addiction. Addiction to stimulants will always rob health and always cause disease. If you care for your children, you would fight to stop them from using heroin. But so often we let them indulge in potato chips, candy bars, tobacco, etc. The seeds of addictive behavior stem from "stimulation dependency" in our youth. If we are to truly conquer drugs, then we must stop addiction to stimulation or depression early in life. To stop addiction break its bond as early as possible. Just say no, if you really care.

4. Relax after meals. Allow at least 30 minutes after a meal to relax with comfortable music (not hard rock and roll), good spiritual books (not tax literature), good conversation (not argumentation), or some other relaxing diversion. Do not lie down. Sitting, standing or a light walk is recommended. Let your body focus on digestion for the best effect.

5. Allow one to two hours for worry or think time per day. Make this a quality think time to completely analyze your problems and concerns. Any more than 2 hours a day and your mind will distort the problem and not produce a solution. Excessive worry will produce more problems and more worry until this violent spiral results in disease. Use your quality think time to develop quality solutions you can act on to really help you solve your problems and concerns.

6. Take 30 minutes a day for relaxation and silent reflection. Concentrate on calmness, acceptance, relaxation, health, peace, stillness, etc. Save your active thinking for later. Let this still time be one for producing calmness. Wear comfortable clothing, find a quiet spot and let those around you know how important this time is to you.

7. During this quiet time, relax tense muscles. Breathe deeply and slowly. Calm and relax your mind as you detach yourself from the turmoil of the day. Let go of your troubles and fill your thoughts with positive thoughts. Use this daily experience to foster your mind and body to develop your inner health.

8. Remember, laughter is the best medicine.

9. Learn the laws of good health.
The Desi-astro Sign of STRESS ANXIETY

LACK OF CONCENTRATION
SLEEPLESSNESS
IRRITABLE
OVERACTING
STOMACH PROBLEMS

FEAR
MUSCLE TENSION
FATIGUE
RACING HEART
HEADACHE

ANTI SY

STRESS IS CAUSED BY THE DESIRE FOR THINGS TO BE DIFFERENT

RELAX
BREATHE FULLY
YOGA & EXERCISE
REDUCE DISTRACTION

SIMPLIFY
PLAN & ORGANIZE
REDUCE CLUTTER
SET LIMITS

IDENTIFY TRIGGERS
THOUGHTS FEELINGS FOOD

AVOID
PROCRASSTINATION
NEGATIVE THINKING
CATASTROPHIZING

IDENTIFY SPIRITUAL BELIEFS

THE VESSEL WORD AREA OF THE BRAIN

The verbal word area of the brain is about the size of a golf ball on just one side of the brain. The Reticular Formation filters the 10 to the 15th bits of data from coming from our cells to the brain. And the Reticular Formation filters the information so that only one million or so bits of data get to the word area of the brain.

The autonomic functions of digestion, immunity, growth, detox and health itself are thus not under verbal control or should they be. Science has made the mistake of thinking that the verbal mind is all that there is. If I am not verbally aware of it how could it be important. This false belief has polluted medicine. The verbal mind is reductionism, simple, and prone to false beliefs. Classic biofeedback enlarged this mistake. The body electric is in the whole and operates non-verbally and holistic a type of total integrity.

By making a cybernetic loop to the body electric the Angel has developed a superior form of biofeedback that can balance and repair the body electric. This is the advent of a new medicine.

The vessel word area of the brain is about the size of a golf ball.
Getting started in body work as stress reduction

Initial Contact, Body reading, and Outline of a Session

Sharing expectations

When your clients arrive for the first session, they may be afraid of you and the unknown things that are about to happen. If you immediately ask them to take off their clothes and begin pointing out the tensions in their bodies, they will probably become more insecure and begin to feel like flawed objects. They will then be giving up responsibility for their changes and creating expectations which you cannot fulfill.

A suggested first step is to just sit together and talk about what you expect from each other. You might at this point explain how deep bodywork is a process which can be tried out. If it doesn’t seem to be right for the person, one can drop out after a session or two. And it is a process with ever deepening consequences: if one gets three or four sessions, basic changes will have begun to happen which need to be worked through to completion. A clear understanding and commitment is needed from both of you. It should also be made clear at this point that there may be some pain, but that it can be relaxing and reliever pain; and that there will be pleasure and joy as well. The process will be a period of transformation and they should think about this into account during their everyday lives. Perhaps major decisions about employment, etc. can be postponed until the end of the process. Also athletes, dancers, and other very active individuals need to be aware that after some of the sessions, the changes in the body structure are incomplete and that over vigorous movement may create muscle strains, pulls, or cramps. The body mind is changing and may not fully realize its new powers and limitations. Point out that the best kind of movement uses the whole body in flowing, effortless motions as in free form dancing, swimming, and walking.

The next step, before any clothes are taken off, before a body reading, might be to sit facing one another making eye contact and breathing together. (You can kneel together on top of the table.) Of course, this kind of contact may be too intimate for some beginning clients. During this initial contact, you may begin asking how they feel. Don’t let them go into ‘‘scar’’ stories about what has happened in their lives (these can be interminable, armor reinforcing tapes). Keep them in the present, taking responsibility for what’s happening. ‘‘What are you feeling now?’’ ‘‘Where is the feeling?’’ are good questions to get them started. Also don’t let them talk about the big ‘‘it,’’ that backache, that pain in the leg or neck which they are treating like some unwanted part of them. ‘‘It hurts’’ can be changed into a personal, claimed experience ‘‘I’m hurting here.’’ Begin helping them take responsibility right at the start. By getting them to express what’s happening you also get them quickly into the process of change and to begin to see problems that may arise again during the course of the session. See Chapter III, ‘‘The Release and Expression of Feelings Through Gestalt Work.’’

Body Reading

Perhaps at this point you have established enough rapport to begin a body reading. Have your clients take off just the amount of clothing they feel comfortable removing. Often after the tissue work is underway, they may cast aside more clothing to help your work. Again, don’t begin by saying some part of them is tense or out of alignment. The second way is to explore feelings and positions. If they are collapsed in the chest, you might suggest that they really inflate the upper chest, hold the position, and get in touch with the feelings which they may be avoiding. Perhaps these individuals are weak, and collapsed because they are afraid of being powerful, and they need to begin to experience and see this. You here have a chance to focus on the positive changes that can take place. You might share, ‘‘I see your legs getting stronger, and you finding a really comfortable, supporting center for yourself,’’ or ‘‘I feel you’re going to get longer, that your hips are going to be thinner, and that you will feel light and flexible.’’ Such simple sharing can create a strong, positive support for change. Later in the sessions you may want to come back to the feelings and positions, which you have initially exaggerated or explored, noting that after the work of a session, they may be easier to express and complete.

2. Connecting the Whole Structure. Not only will your clients need help in expressing certain tensions and feelings more completely, they will also need to be helped in connecting isolated problems or symptoms to their overall structure. If, for example, they say, ‘‘I’m tense all the time, here in my left shoulder,’’ they may be unaware that this is related to a high right hip and collapsing left ankle. Or they may feel a knot in the diaphragm without realizing how connected it is to stiff, locked knees. This is happening emotionally too. When one feels constricted and tight around the heart, it may be difficult to see how a large, seductive pelvis may be robbing feelings from the chest.

3. Avoid Being Overly Analytical. It will probably not be helpful to talk to your clients about what type of structure they have, that it is whether they are burdened, rigid, etc. Many people grab on to these designations and begin judging their behavior in terms of them. A study of types hardened, (rigid, top of pelvis, bottom-heavy, steady, etc,) and elongated, (overlong, neck, etc,) and mesomorphic, (equal,) may be helpful to you, however, as long as you keep this information in the background and allow yourself to accept what your client is expressing and to accept your own intuitions. The same is true of anatomical analyses. When you talk, talk too technically and analytically about muscles or structural patterns, you may take your clients away from the experience of themselves. (For a discussion of how to use types and other information, while maintaining rapport with the client, see the last chapter, ‘‘Between You and Me, Sharing and Transforming Body mind,’’ of the book Deep Bodywork and Personal Development.)

4. Share. It is also appropriate for you to give your impressions to the client. For example, you might came right out and say, ‘‘I feel you have an awful lot of anger, which you could express; I would like to see that anger.’’ When we give our impressions, we can check them out, that is ask, whether they fit. And we can be ready to give our impressions up if they don’t fit. Don’t be afraid of projecting. Fear of imposing your trip on somebody else may itself be a projection.

5. Keep A Record. It will be helpful to take before pictures — side, front, and back — which you and your clients can compare with ‘‘after’’ pictures for any of these sessions, certainly after session 10. Be sure that you have a black background with evenly spaced white cross stripes and that you keep the camera the same distance before and after. Also you may want to take some basic measurements: weight, height, size of chest and waist. Be sure these are exact, e.g., measure the chest with an inhalation or exhalation. These pictures and measurements will help your client be more interested and involved in the process and will also provide you with learning tools. You can later give this information to your trainer for evaluation.

Another way to help clients be more involved is to encourage them to keep a diary, write down dreams, draw their conceptions of themselves before and after sessions. A ‘‘Bodywork Journal’’ with basic questions, exercises, and measurements will help your client be more interested and involved in the process and will also provide you with learning tools. You can later give this information to your trainer for evaluation.
Outline of a session

Each session will begin with some kind of initial contact, then a body reading in which the client participates. Now you are ready for the next steps: preparation, deep tissue reorganization, and final fine energy work.
Before beginning deep tissue work, it is very important to prepare your clients for deep work. The tissue moves, and reorganizes, if the person is really ready to accept and assimilate the tissue changes you are encouraging. Two kinds of preparatory work are needed: establishing the flow of charging and discharging energy and the balance and reorganizes, if the person is really ready to accept and assimilate the tissue changes you are encouraging. Two kinds of preparatory work are needed: establishing the flow of charging and discharging energy and the balance between charging and discharging. The key to this charging and discharging balance is the breath. In the release of armor we practitioners are working with the habitual ways in which the individual blocks and controls breathing. If our clients take in too much air, they build energy without fully expending what is accumulating. On the other hand, if they throw out their breath with an extended, contracting exhalation, and delay their need for incoming air, they literally overextend themselves. There is, for example, the aggressive, active male who keeps his chest puffed out, or the passive, listless female who contracts exhalation, and delay their need for incoming air, they literally overextend themselves. There is, for example, the aggressive, active male who keeps his chest puffed out, or the passive, listless female who overextends herself and tightens her diaphragm.

Explore The Neglected Aspect Of Breathing. Another way of releasing armor is to take attention away from that part of the breathing cycle which is overworked and focus on the neglected part. If a client's exhalation is excessive, if there is too much discharge, I often help in softening and slowing down the exhalation, while supporting deeper inhalations especially in those areas of the chest, belly, or back which are neglected. Conversely, when the inhalation is too great, I shift attention from deep breathing to a larger exhalation, often encouraging exaggerated force and sound.

Be Both Provocative And Soft. Helping clients reach a level of charge and discharge where they can accept deep tissue work may involve vigorous stimulation or provocation of breathing, or subtle, gentle encouragement of breathing. This leads us to make a distinction between coarse and fine energy. When I work to change my general body mind posture - my sway back, my hysterical fear, my schizoid tendency to analyze everything – I am focusing on 'coarse' energy. Here I am concerned with large blocks of energy, with deeply ingrained habits, which set the basic directions of my life.

On the other hand, I can stay within the limits of my general body mind attitude, and without trying to change my sway back, fear, or overanalyzing, I can refine and improve the circulation of the patterns already present. I am in this case working with my 'fine' energy.

Before I invite my clients to change the coarse, overall structure of their breathing, or any part of their body mind, I need to help them to center themselves, to refine and organize their energy. And each time I stimulate an overall, coarse change in their structure, I need afterwards to help them rebalance their fine energy. During this first phase we may work provocatively with the breath, but generally we want to focus on a preparation of this fine energy so that gradually, deeper, coarser more fundamentally changes may take place as the session progresses further.

Deep, coarse work

Many students of bodywork initially have the idea that if they learn exactly where in the anatomical structure they can make a certain type of hand, finger, or elbow manipulation, they can, with some practice, master the complexities of deep tissue work. Actually no amount of observation, study, or practice - although important – can substitute for the need to make contact with an individual through an inner attitude. When I, as practitioner, begin with inner sensitivity, all my movements, all my contact with the other person, are both, receptive and initiating - receptive in that I allow my force to adjust to the resistance or openness of the individual, initiating in that I take the individual beyond the limits of his or her armor.

1. Interaction of Practitioner and Client. Consider what happens when I, the practitioner, or you, the individual with whom I'm working, make contact only externally or superficially. If I push against you with an outer effort alone, then I cannot easily regulate -- increase, diminish, change -- my force would feel my hands unresponsive to your inner needs and defend with your outside armor. Since my effort may be too fast, too deep, too hard, or just the opposite, too slow, etc., you would either become tense or totally passive in your extrinsic musculature. There is, then, no real contact, only an outer clash or compromise. This kind of outer contact, not real touching and caring, simply reinforces our armor. I am dumping on you my old feelings of power, while you are using my assault on your outside armor to reinforce old patterns of self-defense.

Sometimes the practitioner and client begin their contact with careful intrinsic movements but then fail to follow...
through with complete external contact. If we begin together and I apply pressure so carefully that I adjust to
every move I sense you making, I have only followed your needs without helping you discover new possibilities
beyond your armor. Similarly if you submit inwardly to all my initiatives, you never discover your external power
to give and interact.

Establishing and maintaining a delicately balanced exchange between the practitioner and individual calls for a
variety of approaches and methods. Free, spontaneous breathing is essential to the cyclic balance of our energy,
and when both the practitioner and client share and explore patterns of breathing in unison with one another, they
are better able to sense the give and take needed in healing. All the integrating and fine tuning techniques help
maintain this sensitive exchange.

2. Confrontation. This exchange allows for and encourages the direct expression of emotions arising from either
practitioner or client. When I work with you, my role is to encourage you to explore the feelings that arise with
the release of tensions you hold in your body, to confront and work through your unfinished business, and also to
help you realize what you feel here and now about me. I need to give you my feelings of satisfaction, frustration,
and sympathy. In this sharing it is not my job to remain emotionally neutral or objective; rather to give to
myself and at the same time allow you the freedom not to live up to my expectations about how you can transform
yourself.

The body worker and individual should both be free to project their needs on the other and to reject and accept
the roles in which they are cast by each other. I am your parent; you are my child. I refuse to be your parent; you
refuse to be my child. In the process of psychoanalysis the patient may slowly, over a period of perhaps months
or years, transfer his or her parental needs upon the analyst, and thereafter gradually free him or herself from
this transference. In the process of holistic bodywork (through direct and deep transformation of body mind
structures), we are continually and simultaneously both forming and breaking the transference. Of course, some
period of time may also be needed for the integration and assimilation of this dual freedom into an individual’s
life.

3. Selective and Intuitive. In your tissue work respect the strategies we have outlined in Part Two of this manual
for each of the ten sessions. Do not overwork. We have given you many more possibilities than you will need.
Trust your intuition when it says to you, “Maybe I can work a little here and a little over there.” In between
strokes observe what has happened – how the breathing is more connected, how the tissue stretches into a new
area. Keep a charging and discharging breath going and work with the fine energy, brushing along the meridians
as well as using acupressure points. Before ending a session be sure you have worked in enough areas to balance
out the agonistic and antagonistic pulls of the myofascial system. For example, if you have worked on the belly
and chest, work also on the back.

Final fine energy

This is the period in which we want to give space for clients to reorganize and balance the energy they have been
releasing during the session. Always leave enough time for this fine tuning. What is especially important in all
fine tuning is an attitude of not deliberately trying to change oneself. In fine tuning we have a general direction
in which we want to move, a context in which we move comfortably, but we have no specific destination, no
exact goal for our changes. Fine changes call for an open ended, spontaneous process of which we are mindful,
attentive, meditative, but which we do not try to manipulate or control. I have found four areas of fine tuning
especially useful in deep bodywork; breath regulation, energy distribution, movement awareness, and psychological

In holistic bodywork the practitioner recognizes that in touching the body there is also contact with feelings
and thoughts, and that one must encourage the expression of these in bringing about a physical change. The
practitioner and client work together, now with tissue, now with sounds or words – all the time recognizing the
physical, emotional, and cognitive unity of the process.

In contrast to these incomplete attempts, full contact between you, the client, and me, the practitioner, is a special
inner and outer reciprocity, a sharing in which we respect each other. Just as I move with and yet guide your inner
and outer energy, you do not react, but dance with my pressure. This is a dance in which the dancer and the dance
decome one. It is a unifying movement of both of us, without action or reaction, only simultaneity like the moves
of opposing Tai Chi partners.

It may seem that the exchange cannot be equal. After all, you have come to me for help. How can you participate
as an equal partner, if part of your armor is a defense against just such an exchange of energy, a resistance at
some deep level to the possibility of your own self transformation? Even if I am centered and initiate my force
from inside, and make sensitive, respectful contact with you, but you are afraid to surrender, how can the dance
even begin?

For there to be a beginning in the healing process we need to recognize that both of us are incomplete in a
paradoxical sense. You are resistant to change; that is the nature of armor. Yet you are willing to give up that
armor when you are shown a possible path for change. I expect you to change. I want to help you overcome your
blocks, yet I need to be very flexible, to change directions, if the direction I have suggested is not effective. In my
role as healer, as Postural Integrator, I cannot completely accept your armored past. I work on the narrow border
between imposing myself on you and accommodating myself to your, old, armored games. The deep work with
your tissue, blocked feelings and thoughts, elicits both pain and pleasure and is also a contact in which we feel
resistance and release. If my force is too great or too painful for you, I will cut off the possibility of you beginning
your own healing and transformation process. If my force is too weak or accommodating, I give up my power as
healer.
Affirmations are powerful means for fine tuning ourselves if they are not substitutes for dealing with the
when I say "I can get Mary to love me," I am manipulating and armoring myself.
opening myself to the love of other people," my affirmation is broad enough to give me a direction for change. But
claim the power that has been released by the crumbling of our past armor. Whenever I repeat to myself, "I am
Affirmations, when they remain open ended and are not attempts to manipulate ourselves, are ways for us to
4. Affirmations. One way of redirecting our emotions and thoughts is to fine tune them with affirmations.

2. Acupressure. Using the circular flow of the five elements, we can work toward a subtle balance of body mind
energy. Fine tuning with the five elements is not so much helping an individual find new energy or to get rid of
excessive energy. It is rather the delicate distribution of energy throughout water, wood, fire, earth and metal.
Using acupuncture points to regulate this flow requires a receptivity and consciousness. I look at my excessive
fear and see that I can with the help of various points begin to allow this build up of water (fear) energy to spill
over into wood (anger). I already have this energy. I need only allow it to follow its natural course. Consult the
section in these notes on acupressure points and the five elements.
3. Movement. In several styles of working to make us more aware of our movements -- Alexander Technique,
Feldenkrais Method, and Aston Patterning -- we find a recognition of the meditative and watchful but non
interfering attitude. In the Alexander Technique we hold empty zen like images which we repeat but do not
try to execute. "Let the neck be free to let the head go forward and up, while the back lengthens and broadens," is
an Alexander image which guides but does not follow the habitual goals we have built into our posture over
the years. In Feldenkrais work the different parts of the body are given an opportunity to communicate with
each other without the usual habitual commands. In stretching and exploring one side of my body I am already
communicating, if my controlling consciousness does not interfere, with the other side of my body, and if my right
arm moves more easily my left begins to recognize this and respond more freely as well. Or in Aston Patterning we
are encouraged to find simple lines of symmetric movement, which we can explore by coordinating our whole body.
Perhaps these methods of movement awareness are such effective ways of fine tuning the body mind because they
give an opportunity to the nervous system to reorient itself. According to a holistic interpretation, the gates in
certain parts of the nervous system can be said to be set by previous painful experience, set by a protective armor
which freezes the tissue in and around the muscles. As deep tissue is moved and freed, we relive and accept the
event, gaining a new consciousness of the way we have previously set these gates. Now in fine tuning body mind,
we are able to begin resetting the gates for new kinds of experience which involve the whole nervous system.
In Chapter V, "Movement Awareness," you will find an outline of some basic movement awareness exercises,
which when done in the spirit we have outlined above, can help your clients explore and accept the power of
conscious movement throughout their bodies. These exercises can also help you in maintaining your own center
while you work.
4. Affirmations. One way of redirecting our emotions and thoughts is to fine tune them with affirmations.
Affirmations, when they remain open ended and are not attempts to manipulate ourselves, are ways for us to
claim the power that has been released by the crumbling of our past armor. Whenever I repeat to myself, "I am
opening myself to the love of other people," my affirmation is broad enough to give me a direction for change. But
when I say "I can get Mary to love me," I am manipulating and armoring myself.
Affirmations are powerful means for fine tuning ourselves if they are not substitutes for dealing with the
**What Is An Adjustment?**

A chiropractic adjustment is the art of using a specific force in a precise direction, applied to a joint that is fixated, “locked up”, or not moving properly. This adds motion to the joint, helping the bones gradually return to a more normal position and motion. The purpose of this safe and natural procedure is improved spinal function, improved nervous system function, and improved health.

There are many ways to adjust the spine. Usually the doctor’s hands or a specially designed instrument delivers a brief and highly accurate thrust. Some adjusting methods are quick, whereas others require a slow and constant pressure.

After years of training and clinical experience, each chiropractic doctor becomes highly skilled in the delivery of a variety of adjusting approaches.
Two chiropractic belief system constructs

Materialistic:
- Operational definitions possible
- Lends itself to scientific inquiry

Vitalistic:
- Origin of holism
- Cannot be proven or disproven

Dr. Desi says that "the Proof of Innate Intelligence is Intelligence Itself"
How to Perform a Lower Back Chiropractic Adjustment

Thousands of Americans suffer from lower back pain. There are a number of ways to ease back pain, including anything from herbal remedies to spinal surgery. One way to relieve acute or chronic lower back pain is through a chiropractic lower back adjustment.

Instructions

1. Examine the patient's back before the chiropractic adjustment. If the patient's back is swollen, give her an anti-inflammatory and ask her to wait or come back at a different time. Wait for the swelling to go down before you perform an adjustment. Examine the feet length and see if the shoes wear different. Many times new shoes can bring relief quicker than all the adjustments. A small difference in the shoes is amplified through the body. It is better to buy cheaper shoes more often than expensive shoes for a long time to wear unevenly.

2. Ask the person receiving the chiropractic adjustment to sit on a flat surface and cross her arms in front of her body. Have the patient stretch her legs out in front of her.

3. Place her hands on her shoulders. This creates tension in her lower back and spine.

4. Tuck her chin into her body and place one of your hands on the nape of her neck.

5. Place your other hand on the patient's lower back. Your hand needs to be at the base of the spine, with your fingers pointing toward her neck. Be sure the center of your palm is in the center of the base of the patient's spine.

Lean the patient backward. Push up on her spine with the palm of your hand to deliver the chiropractic lower back adjustment. Extend to limit and then push sharply an extra few centimeters.
Why is there a popping sound when a joint is adjusted?

Adjustment of a joint may result in release of a carbon dioxide gas bubble between the joints that makes a popping sound – it’s exactly the same as when you “crack” your knuckles. Carbon dioxide (CO2) is the gas in Champaign.
Body Work

CO2 buildup in the joints makes them shorten and restrict blood and energy flow. The CO2 makes a slight feeling of concern or mild pain the release of CO2 will stop this. So the crack or pop is like opening a bottle of Champaign. The CO2 rushes out of the ligament making the noise and Oxygen rushes in making the ligament area feel better. The noise is caused by the change of pressure within the joint that results in CO2 gas bubbles being released and replaced by Oxygen. Then there is more flexibility. There is no pain involved, patients are just startled and then they feel more flexible and refreshed. The joints have the ligaments between them. If you push a ligament to its natural length slowly till you feel it stop extension. Then with a short extra hard push you extend the ligament 2 centimeters further. This will pop out the CO2 and bring in the oxygen. This is the pop of the adjustment. The ligament is now more healthy and supple restoring flexibility. This is a most pleasurable feeling of release of tension and disease.

The SCIO can be prescribed for HOME USE to help your children with autism, attention difficulties, superlearning, sports, injury, pain, relaxation....

Monthly rental fees can be as low as 350 Euro a month. Contact your SCIO therapist for information...

Maitreya Kft. tel: +3613036043 | web: www.qxsubspace.com | e-mail: info@qxsubspace.com
Chapter III - The release and expression of feelings through gestalt work

We have already seen that it is important simply to be there, to give your clients time and space to assimilate what is happening. Often this is enough, but if your clients are having difficulty sharing and expressing their feelings, you may need to understand something about the nature of their armor and how to help them come out of themselves.

Releasing armor

Armor is developed as a way of avoiding pain and dissatisfaction, but becomes the habitual means by which we unconsciously hold on to pain. For us to experience this armor is for us to begin to liberate ourselves from past attitudes and postures, but this is in no sense in avoidance or destruction of our unique personal histories. Encountering our armor is a distinct process in which we are freed from the past, and yet at the same time, make it part of us. In order to be free from our armor we not only have to contact it and acknowledge its role in our lives, we also have to claim it as a part of us. Helping our clients to allow this contact and to make this claim is our main job when encouraging the sharing and expression of feelings.

1. Sense and Feel Incompleteness. Often we so devalue ourselves that we become totally unconscious of our defense and continually create an environment where we need not encounter any problems. Everything is carefully made safe and uneventful. The first condition for transformation is to sense and feel our incompleteness, to be frustrated. During the release stage of Postural Integration, there comes a point at which clients begin to experience their resistance to change. Without this first step, no amount of tissue manipulation, deep breathing, guided movement, or spiritual and mental affirmation can bring about a significant and lasting release of body mind armor. Encourage your clients to stay with what they are feeling, even if it’s uncomfortable, frustrating.

2. Armor as Self Defense. The second step in the experience of release is the acknowledgement or recognition that frustration, this sense of incompleteness, is the problem itself. So long as daddy, mommy, or society serve as the scapegoat for my problems, I will remain stuck, even if I am aware that I have a problem. Equally, if it is ‘that backache,’ or ‘those aching feet,’ which controls me, I have not yet acknowledged or recognized my armor for what it is, namely my defense against myself. The release I feel in letting go of my armor is not a mysterious event in which my burdens are relieved by some outside force. As the practitioner impinges on my body, I need to be willing to say ‘I’m resisting.’ With this recognition I may be feeling my struggle with myself, or I may simply be noting my resistance. Ask your client to notice their own avoidance and resistance.

3. Self Acceptance. Finally as a last step in the process of letting go of my armor, I need to claim my incompleteness, my pain and dissatisfaction as an important and welcome part of me. Now that I am responsible for creating my pain, I also accept it as a vital and valuable part of me. Here there is a seeming paradox: the moment I really accept my unwanted attitude, I become free from it. For example, when I accept my hatred for my father, the hate becomes complete, whole, and powerful, and I am ready for other feelings. Now that I hate myself, I also accept it as a vital and valuable part of me. Here there is another paradox: the moment I am responsible for creating my pain, I also accept it as an important and welcome part of me. Here there is another seeming paradox: the moment I am responsible for creating my pain, I also accept it as an important and welcome part of me. Now that I am responsible for creating my pain, I also accept it as a vital and valuable part of me. Here there is another seeming paradox: the moment I am responsible for creating my pain, I also accept it as an important and welcome part of me. Here there is a seeming paradox: the moment I am responsible for creating my pain, I also accept it as a vital and valuable part of me. Now that I am responsible for creating my pain, I also accept it as a vital and valuable part of me. Here there is another seeming paradox: the moment I am responsible for creating my pain, I also accept it as an important and welcome part of me.

Gestalt and Zen views of consciousness

In order to better understand how old pain is transformed into a new-free experience, we need a view of human consciousness which does not treat our bodies as objects to be analyzed and manipulated. In many of the classical western models of consciousness, consciousness is located in one place, ‘here,’ while the object in located ‘there,’ and we try to extend our awareness under controlled conditions by analyzing different parts of the object or event. According to this view, I see the pain in my lower back as a problem to be studied, as the effect of causes which I hope can eventually be understood and eliminated. But this separation of the pain from me is the problem.

As noted earlier, so long as I deal with my pain as something foreign to me, I armor myself against the possibility of truly exploring the pain and being released from it. Both the Zen and Gestalt views of consciousness make clear how the experience of being released is a process of claiming previously foreign parts of ourselves. When I fully contact, acknowledge, and claim a part of myself I am no longer just conscious of it as a separate object, I become the object. In Zen I totally blurred with the object; I am both the observer and observed. And in Gestalt therapy, I illuminate the partly unconscious background of my experience by letting the unconscious part of me speak out.

As the practitioner encountered the well developed armor of my lower back, I felt the contact, I acknowledged my resistance to what lies deep inside me, and now finally I began to claim my lower back by being there in it, talking from there to myself: ‘I’m hurting; you’ve got to slow down the everyday pace and give me the attention I deserve.’ Even if this dialogue goes no further, I have already begun to release the unconscious defense which I have stored in my back. But not only can I release my armored parts, I can, through the now released parts, now communicate with other aspects of myself which need to cooperate with each other which need to try out new movements, feelings, and thoughts.

Gestalt techniques for deep bodywork

Here are a few simple pointers to help you help your clients ‘gestalt’ their feelings during sessions of deep work.

1. Preparation. Make adequate preparation by using the charging and discharging methods of breathing described in the next chapter, ‘Breathing and Energy Flow.’ If you make this preparation and maintain a high level of charge and discharge, even the most held back emotions will begin to surface.

2. Start with the Here and Now. The temptation is great to talk about the problem or to discuss what happened yesterday. Ask, ‘What’s going on right now.’ If they ask whether you mean in the body, or mind, or feelings, simply accept any of these. If they shake their head not knowing, ask them to repeat and exaggerate saying, I don’t know.’ In a gestalt session this first step usually takes a while and the first verbal expressions are often empty of many feelings. In bodywork, if there is no response we can continue with breath or tissue work, until the emotions begin to flow more readily.

3. Deepen and Anchor the Flow of Feelings. If your clients jumps from one feeling to another or drifts away into thoughts or fantasy, help them come back to what is happening. Ask what, or where are the feelings, and never why; exaggerating what’s already happening is a good technique, when you begin slowly and gradually with the movements, sounds, and words your clients are already using. You may want to continue your tissue work while suggesting that they continue to share what’s coming up. If they become too active you will need to wait, before continuing the tissue work.

4. Direct Feelings Toward Persons. One way to anchor feelings is to make them specific. ‘I feel a lot of anger,’ can be turned into ‘I hate you.’ Don’t be afraid to let feelings of resentment against you, the practitioner, come into the open. Encourage your clients to shout directly to you, ‘You’re hurting me,’ or ‘I hate you.’

5. Encourage Self Acceptance. ‘It hurts,’ becomes ‘I’m hurting.’ ‘They did it to me’ becomes ‘I created this.’ The feeling of being a victim is, of course, a genuine feeling, and underlying it is also a level of self-victimization. Eventually all gestalt work begins with taking responsibility for all feelings. Even ‘My leg is cramping’ is
more completely claimed when it becomes "I am my leg and I'm cramping." We can do this with all the objects in our consciousness: "I am this room and I'm light and airy," etc. This process of identifying with the objects, ideas, feelings, and people around us is a powerful way we create our own unity and flow. As you penetrate tissue ask your clients to become that part of the body with which you are working.

6. Discover Background and Foreground. The unconscious parts of us are available if we just look at ourselves in a new way. We are like drawings which are trick of the eye. If we allow our perception (experience) to change, the background can become noticed as the foreground. Help your clients notice that the parts of themselves with which they are most familiar are dependent on another unnoticed aspect of themselves. If they are very polite, no doubt they also have an enormous hidden rage. You might want to use some provocative Reichian techniques when you see an opportunity for the unexpressed side of your clients to come to the fore.

7. Let Top Dog and Underdog Interact. We all have a part of us which controls and another part which is controlled. If, for example, we usually play underdog, or victim, we can by a conscious choice shift our attitude and become the top dog which our underdog has been creating. Help your clients get a dialogue going between the two parts. Use psycho-dramatic methods to support the weaker half. When the battle between the two becomes cooperation and sharing there may be a new insight, a momentary reshaping of the whole self, after which the dialogue goes on at a new level. To encourage this reformation, ask one side what it really wants from the other and what it is willing to give. Also help explore the feeling that each side really needs the other.

8. Finished or Unfinished? At some point the interaction between top dog and underdog will have to take at least a temporary rest. Often it is enough that your clients feel both sides of themselves. There may be no resolution, but there can be a feeling that this is enough work for right now. Ask, "Are you finished for now?"

Hyperventilation used to create a complete loss of physical and psychic control

Chapter IV - Breath and energy flow

Bioenergetic and Reichian Exercises

We have already seen in the 'Outline of A Session' how it is important to work with the charge and discharge of breathing. Below I want to outline a number of exercises which you will find helpful in the ten sessions. In the later discussion (part Two) of each session I will indicate which of these exercises may be especially helpful. If you use several at once, try to alternate the ones which bend the body backward with those that bend the body forward. Each can be used in either a provocative or soft way, and it is important for you to stay in touch with the ever-changing need for one or the other. Don't get stuck in using these exercises as only a way to charge or only a way to discharge. You may also use them not only as preparation for deep tissue work, but during the deep work to enhance the full release of emotions which are beginning to surface. You may also use some at the end of a session, along with affirmations, to reinforce new feelings and attitudes. I have explained these exercises in such a way that you can do them for yourself. You will, of course, eventually be assisting your clients.

Before turning to these exercises I want to discuss further the mechanism of breathing and to point out how in our work we are encouraging a special kind of spontaneous breath.

Spontaneous breathing

The breath functions as a part of the whole body mind and helps to establish a flexible balance by finding a level of recurring charge and discharge where our energy remains even and self-nourishing.

A complete cycle is not simply a repetitious building of energy followed by a discharge of energy, followed by another recharge. Nor is it an unbroken steady contraction, followed by steady expansion and then another contraction. An unarmored cycle of energy is made up of many smaller cycles, just as a liberating orgasm is a series of lesser, rising and falling orgasms. We see this in the rhythm of a free spontaneous breath.
Whenever I surrender and really let my breathing go, the rhythm is not merely in and out. As I inhale I quiver throughout the rib cage, and my whole breathing apparatus may even momentarily slow or stop the incoming air with subtle counter pressures, then continue with inhalation until I pause again. My inhalation is, then, an accumulation of small inhalations with some smallcountering exhalation-like movements. My exhalation is just the reverse: exhalations with partial momentary “inhalations.” This action is actually an interplay of the agonistic and antagonistic groups of muscles governing respiration. For example, the superior posterior serratus muscles in the upper back lift hand open the rib cage during inspiration, while the inferior posterior serratus muscles in the lower back pull down and inward. Not every inhalation or exhalation moves the total possible volume of air. The volume and depth of the breath varies continually with our physical, emotional, and mental demands, and the breath may change directions at any moment. An inhalation may, part way through, become an exhalation. The overall effect is a rippling, spontaneous rocking of the torso, which spreads up and downward through the whole body. It is just this spontaneous, variable character of an unarmored breath which permits it to be complete. Each inhalation or exhalation, being free to pause or even reverse itself, is also free, under the right conditions, to fully expand or contract, so to a completely filled or empty breath. When we deliberately try to make breathing ‘complete,’ we create tension which prevents the variable streaming of energy necessary to the breath eventually completing its cycle. We then revert to using armored habits, and deal with ourselves as objects, instead of following the rhythm of our changing needs. The capacity to be flexible in every aspect of body mind calls for a sustained and equal level of both charge and discharge. The breath now can be charging, or now discharging, but it equalizes itself. In contrast with the initial release stage of work, in which we exaggerate or support over and under-accentuated parts of the breathing cycle, during the integrating stage of Postural Integration, I help clients explore their capacity for variety and duration in breathing. I encourage them to experiment with charging by alternating between rapid and slow, shallow and deep, excited and calm breaths. Practitioners need to work with such sensitivity to the movement of their clients’ breathing that their own bodies and breathing rhythms synchronize with even the slightest change in the direction of the breath. Frequently I take my clients through cycles of charge and discharge where a single charge can be a long series of ever increasing inhalations, finally reaching a plateau, but the charge does not become excessive because it is always balanced with same discharge. I help them gradually descend them this plateau by focusing on a series of increasing exhalations, until charge and discharge are balanced at a lower level. Exercises for overall energy flow

1. The Bow. The feet are spread (not too wide or too narrow). The toes are turned inward. The whole body is arched upward and backward from the ankles to the top of head. Be careful not to concentrate too much arch in the small of the back or in the back of the neck. The fists rest on the back of the hips with the elbows pointed backward. Adjust the knees, flexing or extending them slowly until you find the point at which your body begins to vibrate. You may find that only one part of your body, the things of belly, for example, will vibrate, indicating that order unmoving parts are heavily armored. You may need to stay in this position until, after having breathed for some time, there is adequate charge and discharge for the vibration to begin. Maintaining the position, keep on deep breathing for at least five minutes. Remember that if you need more discharge, focus on the exhalation, along with perhaps a crisp ‘ha’ sound, and if you need charging, focus on the inhale, with a softer exhale. Work with both feelings of being grounded and uplifted.

2. Between Heaven and Earth. Same as Bow, except the arms are extended above the head, the elbows passing along a line even with the ear.

3. Forward, Surrendering Bend. Legs are the same as in the Bow. Bend forward at the waist until the hands touch the floor. Don’t use the hands for support. Sometimes shifting the weight forward onto the balls of the feet will help create more vibration: Experience feelings of being grounded while letting go.
4. **Panting**

1. **High Chest Pant.** Hold the belly in, forcing the air into the upper chest. Pant, beginning slowly and gradually increasing the rhythm. Keep the chest high without breathing in the diaphragm.

2. **Belly and Waist Pant.** While on back, prop the pelvis high with the elbows. Breathe only into the belly, letting it balloon out on the inhalation. Slow down the panting, it becomes confused. A vigorous shout on the exhale helps.

3. **The Jelly Fish.** While you are on your back, keep your arms extended above, shoulders following and head falling back. The knees are pulled up toward the head, so that the belly stays slightly contracted. Make small circles with your knees until a vibration sweeps through the whole torso and the circles become more confused.

4. **The Bear.** Bend over at the waist, head and arms hanging free. Walk with stiff legs, letting the torso swing forward (upward). At the same time, with each exhalation, the legs, which are propped up and bent at the knees, fall outward until the legs are spread. On the inhalation bring the knees together and lower the arms to the sides. At the same time (with the exhale) throw your head up and out and arch your back at the same time, making a loud “whoof.” The practitioner can stimulate the groin area by slightly pinching with the thumbs and forefingers around the gracilis.

5. **The Ape.** Inhale very deeply. With the chest inflated, beat out the exhalations by raping on the chest and roaring. Reinforce the feeling that it’s O.K., to be powerful, to be in control.

6. **The Splattering Snow Flake (The Andreas Vontobel Special).** Stick out your belly and collide with someone else’s belly, exhaling and shouting as you make contact. Try the same but meet belly to belly in midair. Explore the fantasy of the worst possible thing that could happen. If the feeling of dying comes up, what it feels like to die, and ask “O.K. now that your d what do you feel.”

7. **Spread Eagle.** While lying on the back, let bent knees flop and extend arms outward (not upward as in crab) and with a vigorous exhale shout “yes.”

8. **Between Heaven And Earth position swing forward giving an exhale and relaxing into swinging of arms and legs.** Swing back up with an inhale until arms and head are back. Be careful not to overarch the back or neck. Begin slowly until you find a smooth back and forth swinging rhythm. In this exercise we are combining discharge and charge. You may, of course, focus more on one or the other.

9. **Belly and Waist Pant.** While on back, prop the pelvis high with the elbows. Breathe only into the belly, letting it balloon out on the inhalation. Slow down the panting, it becomes confused. A vigorous shout on the exhale helps.

10. **Power and assertiveness**

1. **Pick Up.** Take a series of short inhalations without exhaling. With each inhalation expand the chest further. Explore the feeling of being expanded.

2. **Spread Eagle.** While lying on the back, let bent knees flop and extend arms outward (not upward as in crab) and with a vigorous exhale shout “yes.”

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Disgust

1. Gag. Place your first finger deep into throat to activate gagging. Keep the finger there just long enough to start
the reflex. Reinsert the finger briefly to keep the reflex going. When possible don’t stop to clean the mouth
with tissues until after one has really gotten fully into a series of gags. Direct the feelings of disgust toward
specific individuals. This vibration may also turn into a feeling of relief and sadness.

2. Blahs. Stick the tongue out as far as possible and shout "Blah" from the gut. Each time increase the force of
the exhale until one is doubling over in mild spasms, perhaps with coughing and choking.

Centering

1. Eye Focus. The practitioner uses a pen light, pencil, or finger to direct the eyes in circles, squares, figure eights,
and other irregular patterns. This is done slowly in the beginning and then unpredictably. Also try moving
from far away to a point in the center of and close to the eyes, then moving quickly farther away.

2. Whammy. Suddenly without warning the practitioner slaps the hands together in front of the face of the
client and asks “What are you feeling now.”
Sensuality

1. Roof Tickle. Rub the palate of the mouth with your finger. Often the person shivers and you can gently stroke the whole length of the body.

2. Sucking. Suck your thumb and hold your genitals at the same time. Explore simultaneously neediness and satisfaction.

3. Biting. Bite the heel of your hand without drawing blood. Bite a towel and hold on while its being tugged. Biting is not necessarily an expression of anger. It may be a playful way of making intimate contact.

4. Stand Me Up. Slightly rub and pinch the nipple tips until they become erect. Combine this with gentle rubbing of the whole body.

5. Sexual Surrender. With the legs open, massage the groin area with thumb and fingers around the gracilis. This can be pleasurable.

6. Rock and Roll. While on the back with knees bent, gently curl the pelvis toward the nose. Inhale as you curl up. Don't arch the back on the exhale. Gradually increase the rate of the rock until you are panting, rocking, and vibrating. Have a fantasy of something (someone?) you really want. Let it be alright to be excited.

7. Tickles. Enjoy being tickled all over. If you want to go further, explore the anger and helpless that may be underneath by being tickled to the point of rage or desperation. Tickles the bottom of the feet or the armpits.

8. Face Stimulation. Rub, gently pinch, and shake the face. Let this be playful contact, breaking all the taboos about being careful not to be too intimate with the face. Try out playful sounds at the same time.

9. Bottom Rub. Massage, roll, and shake the bottom. Alternately tighten the buttocks. Lift the bottom in the air spread the cheeks. Stay in touch with your fear and anger and dare to surrender to your sensuality.

Chapter V - Movement awareness

We saw in the "Outline of a Session" that clients play an active role in interacting with the practitioner. Not only must they be willing to actively charge and discharge their energies and take responsibility for releasing blocked feelings and attitudes, they need also to carefully move their bodies to interact with the practitioner’s pressure and to explore their new flexibility. And as the practitioner gives his energy he needs to maintain his own balance and center. Both the practitioner and client need to understand how to move with awareness and freedom.

We have also seen that a meditative, non-efforting consciousness is important to easy, free movement. If I am trying to accomplish a specific goal my body prepares itself by contracting according to habitual patterns. If I want to get up and shut the door, the muscles of my neck and back begin to tighten, as they always have when I have stood up. In breaking free of these habits I need to let myself unify with my environment, so that I am extended throughout my space. I am in a sense the room and the door. If then I move in a direction, rather than toward a specific goal, such as closing the door, I simply expand part of me toward the door. I spontaneously move in wave-like movements in that direction and in the process my door gets shut. My directives are not specific goal-oriented commands, rather they are empty, zen-like images, e.g., "I am moving upward; I float this way; I
In helping clients find this kind of spontaneous movement you can give them meditative images. You can also gently guide their bodies. Placing your hands on the shoulders or back, you simply wait for them to follow the spontaneous movement of your hands in a given direction. This can be especially helpful at the end of a session, after the deep tissues have softened and the emotions and thoughts are flowing more freely.

During the deep work itself, you can invite your clients to slowly move into your pressure, to follow a direction of movement which leads to those areas which need and want to be touched and released. But if they try too hard they will be using their armored habits to deal with stiffness and pain in the old defensive ways they have always used. Finding the place, the pressure, the attitude which has been largely unconscious is then part of our goal. I might say when working with someone, “It’s o.k. for you to scream and kick like this when you feel pain, and it is important for you to move and express yourself in ways that you have been avoiding; try surrendering and accepting the pain and moving more gently.”

All free, spontaneous movement is only ‘in a direction’ and never toward a specific goal. The following exercises, although they have been written as a set of instruction should be taken in the spirit of exploration, without efforting.

<table>
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<tr>
<th>Preliminary orientation for movement</th>
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<tr>
<td>1. <strong>Parallel Lines.</strong> Imagine the body as organized along two parallel lines. When the legs are turned in or out, or if they are spread too wide or too narrow, the body cannot move efficiently along these straight ahead rails.</td>
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<tr>
<td>2. <strong>Right Angle Axes.</strong> Imagine that the body functions by means of a series of axes at right angles to these parallel lines. These axes pass through the joints at the toes, ankles, knees, pelvis, mid-thorax, and head. If these axes are tilted away from right angles, the body alignment moves from side to side.</td>
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<tr>
<td>3. <strong>Stacked Blocks.</strong> Imagine a vertical line which passes through the ankle, pelvis, mid-lateral thorax, and ear. If this line is tilted forward or backward, the segments of the body can no longer stack one on top of the other. The image of a dragon tail can help bring the pelvis from a sway position into easy alignment. The image of the thorax opening evenly outward like an umbrella helps make the cage rounder and more balanced. The image of a string lifting from the crown of the head allows a chin which is lifted too high to drop down.</td>
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<tr>
<td>4. <strong>Shaking Tree.</strong> Imagine that this whole structure is static, but vibrates in waves and pulsations with the flow of balance always changing.</td>
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<tr>
<th>Exercises for feet</th>
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<tr>
<td>(From sitting position, knees up and in alignment). These instructions are reminders for students who have already guided through the exercises and are not an independent guide</td>
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<tr>
<td>1. <strong>Toe Wake Up.</strong> Feet are flat on floor. Toes moving her, up and down. (Remember all these exercises are the parallel lines and axes of the body).</td>
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<tr>
<td>2. <strong>Tip Toe.</strong> Toes up, ankles up, ankles down, toes down.</td>
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<td>3. <strong>Toe Scrunch.</strong> Pull toes under, then ankle up, ankles down, toes down.</td>
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<tr>
<th>Rotation of legs</th>
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<tr>
<td>1. <strong>Achilles’ Tendon Stretch.</strong> Ankles up, rotate legs out.</td>
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<tr>
<td>2. <strong>Tip-toes (Toes up, arched foot).</strong> Rotate leg out.</td>
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<tr>
<td>3. <strong>Ballerina Toes.</strong> Rotate, tracing semi-sphere.</td>
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<th>Ankle and knee coordination</th>
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<tr>
<td>(Sitting position, legs extended).</td>
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<tr>
<td>1. <strong>Automatic Flex.</strong> Bend one knee, move the knee by moving the foot up, rolling on calcaneus. Do not use the hamstrings or quadriceps. Place your hands around the thighs to make sure.</td>
</tr>
<tr>
<td>2. <strong>Super Knee Bend.</strong> With knee already bent, begin movement of knee by moving foot as above. Continue flexing the lower leg with Achilles’ tendon stretched until heel reaches buttock.</td>
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<tbody>
<tr>
<td>(Lying on back, knees up, feet on parallel lines, chin in, shoulders down).</td>
</tr>
<tr>
<td>1. <strong>Pelvic Curl.</strong> Curl pelvis, using psoas. (See notes on intrinsic and extrinsic muscles).</td>
</tr>
</tbody>
</table>
2. Pelvic Curl With Lift. At the end of the curl continue until the pelvis is slightly lifted. Come back down one vertebra at a time.

3. Pelvic breath. Inhale with pelvis curl. Take air all the way to collarbone and up the throat to the third eye. Exhale down the spine. Imagine the air going out your tail bone and feel a slight automatic rock in the pelvis.

**Coordinating pelvis, back and shoulders**

1. The Monkey. Squat with back flat. Spine is slightly rounded forward. Back of neck is flat. Shoulders are back, arms hang free.

2. Monkey With Shoulder Pull. From the monkey, hold both arms behind the back, pull shoulders down and back using lower, not upper rhomboids.

---

**As this book teaches you to expand and control your mind, the subtle sexual imagery becomes the cosmic joke spark to relax your judgmental mind.**

---

**So we see that we are energetic fields in a vast interconnected subspace field interacting with other energetic field beings. If we keep this perspective and our reverence for the whole we are working within the rules of existence.**

---

**If we start doing our own thing with no respect for God, his name, our parents, for others, or for ourselves, it is wrong.**
Deep bodywork can help a person establish an easy balance between different muscle groups. Often when we move an arm, we unconsciously overstretches muscles in the middle of the back, (the lower rhomboids), which help to hold the scapulae and shoulders in place. When this happens the opposing muscles on the front of the body (e.g., pectoralis minor) are over contracted, and as the arm moves forward, so does the shoulder. Here the practitioner is working simultaneously on the rhomboids in the back and the pectoralis minor in front, encouraging the client to move his arm from the elbow, while keeping the shoulder stable.

Coordinating shoulders, neck and arms
(On back, knees up, arms extended, elbows locked, thumbs down, palms toward ears).

1. Crucify. Bring arms together, in front of chin. Return down to floor. Shoulders are kept in place by rhomboids. Notice the unevenness of arm movements: how one arm may want to be higher or lower than the other. Explore the angles and areas through which you do not want to move.

2. After a quarter rotation of the arms, the palms will be up. Repeat #1.

3. After a quarter rotation, the thumbs will be up. Repeat.

4. After a quarter rotation, the palms will be down. Repeat.

5. Reach to Heaven. (On back, knees up, arms down at sides, palms down, and elbows locked). Bring arms up, along parallel lines, all the way over the head until the backs of the hands touch or almost touch the floor. Keep the shoulders down by using the lower rhomboids. Now rotate the hands until the palms are down as you sweep along the floor and reach the original, beginning position of the arms.
Chapter VI - Working with the core and shell

Integration
1. Spinal Roll (sitting on the edge of a chair or on knees). Rock to find a point of balance. Drop the neck forward, bending the uppermost cervical vertebrae, the thoracic and lumbar vertebrae. Reverse the sequence and let the neck finally go back into position. Repeat 10 or 15 times until the vertebrae move freely and independently.
2. Side Stretch. (On back with knees bent; hands are together over the head). Cross right leg over left. Shoulders stay down. Swing legs to the right at least 20 times. Keep the hands together and in position even as legs flip to side. Reverse by putting left leg over right and letting legs fall to the left.
3. Pelvic and Third Eye Breath. (On back with knees bent. Do pelvic curl as above and imagine that a string gently pulls the anus and genitals upward to the third eye with each inhalation and let the string then relax on the exhalation when the pelvis drops. This is a very subtle, easy movement.
4. Pelvic Curl Coordinated With Legs and Arms. (On back with knees bent, arms bent, lying against floor with palms up). While doing pelvic curl, stretch the ACHILLES' TENDON. At the same time pull the elbows down along the floor. Back and neck stay flat, knees stay on parallel lines.

Fluidity of insides and outsides

The alternative to this armored splitting of ourselves into a core and shell is to move, to feel, to think with our whole being, letting what is happening in our outside life be what is happening in our inside life. When we are most alive, that is, fully responsive to our environment, as well as active in it, our energy is not limited to surface reactions or to inner initiatives. Fear, anger, joy, sympathy, and grief move freely through us, from the outward contact with the people around us, pouring right into our deeper feelings of empathy and sharing. At the same time, those emotions can begin inside us and without repressing flow outward toward others. Thus when we are fully alive, the core and shell both disintegrate, and our energy moves easily from outside to inside and from inside out outside.

Reaction and action are different views of the same event. My reaction to you is a mode of my action toward you. When you touch me, my response is my active acceptance or rejection of you. My inside and outside energetically function together as aspects of my single unified reality. This unity can be felt in the body tissue. When there is unity, there is balance between the larger extrinsic muscles (which give power to our movements) and the deeper intrinsic muscles (which give subtle direction and stability). The unarmored, active and receptive individual has a consistent, soft yet firm tone from the skin inward to the deepest structures.

If we become conscious of the over developments of the outside of ourselves, of the hard protective shell we have created, we might try to soften this defense by working gradually from the outside toward the core. One of the most frequently used strategies in deep bodywork is to work from the shell to the core. In this work the body is considered to be layered like an onion, in order to affect and reach the inside layers, the outside has to be peeled away.

We can understand this approach to the body better, if look, for a moment, at the nature and arrangement of the tissue being manipulated. The muscles of the body are wrapped in envelopes, consisting of a pliable tissue called fascia. This material organizes and guides our muscles by forming a system made layers of tissue. On the outside of the body we have a large, encompassing layer, which like a big shopping bag holds everything together. As we go deeper we find individual sheets of each muscle. As we develop rigid physical and emotional patterns of behavior this system of fascia becomes less flexible, restricting our movements and overall body mind attitude. The strategy in this kind of work (from outside toward inside) is to soften reorganize those parts of the fascial system which have become hard and stuck, and this, in turn, it is thought, gives mobility and balance to the muscles held in the fascia.

I have found that if we begin working with the outside, ourselves in the belief that we can affect and make more available our insides, we overlook how our armor subtly shifts defenses. The tension that we release superficially may work toward a deeper more protected place. It is, of co important to respect the rate at which a person undergoes assimilates change, and often in my work I focus on the on superficial planes of fascia, and then gradually go deeper. Have found that when real transformation occurs, it is not the outside that is changed. The inside is also simulation undergoing corresponding changes.

As I begin working with superficial layers of tissue, I am coordinating this work with the individual movement of intrinsic muscles, such as gentle rocking of the pelvis or short, slight movements of the spine. Also as I work with the extrinsic muscular, as well as the outer feelings and attitudes, I may, for example, work simultaneously inside the mouth, which holds some of the deepest structures, emotions, and attitudes of the body. Rather than viewing the body, the body mind, as a many layered onion, I see it as a vibrant plastic mass, less viscous in some places than others, and composed of the same interflowing stuff from outside to inside and from inside to outside. Thus when touched at any level or depth, it instantaneously responds, reshaping itself in every other dimension and part.
Techniques for loosening and reorganizing fascia

Although we are always working with all the layers of fascia simultaneously, we do in the beginning concentrate on the superficial, next the intermediate, and finally the deep. My use of these three layers does not correspond to any one system of anatomical classification but is a mixture of classifications taken from German, French, English texts. (See A. Forster, Ueber die morphologische Bedeutung des Wangenfettflethes; A. Richet, Traite pratique d’anatomie medicole-chirurgicale; E. Singer, Fasciae of the Human Body and Their Relations to the Organs They Develop; and B.B., The Planes of Fascia).

What I call ‘superficial’ comprises both the fatty and denser subcutaneous layers. What I call ‘intermediate’ is referred to in some texts as the ‘superficial subserous fascia,’ and what I call ‘deep’ as the ‘deep subserous fascia.’

In working with fascia we are interested both in softening and reorganizing it. Sheets of fascia have a tendency to thicken and adhere to surrounding tissues. An important part of our work is to separate these sheets of fascia such that muscle fiber can soften and function more freely. In the separating and softening process we need to pay attention to the depth of our strokes. In the following diagrams you will see that depth is controlled by the angle at which we apply force with fingers, fists, etc. Depth is also to a certain extent controlled by the amount of force we use. (But this is not nearly as important as beginning students sometimes think).

We also need to encourage the coordination of different parts of the fascial system. In superficial work, we are working with flat broad strokes toward a spreading of the outer body envelope, a general, spacious, fluffing out of the whole subcutaneous layer. In intermediate work we go slightly deeper with shorter strokes and begin touching and opening individual myofascial envelopes, the wrappings around each muscle. In deep work we are going in between and under envelopes. Now our strokes are very slow and short.

During the final phase of work sessions 8, 9, 10, we use a special type of stroke which is almost as broad as superficial work (we want to encourage major sections of fascia to shift with each other), but it is also deep enough to move all three layers of fascia (which are now soft and more malleable).
A superficial stroke uses a slightly open fist over a broad area, while a deep stroke is shorter, firmer, and more specific.

As illustrated, this stroke is superficial, but it can also be made deep. In either case it is important that the fingers be kept arched and not allowed to buckle inward.
When this stroke is used with the hands at a wide angle and with outward movement, it spreads superficial fascia over a fairly wide area; it is used extensively in sessions one and two. If the angle were more acute, more force applied, and the stroke shortened, it would then be appropriate for the intermediate and deep work of sessions 3, or 4 through 7.

This stroke is also a superficial stroke, appropriate for the beginning sessions. When, however, either the knuckles or the hand is used to anchor the tissue and one hand penetrated more directly over a shorter distance, then the stroke becomes deep and begins separating tissue rather than spreading it, and would consequently be used only after the superficial work is complete.

The same is true for this position as for the Cross Hand Finger Spread on the previous page. Notice that in both cases these is not just an outward movement, but also a spinning motion which helps hook the tissue being spread or separated. This hooking of tissue is essential to all connective tissue work.
This is a basic hand position, which can be used in either a superficial, intermediate, or deep stroke.

This stroke can be superficial, intermediate, or deep, although reinforcing the first knuckle with a second helps in deep work. In order to get good tissue separation or spreading, add a twisting motion.

These strokes are for deep, specific penetration, e.g., quadratus lumborum, iliacus, and pectoralis minor. Keep your fingers arched.

This illustrates how many deep strokes separate (instead of spreading) tissues which have become stuck together at a deep level. A slow wave-like movement can help this separating.

Here separation is achieved by a deep, pincer motion, sometimes with an upward lifting movement added.
Chapter VII - Fine energy and the five elements

In the ‘Outline of a Session’ we saw that working with fine energy is important for preparing, sustaining, and finishing deep tissue work. Let’s look now at some specific ways you can regulate fine energy.

Giving space and time to your client

Even if you have no knowledge of acupuncture, polarity, or the soft aspects of Reichian work, you can work with fine energy simply by respecting your clients’ need to assimilate the changes which you have initiated with deep breathing and deep strokes. Just be there, making yourself available but not intruding on your clients’ need to reorient themselves. If they are stuck, and need your intervention, you will soon know. Sometimes this waiting should be done without any contact. Sometimes you can gently touch. Place one hand softly on the forehead the other on the chest (over the heart, e.g.) or on the belly and continue to wait. This will usually have a calming, nurturing effect. Or you may simply hold your client’s hand or head.

It is important to give this space and time frequently. Be sure any active expression of anger, fear, etc., however, is finished for the moment, before you begin trying to calm anyone. Cultivate a rhythm in your work in which you feel the need to alternate coarse and fine work. Be ready to stimulate and provoke, or to calm and reassure without pushing your own needs onto the client. This is like riding the waves of change, flowing with ever-changing energy flows.

Simple verbal support and direction

Often simple asking, “How do you feel now,” or saying “I know how you feel,” or “I have often felt that way too,” or “It was good that you let yourself go like that,” can give a great deal of support without pushing the person further. (If you are encouraging more active or even explosive expression and release, other types of directives would, of course, be needed).

Fine energy often has to do with seeing, understanding, meditating, watching. After a cathartic release you may want to point out that there are various choices, various routes for letting experience flow. You might, for example, say, “It was great to see you express your hate toward your father, and I feel you don’t allow that feeling to come out often enough; when you hate him you aren’t denying your love; that can be expressed again at another moment.” Or “Did you notice how alive you were as you reached out to your mother?” With such questions we are not trying to further confront frustrations, or incomplete feelings, but are merely taking stock of what’s happened to this point. Help your clients assimilate their experiences frequently during a session. Avoid discussions about what has happened in the past or theorizing about the human condition. These verbal sidelines will stop the momentum of the session, and make reentry into the tissue more difficult.

Another way to direct fine energy is to help your clients formulate a supportive and attainable affirmation. As we saw in Chapter II affirmations, when they remain open ended and are not attempts to manipulate ourselves, are ways for us to claim the power which has been released by the crumbling of our armor. Whenever I repeat to myself, “I am opening myself to the love of other people,” my affirmation is broad enough to give me a direction for changing energy flows.

Another affirmation that is also an overall energy regulator and can be especially effective when used with 636.

Li 4 (Large Intestine) Joining of the Valleys. Although this point is specifically for the colon, throat, and nose, it is also an overall energy regulator and can be especially effective when used with 636.

Cvl 7 (Conception Vessel) Within the Breast. This is often called the chi or breath point. Helps in opening breathing, as well as balancing overall energy.

S 36 (Stomach) Leg Three Miles. One of the most powerful all-purpose points in the entire meridian system. Notice that this point is an earth point on an earth meridian which means it reinforces and stabilizes earth, the nurturing element.

S 14 (Large Intestine) Joining of the Valleys. Although this point is specifically for the colon, throat, and nose, it is an overall energy regulator and can be especially effective when used with 636.

Some systems of fine energy

Below is a brief outline of some ways you can use the five elements and acupuncture points to regulate fine energy. There are, of course, many other systems which you could effectively use but which we will not discuss. For example, in the Polarity approach there is a careful regulation of the energy of the chakras. Many very powerful points are used simultaneously to connect positive and negative energy. Reflexology, which is a system passing not only through the feet but through the hands and other parts of the body, also provides many useful points for regulating fine energy. Some systems of movement awareness which we have already mentioned in the ‘Outline of a Session’ are: the Alexander Technique, Feldenkrais Method, and Aston Patterning. Some other equally important ones are Triggering and Pulling. Although to some extent passive, these help bring the client in touch with a subtle, deep, inner movement.

You will discover the techniques which are best for you as a practitioner. I have chosen to focus on the five elements and acupuncture because they come from one of the most rich and flexible systems I know which takes body and mind as a working unity.

The five elements

If you understand the basic flow of energy between the five elements – water, wood, fire, earth, metal – you have an orientation which can help you diagnose and redirect the energy of your clients as you work with breath, emotion and fascia.

Study accompanying five element charts so that you have a sense of the properties and interrelationships between the elements.

As you do deep work you will be helping your clients confront the excesses and deficiencies of energy in their five elements. When encountering an excess, e.g., you may wish to provoke the expression of the held-back attitude before trying to reorganize tissue. If, for example, someone has an excess of wood energy, I might prod them (with Reichian probes, pokes and scratches) into kicking or slamming out their rage, before trying to move, slowly and deeply, their hardened layers of fascia. As the excess releases in wood, more energy is available in fire to sustain and support lasting body mind changes. On the other hand, if someone has, for example, a deficiency of metal, I might find it helpful to begin deep tissue work and wait for other elements (fire or earth!) to nurture the hidden sadness. In the first example we have someone who is hard and held-back and needs to express themselves before opening up to deep tissue work; whereas in the second example we see tissue which can be entered but needs to be nurtured. As you work with the five elements you will begin to discover many ways of connecting your knowledge of the five elements with your deep work.

Acupressure points for sessions

1. All Purpose Points. There are numbers of powerful self-regulating points that you can use at anytime. Self-regulating means that the point will either supply or diminish energy to the elements automatically as needed.

S 36 (Stomach) Leg Three Miles. One of the most powerful all-purpose points in the entire meridian system. Notice that this point is an earth point on an earth meridian which means it reinforces and stabilizes earth, the nurturing element.

Cv 7 (Conception Vessel) Within the Breast. This is often called the chi or breath point. Helps in opening breathing, as well as balancing overall energy.

S 14 (Large Intestine) Joining of the Valleys. Although this point is specifically for the colon, throat, and nose, it is also an overall energy regulator and can be especially effective when used with 636.
Sp6 (Spleen / Three Yin Crossing). This point is called the woman's point and affects the ovaries. It should be used frequently since menstruation is often thrown out of its normal cycle. In men this point also has a strong effect on the prostate. Since it is a crossing point of the lower yin meridians it affects the whole length of the inside of the body.

K27 (Kidney). Store House. This is the point for balancing the right and left halves of the body, for harmonizing the masculine and feminine parts of ourselves.

Sp21 (Spleen). Great Enveloping. This point helps balance the energy of the whole thoracic cage.

2. Tonifying Points. If the client needs more energy in a given element and the previous element has an adequate supply, you can use a tonifying point to pull the energy into this deficient element (meridian). For example, if the Gall Bladder is weak and the Bladder is strong -- anger under supplied, fear excessive -- then use the water point on the Gall Bladder Meridian. Using the point that relates back to the previous element (water, earth, metal points, etc.) you can find you can find the tonifying points for all 12 meridians. I list only some of these tonification points below as well as first some other stimulating points.

H9 (Heart). Little Rushing In. Since the fire element has four meridians -- heart, small intestine, circulation, and triple warmer -- supplying energy to this element has a strong overall tonifying effect to the whole system. Fire is the great coordinator and regulator of the whole meridian system so be careful not to over stimulate.

LI (Large Intestine). Crooked Pond. This tonifying point is especially effective when used with 536.

Gvl4 (Governing Vessel). The Great Hammer. This point is a judo revival point and can be hit with a glancing, crisp blow to bring back the energy of a client who is falling into a lethargic, unresponsive state.

Lv8 (Liver). Crooked Spring. This point is good for stimulating the capacity to build and maintain assertiveness -- not explosive anger, but steady initiative.

B67 (Bladder). Extremity of Yin. The bladder meridian is the longest meridian. Stimulating this point will bring this energy down the whole length of the back of the body.

H3 (Heart). Little Sea or the Joy of Life. This point stimulates fire but at the same time calms water. It turns fear into joy.

3. Sedating Points. If the client has an excess of energy in called the an element (meridian), you can disperse this excess by using should be a sedating point to send this excess on to the next element thrown out (meridian), assuming the next meridian is not already overloaded. For example, if my client has excessive fire in the heart meridian (too joyful, nervously overactive), and needs more nurturing earth energy, I can use the earth point on the heart meridian to reduce fire and supply earth, diminish joy and increase sympathy. All twelve sedation points can be found by taking the point which relates to the next meridian in the five element cycle. I list some of these, as well as other calming points.

K1 (Kidney). Bubbling Spring. This point not only calms but has a harmonizing effect upon the sympathetic and parasympathetic nervous systems. After the intense upheaval and release during a session, these systems can be out of balance. We may be sympathetically over stimulated, or parasympathetically lethargic (as a defensive reaction).

H7 (Heart). Spirit Gate. Very strong sedating point. Note that earth, which by nature is nurturing, will be further nurtured. Neighboring points, H4, 5, and 6 can help with speech which is too rapid or tongue tied. To calm oneself is to find the door to one's spirit and capacity to speak, with one's heart.

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3. Points for Pelvic Release.

Doors of Life. These points are in an area which is very active during birth. Often in rebirthing session massage of this area prompts a reliving of birth itself.

Gv4 (Governning Vessel) Gate of Life. Locate by drawing a line horizontal between the twelveth ribs and crests of each ilium.

823 (Bladder) Kidneys Correspondence.

847 (Bladder) Ambition Room.

Groin and Genitals

S30 (Stomach) Rushing order. Located right along the superior line of the public bone. Erotically stimulating.

Lv9 (Liver) Five Miles.

Lv11 (Liver) Yin Angle.

Lv12 (Liver) Hasty Pulse.

4. Windows to the Sky. These points bring energy upward. When working on the upper half of the body, they can supply energy taken from the lower half. After having worked on the lower half of the body, you can also balance out the effect by returning energy to the upper half with these points.

• Cv7 (Circulation Sex) Heavenly Pond.
• Cv22 (Conception Vessel) Heaven Rushing Out.
• L14 (Large Intestine) Support and Rush Out.
• S9 (Stomach) People Welcome.
• Si6 (Small Intestine) Heavenly Window.
• Si7 (Small Intestine) Heavenly Appearance.
• Tw6 (Triple Warmer) Heavenly Window.
• B10 (Bladder) Heavenly Pillar.
• Gv6 (Governning Vessel) Wind Palace.
• L3 (Lung) Heavenly Palace.

5. Points in Areas Covered by Sessions. During the session you will be working in areas of the body where there are points which can help you open and relax the structure before making your strokes.

• L1 (Lung) Middle Palace.
• L2 (Lung) Cloud Gate. These first two lung points open the upper chest.
• Lv4 (Liver) Gate of Hope. This point helps elongate the belly.

• Gv34 (Gall Bladder) Yang Mound Spring. This point is good against muscular cramping. Helps relax the entire musculature. You can use it just before deep, difficult strokes.

• Gv4 (Governning Vessel) Gate of Life. Locate by drawing a line horizontal between the twelveth ribs and crests of each ilium.

• B47 (Bladder) Ambition Room.

• S30 (Stomach) Rushing order. Located right along the superior line of the public bone. Erotically stimulating.

• Lv9 (Liver) Five Miles.

• Lv11 (Liver) Yin Angle.

• Lv12 (Liver) Hasty Pulse.

• Gv4 (Governning Vessel) Gate of Life. Locate by drawing a line horizontal between the twelveth ribs and crests of each ilium.

• B25 (Bladder) Capital Gate. Opens the back of waist. It is also an alarm point for the kidneys.

• Gb39 (Gall Bladder) Dwelling in the Bone.

• Gv30 (Gall Bladder) Jumping Circle. These two Gall Bladder points release the lateral hip and iliotibial tract.

• K10 (Kidney) Yin Valley. Water point on a water meridian. Stores and stabilizes energy.

• B50 (Bladder) Receive and Support. This point connects the legs and pelvis.

• B54 (Bladder) Equilibrium Middle. Earth point on water. crests of . Brings sympathy into fear. Helps knees be more flexible and supportive.

• Gv20 (Governing Vessel) Wind Pond. Releases excess aggressive energy which collects at the base of occiput.

CHAPTER VIII - Body mind types and the limits of change

When I give my force, feelings and ideas to you from a receptive and unified inner and outer space, I am simultaneously allowing you to explore your own energy. Whenever I “read” you as belonging to a certain body mind type or structure, I am respecting your capacity to break the limits of this classification and to find your own limits.

A number of body workers and therapists have explored a wide variety of physical and psychological types. In Know Your Type Ralph Metzner outlines and summarizes a selection of types, including those of Sheldon (mesomorph, endomorph, and ectomorph); Kurtz (bottom-heavy, top-heavy, burdened, rigid, and needy types); and Jung (introvert and extrovert). He also gives various psychiatric types from Freud, Reich, and Lowen, and the classic western types (choleric, sanguine, phlegmatic, and melancholic). Rather than a further review of these types, I offer a classification system which has evolved from my work over the years. My schema is intended to supplement and not replace the types specified by Metzner and is designed to be flexible in providing individuals with a framework which allows interaction with the practitioner.
## BODIMIND TYPES

<table>
<thead>
<tr>
<th>TYPE</th>
<th>OUTSIDE STRUCTURE, SHELL</th>
<th>INSIDE INTRINSIC STRUCTURE</th>
<th>FUNCTION</th>
<th>COMPARISON TO OTHER TYPES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. EXPANDING outer directed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. SOFT</td>
<td>LOOSE: superficial tissue available, fat porous, voluminous; reaction is slow but responsive</td>
<td>UNITED CORE</td>
<td>Outer sleeve is protective cushion for unused inner energy</td>
<td>Extrovert who hides inner feeling, bottomheavy, seductive, rigid inside, paralyzed paraotic, masochistic, burdened, endomorph</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TIGHT: hidden, frozen, immobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. HARD</td>
<td>TIGHT: thick skinned, muscular, dense, quick voluminous, massive</td>
<td>LOOSE: little tone, weak, confused, underdeveloped</td>
<td>Strong, active exterior covers fragile inner energy</td>
<td>Extrovert with little inner development, toph]heavy, manipulative, sadist, rigid outside, mesomorph</td>
</tr>
<tr>
<td>II. CONTRACTING inner directed</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A. HARD</td>
<td>TIGHT OR LOOSE: unconscious, unresponsive, rubbery, frozen, stoic</td>
<td>OUTER CORE</td>
<td>Lack of outside consciousness compensated by active introverted energy</td>
<td>Active introvert, phlegmatic outside, choleric inside, compulsive, anal, ectomorph</td>
</tr>
<tr>
<td></td>
<td></td>
<td>INNER CORE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. SOFT</td>
<td>LOOSE: unconscious, unresponsive, rubbery, frozen, stoic</td>
<td>TIGHT: outer core and loose: inner core is weak</td>
<td>Inner activity is not well directed</td>
<td>Confused introvert, needy, oral, masochist, melancholic, burdened, endomorph, hypercyclic</td>
</tr>
<tr>
<td>III. UNSTABLE excess inside or outside</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A. OVEREXTENDING</td>
<td></td>
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</tr>
<tr>
<td>1. CONTRACTING</td>
<td>STABLE</td>
<td>TIGHT: entire core is overactive</td>
<td>Under stress energy is focused inside or outside for protection</td>
<td>Parttime introvert or parttime extrovert, neurotic, body changes frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TIGHT: outer core traps inner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. EXPANDING</td>
<td>LOOSE: overconscious or unresponsive</td>
<td>STABLE</td>
<td>Unpredictable and excessive movement toward both expansion and contraction</td>
<td>Schizoid, manic depressive, hysterical, oscillating mixture of many types</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TIGHT: overprotective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. FLUCTUATING</td>
<td>UNSTABLE</td>
<td>UNSTABLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. EVEN equal tone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. HARD EVEN</td>
<td>TIGHT</td>
<td>TIGHT</td>
<td>Even but excessive tone; too protective in both shell and core</td>
<td>Has capacity to be open but holds back some of energy</td>
</tr>
<tr>
<td>B. SOFT EVEN</td>
<td>LOOSE</td>
<td>LOOSE</td>
<td>Even but inadequate tone; too open in both shell and core</td>
<td>Has capacity to conserve energy, but gives away too much</td>
</tr>
<tr>
<td>C. BALANCED</td>
<td>OPEN TO CHANGE</td>
<td>BALANCED: outside and inside is even; shell and core disappear</td>
<td>Allows energy to flow where it is needed</td>
<td>Genital, spontaneous, loving, both open and selfprotective</td>
</tr>
</tbody>
</table>
This schema does not try to classify the individual directly but indicates that some detectable characteristics or structure may belong to a type or number of types. This gives a starting point from which the individual can be expressive, without being treated as an object. For example, instead of indicating that you are a "burdened type," I may share with you that your shoulders look heavy, and ask you how you feel in your shoulders. With this kind of shared impression and interrogation our interaction can more likely develop into a discovery of what you feel and want and what I, in turn, can give to you.

We may discover in the process of interacting and sharing that what is happening in your shoulders is of less importance to your release and integration than what is happening in other parts of your structure. We may discover that a feeling of neediness around your mouth and throat is equally significant as, or even more significant than, my initial observation about your shoulders.

Type consideration is merely a suggested starting point for discovery and transformation. After the client moves through his or her process of transformation, we can then look back and consider the degree of change and how much movement has been made away from the type with which we started. Now that there has been change, the client, for example may no longer be very much like a "needy" type, he or she may be fuller, softer, and more expanded, and more closely resemble what I presently shall describe as an "even" type. This flexible approach to types allows a discovery of limitations and a decision about what one wants to accept or work to overcome.

Early in life we begin to develop our strength and consciousness by concentrating more on the outside or more on the inside of ourselves. So in doing we armor ourselves in characteristic ways that resemble what I call "expanding" and "contracting" types of body mind. When we fluctuate unevenly between outside and inside, we may resemble what I call an "unstable" type. When our inner and outer rhythms are somewhat equal, we may resemble what I want to call an "even" type. Even when the range of expansion and contraction is to a certain extent restricted, we may still be close to an even type.

The following classifications evolved more from tactile than visual cues, so are difficult to illustrate, except in the accompanying cross sections of the body. They also cut across previous classifications, that is to say, one of my types may be similar to more than one traditional type. The chart provided is not complete or definitive, but I hope it suggests to you examples of such types from your own experience.

**Expanding types**

**Taking Up Outer Space**

We have moods in which we are outgoing, in which we make contact with the people around us or the objects in our environment. In this external movement we may be enthusiastic and filled with vitality and purpose, or quiet, slow, and not so clearly directed. There are many individuals who focus the main part of their lives on this extroverted dimension and who in some ways neglect the inner side of themselves. They display a kind of expanding, well-developed outer armor or defense in dealing with life. The chart shows two possible expanding types: a soft one, which is loose outside and tight inside, and a hard one, which is tight outside and loose inside. The first kind of expanding person has developed a loose outer sleeve around the body (mind), providing a soft, fat, porous protection for absorbing the pains, demands, shocks, and tensions of everyday life. Although this large, elastic surface creates a broad, flexible contact with the world and other people, it is a shell, a kind of cushion, allowing the individual to react from the outside, perhaps slowly, without expressing the more contracted inner feelings. The inside remains frozen and mostly unconscious, used only when the individual is touched deeply, or when called upon to use his or her reserve strength. Whenever I am working with a person whose tissue and personality show some of these traits, I explore the direction of our work together by either provoking the person outside, encouraging a quicker response to me, or by trying to work my way slowly through the soft, outer shell to

the evasive deepest tissue, feelings, and thoughts.

The second kind of expanding type is muscular, massive, dense, or thick-skinned. These individuals also use their body volume as a protection device. Since they are tight outside, they can take, and even enjoy, more rough contact to the point of aggressive interaction with others. Although their reactions may be quicker, they remain superficial unless the hard shell is broken or dissolved. I try forceful, aggressive encounter with such hard shelled individuals, or else I try circumventing their outer armor with gentleness, encouraging them to expose their looser, inner selves. In either strategy, when the outside armor begins to disappear, I find it helpful to explore ways of keeping the often confused, underdeveloped interior intact with guided movements, and slow, careful initiation into new attitudes.

**Contracting types**

**Busy Inner Worlds**

Whereas the life of the expanding type is filled with outer contact, the contracting individual withdraws and holds back from external engagement and interaction. These individuals perhaps appear calm on the surface, but underneath create conscious, active, and tense inner movements (which contrasts with the frozen inactivity of the soft, expanding type who is also tight inside).

This inner activity takes two forms. First in the hard, contracting type, the entire core structure is overactive and the shell neglected, as in the case of the person who is continually avoiding any outer contact by a frenzy of inner movement. Here the outside may be relatively loose but lacking in the receptivity of the soft, conscious responsiveness of the soft expanding type.

Second, the soft contracting type has a contraction of the deep extrinsic muscles (which we can classify as the periphery of the core), surrounding the even deeper intrinsic muscles (the inner core). The contraction of the relatively deep extrinsic muscles (peripheral core) traps the deeper intrinsic muscles (inner core) and restricts their mobility and power. (We saw in previous chapters how the psoas can be overpowered by surrounding structures). The outer core is then, tight and overdeveloped, while the inner core is loose, inactive, and weak.

This soft contracting type differs from the hard expanding type (who is also loose inside) in that in this type the shell is loose and relatively lacking in energetic response.

With both contracting types I encourage exploration and use of their external power -- the expression of anger, joy, enthusiasm, the open display of thoughts and feelings. With the second type, however, since the inner and outer extremes are weak (the shell and inner core are soft), I suggest that their outer movements and expressions be slow and careful explorations, accompanied by subtle, conscious inner attitudes.

**Unstable types**

**Over The Edge And Swinging Back And Forth**

Some individuals the direction of their energy and awareness between inside outside so that they are not stuck in either, yet make these changes as a result of their instability and not in harmony with their needs and environment. There are two kinds of instability. One results from over extension of the self, and other from disruptive fluctuation within the self.

Over extension is toward expansion or toward contraction. These individuals may be usually balanced in their outer and inner activity, but under stress, they focus too much of their energy either outward or inward. They may have no problem with one half of their lives. If they sometimes exhaust themselves in expanding, they may not have a corresponding degree in contracting, and though inclined to withdraw into themselves, they may still...
manage to cope with outside demands. Their weakness is in one direction, and unlike the previous expanding and contracting types, they can eventually, even if temporarily, regain a balance between inside and outside.

The second kind of instability is seen in the individual who, perhaps wildly, fluctuates between extremes. These persons are unpredictably expanding in one moment and contracting in the next. Typical would be the person who gains excessive weight in a matter of days or weeks, and loses it just as quickly. This could be the manic-depressive, now joyful and overflowing, and then suddenly gravely depressed. We all expand and contract. However, depending upon the extent we are balanced and flowing, we exercise a centered and spontaneous choice about the timing, degree, and rate of our expansions and contractions.

Both unstable types show an unevenness in tissue and attitudes. They may collapse under pressure, into a slack, disorganized state. Or if they are touched deeply, they may pull together in an over contracting defense. In consideration of these fragilities, I have found it important to work with these individuals in a non provocative and predictable manner, helping them learn that change can be safe, gradual, and progressive.

**Even types**

Staying Consistent and Flexible

There exist those rare individuals who balance their expanding and contracting sides, their outer and inner selves, and who change with their environment, but not because of it. They have body minds whose outer, intermediate, and deepest layers are all more or less equal in tonus, flexibility, and responsiveness. Their body minds have little in the way of a protective core and shell, since they are able to mobilize their entire selves when threatened from within or without. As previously stated:

> When we are really alive, the core and shell disintegrate; our energy moves easily from outside to inside and from inside to outside. There is a balance between the larger extrinsic muscles which give power to our movements and the inner intrinsic muscles, which give subtle direction and stability.

When subjected to severe stress for long periods of time, even types may tend to protect themselves, by equally restricting the range of both expansion and contraction, but not by losing their balance between inside and outside. I find them most satisfying to work with, since their transformations are rapid and smooth. Compare this kind of balanced change with the changes of expanding types, who are slow in responding to probes into their soft buffer or who melt in confusion as their hard exterior breaks open; or with the changes of contracting types, who stubbornly resist deep, gentle surrender; and with the uneven types who keep changing directions to avoid confrontation.

In working with each individual, I recognize, that a type is a stereotype, and that we are only looking for starting and comparison points. Each person will respond differently to the above suggested ways of exploring and working with different types. The same individual may even react differently at different times. That is why I keep making new suggestions, posing new questions, trying to discover new ways of making contact with each individual and in the process find that I am changing myself.
PART II TECHNICAL SUMMARY OF TEN SESSIONS OF DEEP BODYWORK

PHASE I: INITIAL OPENING OF BODY MIND
Sessions 1 and 2

GENERAL PURPOSE
At the outset we want to help our clients feel that they can and will change. This is an inspirational session which communicates the feeling of a fresh and powerful beginning with the promise of more changes to come. We will be releasing superficial fascia, and surface emotions and attitudes. The focus will be on more freedom for the ribcage.
shoulders, neck, and hips to move in their large superficial fascial envelopes. At the same time it is important to do sufficient deep work (e.g., gag and cough reflexes, massage of abdominal contents) for the deep, inner energy to surface and make this superficial work easier. Be careful to not do more deep work than your client can assimilate in initial bodywork.

We want to encourage the large superficial myofascial envelope to expand, to separate from deeper layers, to fluff out, to give room for underlying structures, or where this envelope is too loose, to encourage more response and contraction. We also want to build the energy level to a point where basic problems can be confronted. In cases where energy is excessive to encourage discharge of pent-up feelings and begin to work with underlying needs.

**BODY TYPE**

1. **Hard Outside, Soft Inside.** When the outside is hard, the practitioner can either a) work with force to break directly through the superficial armor (in which case enough attention has also to be given to the underlying deeper structures which are soft, disorganized and confused) or b) work subtly to activate deeper feelings which can in turn allow the superficial surface to soften and become more receptive.

2. **Soft Outside, Hard Inside.** When the outside is soft or rubbery more twisting and hooking of the superficial tissue may be needed. Rubber types can usually withstand a great deal of superficial manipulation without feeling much discomfort. Slapping, pinching, scratching, tickling may be called for when the exterior is unresponsive. More response in the tissue and feelings is needed, before the slower systematic work can be effective. Soft types who bruise easily may be using their fragility as a protection against deep work. Go slowly, reassure them, but work deep enough.

3. **Top Heavy.** When this type lacks consciousness in the pelvis and legs, one may begin on the lower half first, or if you find it important to begin working with the rib cage in order to encourage better breathing, then combine, in the same session, at least some work on the legs.

**EMOTION**

It is not essential that very deep feelings be released during this session (if they arise, certainly give space for them to complete themselves); often playful or extroverted feelings, attitudes, and movements will be enough of a preparation for deeper feelings to be expressed in later sessions. Confrontation may be more appropriate in later sessions; whereas light and positive affirmations may be easier for the client to assimilate at this point. Remember what is superficial to the practitioner may be deep enough for the client. If the client, however, is not responsive enough for there to be movement of superficial structures, some deep work around the jaw, in the nose, or with the gag or cough reflexes may help get an overall reaction started, then the superficial tissue will be more receptive. We are not peeling an onion (that is, working only on the outside) but helping the individual make connections between the surface and interior feelings.
THOUGHT AND AFFIRMATION

Many clients may realize, for the first time, that their old thought patterns were limited to considering that either this or that is the only choice. The release of tissue opens new possibilities for them which can be supported and affirmed. For example, “I can begin completely fresh,” (that is without the past), “I can handle my pain,” (without armor), “I can open myself.” “It’s O.K. to be afraid (angry sad, happy).”

MANIPULATIONS

1. Broad strokes. Just below the skin help to distribute areas of bunched superficial fascia. Working too deep, too soon, may confuse complicated myofascial structures.
2. Two handed strokes can help broadly distribute tissue.
3. Hooking, twisting, and spinning may be needed with fingers, elbows, knuckles, or sides of hands in order to capture hard or evasive tissue.
4. Follow the contours of the outer surface of the body. Do not try to imagine the underlying myofascial structures which envelop individual muscles.
5. Focus on seams, where connective tissue attaches to bones or is thickened around tendons and ligaments, such as the mid-line of the breast bone, the edge of ribs along the line of the diaphragmatic arch, either side of the vertebral column, the trac, the inner and outer edges of the tibia, the contours of the inner and outer malleolus. Do not try to penetrate to these attachments, but deal with the thick areas of superficial tissue over them.
6. Strokes are generally transverse, across the underlying muscular structures. Work across the grain lengthens the structure. Think of plucking across a guitar string. This is especially true of later, deeper work.

BREATH AND ENERGY WORK

1. The first phase is an exploration of the individual’s need for more charge or discharge. Experiment with building energy through inhalation or releasing excessive charge through exhalation. Let this be experimental and playful. Do not begin tissue work until there is some equality in incoming and outgoing energy.
2. During the first phase it may be better to back away from hyperventilation, which can be a frightening experience for many people; later they will be better prepared to go through the accompanying cramps by fully experiencing their fear or hidden anger. If both of you are ready to go through the hyperventilation, then encourage, movement and the expression of feelings locked in the hands and mouth.
3. When working with excessively charged or discharged individuals, it may be important to encourage them to run the course of their excessive breathing pattern, before suggesting that they focus on the neglected aspect of their breathing. For example a highly charged person may need to charge even more, to the point of an explosion, before you can guide him or her to a gentle way of charging, and an undelayed way of discharging.
4. Some exercises that will be good for the first session (See Chapter IV, “Breath and Energy Flow”: Those for overall energy flow (The Bow, Between Heaven and Earth, Forward Bend, Wood Chopper) Panting (Chest explosion, before you can guide him or her to a gentle way of charging, and an undelayed way of discharging). Two handed strokes can help broadly distribute tissue.

MOVEMENT AWARENESS

Emphasize extrinsic movements of the arms and legs. During the first sessions it is especially important that the client compares the new freedom of one side of the body with the deadness and stiffness of the untouched side. Although you can start teaching the intrinsic use of the psoas (rolling of the pelvis with inhalation), it is only during later deep work that an actual manipulation of the intrinsic muscles is possible. Interaction with the model is essential in helping create maximum change. The first step will be to get relaxation and surrender from the individual; over eagerness to help or anticipation of what’s to come will work against complete change. After you have found the right depth and begin to hook the superficial tissue, ask for an appropriate but gentle movement, or at least a slight contraction of the muscles. Be sure the model is using only the muscles needed for change toward a more balanced structure. We want to help isolate the awareness and function of different muscle groups.

MERIDIANS AND POINTS

Check to see if there is a general concentration of energy in the upper half (overinflated chest, overenergized contracted arms; large, stiff neck; red, explosive face) or lower half of the body (contracted medial arches, bow legs with overdeveloped thighs; puffy ankles or knees with water retention). Before and during the session in question, brush the meridians which terminate where there is less energy. For example if the chest is weak, and collapsed, brush the lower yin meridians (spleen, kidney, and liver) upward to the chest and continue this circulation of energy by brushing the upper, inner yin meridians (heart, circulation, lungs). In the upper half of the body general points to be used are: Cv 17, Sp 21, Li 4, Liv 14. In the lower half: S 36, Sp 6, S 41, Liv 10, 11, 12, Gb 25, 29, 30; Water points on inner knee: Liv 8, K 10, Sp 9.

CHAKRAS

The focus of the first session is around the heart and throat centers. We want to encourage openness and receptivity. Be sure not to push your client’s aggression beyond the capacity of these centers to assimilate and absorb change in a nurturing and self-loving way. The second session on the lower half will activate the basal chakras, and as long as there has already been some opening around the heart will send a charge upward in the body. Use Polarity or acupuncture points to help bring about a balancing of these centers. Using meditation bells and quiet O.S. can help.
When the rib cage is free, it appears to float like a parachute, and the pelvis and legs lightly dangle below. The body weight is then evenly distributed throughout the structure and is supported by the myofascial (tissue) network, rather than bearing down on the spine, pelvis, and bones of the legs and feet.

As a natural response to pain or danger we may tighten or paralyze ourselves. Armor (overly contracted or excessively soft tissue) develops from our habitual responses, which form when we begin to anticipate a danger which is no longer really present. Armor can be looked at as physical, emotional, and mental segments which encircle the body and block its flexible and spontaneous movement. Here we see seven segments or bands of armor: 1) the ocular segment forms a defense which includes contraction, stiffness, or immobility around the scalp, forehead, eyelids, eyeballs and tear glands and reveals a frozen masklike, or empty expression; 2) the oral segment includes the lip, chin, and throat and holds repressed needs to suck, bite, and yell; 3) the neck segment often holds back anger and swallowed feelings; 4) the thoracic segment can be stiff with controlled, pulled back shoulders or collapsed with chronic sorrow and weakness; 5) the diaphragmatic segment may cut the upper half of the person from the lower, not allowing the head and heart, above to connect with the pelvis, below; 6) the abdominal segment is around the intestines, stomach, pancreas, liver, and kidneys and holds deep gut feelings such as disgust and fear of dying; 7) the pelvic segment has two parts, 7a the pelvic basin, which holds our deepest sexual longings and frustrations, and 7b the legs, which hold our insecurities and lack of grounding.
SESSION I - THE UPPER HALF

BODY READING

See general notes on body reading. Share what is happening with your client’s breathing. Notice that either the upper chest or diaphragmatic breathing may be neglected. Experiment with breathing in the neglected half. Also note that even when there is movement in both halves of the rib cage, there may be a block between the two which prevents a flowing, rocking breath. Share your attitude about how your client blocks feelings in breathing. Notice the position of the shoulders: whether they are pulled forward in protection, fear, or sorrow; or whether they are pulled back (and often too high) in pride or over striving. See how the neck and chin connect with the cage and shoulders. Also share what you see with respect to the flatness of the torso: whether it is short and square -- share possibility for lengthening and rounding. This may seem simple and obvious but most people have ideas from fashion and sports, and it is important to help them understand new directions.

BODY AREA

Although this session is normally the upper half of the body, it is interchangeable with the lower half. If for some reason it is not appropriate to begin on top, begin with the legs. Also the first and second sessions can be mixed, a part being on top, a part on the bottom in each session. Normally it is important to open the breathing so that the energy can be kept at a high level for work on other areas.

1. Segments of Thoracic Cage. Generally the strategy is to begin at the bottom of the cage and work upward, the upper chest and back being released after the diaphragm and lower ribs.

A. Diaphragmatic Band and Abdominal Mid Section. See circled numbers 1, 2, and 3 in illustrations for first session. These two bands of armor are treated together at the bottom of the ribcage where we cut off our breathing and at the middle of the abdomen where we hold in our gut feelings. Most people have contracted bands around these areas and place too much power in their exhalation and work too hard at holding in their bellies. The job is to open the abdomen-waist and lower rib cage all the way around the body and to stretch the superficial tissue under and over the diaphragmatic arc.

Think of the abdomen as a balloon that opens in all directions allowing the abdominal contents to settle into the pelvis, rather than a heavy lump of organs which has to be pulled back into the abdominal cavity. Eventually this falling inside the pelvis can happen, although in the beginning (since our work is incomplete) we may even accentuate the belly falling out. Also consider the lower rib cage to be like an opening parachute or umbrella which needs to open all the way around at the bottom.

A strategy for encouraging these openings is to split the sides of the rib cage spreading tissue in one direction toward the front and toward the back in the other. The chest and diaphragm nearly always need to be lifted in the front, so strokes will be upward. Also we are working across muscle structures in order to allow the musculature underneath to lengthen (as plucking across a guitar string eventually lengthens it). This work on the diaphragm will be symmetric -- some on one side some on the other, before proceeding higher on the thoracic cage.

S. Mid/Thoracic Band. See circles 4, 5, 6, and 7 in illustrations. This band of armor prevents rocking and fluttering of the chest during breathing in the front and disorganizes the shoulder blades in the back by pulling them too far forward, leaving the lower rhomboids too weak and the upper rhomboids too contracted. In the front it is important to work upward and inward in short strokes toward the breast bone. A vibrating Reichian style hand pressure on the middle of the chest, before and after tissue strokes, can help the chest collapse and expand in this central region.

In the back you can use the rope-like muscles on either side of the spine (sacrospinalis) as a support for horizontally pulling the superficial tissue outward or inward (strum across these muscles). This strumming can also be rapid and provocative and can be coordinated with stimulation of the cough reflex (press on the wind pipe in front). This is not an attempt to get a full release of these deep muscles, rather they are being used as an underlying support for gripping the superficial tissue. See segment 9.
measures treats

Vols and Oscillations (EMG, EEG)
Amps and Oscillations (ECG)
Resistance (GSR)
Hydration
Oxidation (Redox potential)
Ph acid vs alkalinity
Reactivity evoked potential to
voltage fields of substances
(TVEP) over 228,000 measures a
second of these energetic factors

Brain wave and emotions
with (MCES)
Pain with (MENS) (TENS)
Trauma or wounds (EWH)
Electro Weakness Ph,
Redox disorder (VARHOPE
Correction)
Trickle charge the body
electric

The SCIO Universal Electrophysiological Biofeedback System can
safely measure over the skin (transcutaneous) skin electro-potential
down to the micro-volt range. Virtual and mathematical calculations
of the attained data can provide CNS (Central Nervous System)
biofeedback data, so as to include (simple EEG
electroencephalography), 3-pole ECG (simple stress
electrocardiography), global transcutaneous EMG (electromyography).
The system can measure the transcutaneous skin resistance by
application of a medical safe micro-current voltammetric pulse, so as to
measure GSR (galvanic skin response) and TVEP (transcutaneous
voltammetric evoked potential).
The system is designed for the detection of stress and reduction of
stress through CNS biofeedback data or stress lifestyle
questionnaires. The stress and lifestyle questionnaires provide
educational feedback through library referenced functions. And the
device can be used for the treatment of muscular re-education from
injury, muscle weakness, sport muscular enhancement or various
dystonia. The applied voltammetric pulse can be used to detect and
affect in established modalities such as pain [TENS (transcutaneous
electro neural stimulation)], trauma/wound healing, charge stability
imbalance, redox potential and electrophysiological reactivity.
The device after 20 years of use is quality tested, clinically
evaluated and scientifically validated as safe and effective.

All designed to detect + reduce Electro-stress and Balance the Body Electric Automatically

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e-mail: info@qxsubspace.com
Body Reading: At this point stand your model up and look at what’s happening.

C. Upper Thoracic Segment (Upper Chest, Clavicle, and Upper Trapezius as one Segment). See circles 5, 6, 7, 8, 9 and 10. In front work across the grain of the pectoralis major. Lift superficial tissue from under the clavicle, pulling it in single, sustained strokes over the bone. Same for coracoid process, pulling superficial tissue over the anterior shoulder. Here we are not working with deep fascia on the bones, but merely using the bones (tendons and ligaments) as supports for gathering and holding the superficial tissue while we stretch it. While working with the pectoralis major, use a gentle but stimulating Reichian shaking maneuver; grab both sides of the pectoralis major with the fingers underneath and thumbs on top and shake the whole body back and forth, encouraging the client to make open sounds. The same can be done with both sides of the upper trapezius, while the model is lying face down. Some slow tissue strokes may also be needed over the shoulder blades in the back and across the latissimus dorsi on the sides in order to connect the opening of this band all the way around the body (upper chest under the axilla on the sides and upper shoulder blades and trapezius on the back), be sure to keep your provocative Reichian strokes separate from the slow, reorganization of connective tissue.

Finally reach inside to the medial, flat surface of the ischium and pull the tissue out and over the surface of the symphysis pubis. (Sometimes it helps to have the client pull one knee straight toward the chest. (Be sure to respect the parallel body lines). Work across the capitis muscles, to lengthen the back of the neck (either with knuckles from the side of neck or with finger tips while model is lying on back). This is important: to equalize the lengthening of the anterior chest with the lengthening of the posterior neck, This lengthening of the posterior neck can also be coordinated with work over the top of the trapezius. Have your model sit on a chair or on the knees and with the flat part of your elbow pull the superficial tissue from the anterior superior part of the trapezius, over the bulk of the muscle back and then downward to the shoulder blades. The model needs to maintain an upright symmetric position. As you execute these moves, have your client imagine a milk maid’s wooden collar with buckets of milk on either end of the shoulders.

Body Reading: Look at what’s happened to this point.

3. Pelvic Segment. (If there is not enough time, this segment can be done during the second session). See circles 21 through 28. This area, around the pelvis and on the outer surface of the iliotibial tract, is important for balancing the changes which occur in the thoracic segment with the lower half of the body. (It can be done before the neck segment). If, after opening the thoracic area, we were not eventually to work with the pelvic segment, the upper half of the body would lift forward, pulling the lower posterior half with it, and exaggerating any lordosis and not allowing the diaphragmatic breathing to be complete in the back, where it needs to connect with the sacrum and hips.

A. Around the Greater Trochanter. Split the tissue above the trochanter by first working backward and downward over the gluteus maximus. The fists or flats of the elbows will be helpful with this often dense and resistant tissue. Have your client use the pelvic curl as an interacting movement. Then, while still above the trochanter, use the knuckles, or slightly sharper elbow to hook the superficial tissue, just behind the tensor fascia lata, and push the tissue in an anterior-superior direction over the muscle. Careful, this area calls for balance, force, and calm and can be painful for the model, but don’t worry, the structure is not fragile. Client abducts thigh and rotates medially.

B. Iliotibial Tract. The client lies on side, a pillow between the legs, to preserve parallel lines between legs. This area has much to do with whether the hip and knee can function together in a forward straight line. Our earliest feelings, as we learn to-walk (confidence, fear, insecurity), are locked into this hard string, which guides the upper leg. Use a double stroke, one flat elbow above, another below, zigzagging along the tract. Careful at the bottom of the tract not to bunch the tissue at the lateral knee. You can use extra strokes to stretch the tissue toward the front and back of the upper leg on either side of the tract.

C. Iliac Release. (This work can also be done in the second session). With the client on the back, knees bent, have the client pull one knee straight toward the chest. (Be sure to respect the parallel body lines). Work across the tissue just inferior to the ischium on one (bent) side; then pull the tissue across the middle of the ischium. Finally reach inside to the medial, flat surface of the ischium and pull the tissue out and over the surface of the
ischium. You can use the fingers to reach this inner area, while clamping with the thumb on the outside. It’s really important for the whole body structure that the ischia are not too narrow in their distance from one another. If they are too close together, there will not be a sufficient arch (across the pelvis), as in a cathedral, to support easily the above weight, and stress will be thrown into the hips and knees. Many women have excessive flesh around the hips because their ischia are too close together. Clearly there is a great deal of sexual significance to this area as well.

D. Pelvic Curl. Take time to begin teaching the use of the psoas. Use your fingertips under a flat back, during a pelvic curl, to stretch the lumbar fascia, while the psoas is activated and belly is relaxed. The client may need this work in every session to learn finally what’s happening.

4. Final Neck Movement. See circle 19. Repeat the stroke diagonal across the neck with the eyes looking at the opposite shoulder, while the head turns. This is used at the end of every session to rebalance the neck in relation to the changes that have taken place during the session.

5. Spinal Roll. See circle 27. From a kneeling position or while sitting on a chair (shoulders stabilized), have the model roll forward one vertebra at a time, while you slowly zigzag with your elbows down the side of the spine, pulling superficial tissue over the sacrospinalis. Let this be a gentle roll. Pressing too hard will require too much resistance from your client. Use your fists (both simultaneously) to complete the lower back and sacrum.

**Final Body Reading**

Help your client feel the difference in the range of breathing by holding your hands on chest, belly, and diaphragm. Use a mirror to point out the changes in shape: higher upper chest, rounder in the cage, etc.

**Final Fine Energy**

Be sure to save time at the end of the session for this work. Brush meridians, and use points to harmonize the energy flow. But if there is unfinished business, work with this, before regulating fine energy. Bring some energy back down into the legs, where there has been little work, so that the client can rediscover his or her grounding. During the session it is important, from time to time, to do some energy work on the lower part of the body, so that it will not be too neglected. You can use images to help harmonize the energy.
SESSION 2: THE LOWER HALF

BODY READING

See general notes on body reading in Part I. Notice that the foot has three arches (medial, transverse and lateral). The weight of the body can be evenly distributed through these three. In the case of a weak medial arch (flat feet) note how the excessive eversion places tension on the lateral arch and the tissue around the fibula. The shaft of the fibula may be rotated and shifted too far forward. Notice in the case of an overly arched medial arch that the tension is on the inner lower leg, lifting the arch inward and upward. At the same time the transverse arch may be also too high and narrow. Notice the connection between these arches and what happens in the rest of the body, e.g., flat feet and knock knees, high medial arches and bow legs. Help your clients experience their structural tendencies and alternatives. Look at what’s happening with dorsi-flexion and plantar flexion. Women who wear high heels will be excessively plantar flexed with a shortened Achilles’ tendon. (Even normal men’s heels will have some effect in this direction). On the other hand, look at the excessive dorsi-flexion involved in cases where the weight is mostly on the heels. Note that shoes with negative heels and built in arches are eventually counter-productive, since these artificial positions will produce compensatory tensions in other parts of the structure. The foot needs a natural, broad last, and an even (flat) and soft sole.

BODY AREA

The general aim is to bring together the sections of superficial fascia: fascia pedis, plantar fascia, fascia cruris. This gives space for the toes, ankles, and knees to begin working more together. Also this opening of tissue from the feet upward into the legs need to be connected with the work already started on the fascia lata (envelope around the whole thigh) by work around and above the knee and with the hamstrings as far upward as the ischium. Before beginning, you may want to use some of these exercises: Marching, Snap

1. Fascia Pedis (top of foot). See circled number 1. Imagine old - fashion spats or anklets covering the top of the foot. We want to expand them all the way around the foot and ankle. With the client on the back, begin on the front and work across the tendons of the toes, while interacting with toe movements. Continue around the sides of the foot, crossing the tendons of the tibialis anterior on one side, and the peroneals, on the other. Let this work go all the way back to the Achilles ‘tendon. Remember we are not trying to work on deep fascia, but are using the underlying structures to help us get hold of the superficial tissue. One common problem is gripping (or in the extreme, hammer) toes. Note that the tension is not only on the top of the foot, but also underneath, in the plantar fascia. Try to hook the top and bottom of the toes at the same time (with thumb on top and first knuckle on the bottom), and pull toward the end of the toe.
2. Connecting Fascia Pedis with:

A. Anterior Cruris (Front of lower leg). See circled numbers 2 and 3. Work across the front of the ankle. Pull tissue across these large tendons, while the ankle moves (in alignment with the knee). To get hold of the tissue you may need to use relatively sharp knuckles, inserted between the internal and external malleolus. Continue upward, going in between the tibia and the tibialis anterior, across the tibialis anterior, digitorum and peroneus (outward toward the fibula). Separately, or simultaneously, you may work across the tibia, across the flat part of the shin. Working in these two opposite directions opens the fascia cruris in the front of the lower leg. Here your client may encounter pains and memories from old injuries. We have all banged our legs a lot, sometimes so painfully that we have repressed the experience completely.

B. Plantar Fascia (bottom of foot). See circled numbers 4 through 6. The sole of the foot can be broadened by
Cranial-Sacro Chiropractic Body Work

using the heels of the hands on top for reinforcement, and the fingers underneath to spread the ball outward in all directions. Lift the foot and bend the knee. Now you can use your knuckles on the sole of the heel. You can also work simultaneously on the bottom and top of the foot – the knuckles of one hand work diagonally across the tendons on top, while the other hand works on the bottom. Continue working across the entire foot, spreading the plantar area allows other connections above, and also allows the weight of the foot to be more evenly distributed. After working on the foot, have the model stand and feel the possibility of having a broad foot which spreads in all directions. Do this again after you’ve worked on the whole leg.

C. Medial Cruris (medial lower leg). See circles 7 and 8. Have your client on the side with a pillow to keep parallelism between the legs. Connect the medial foot with medial lower leg, while the ankle moves – use of a two-handed cross movement working across tibialis posterior, soleus, and gastrocnemius. Continue hooking along and across these muscles. One possibility is to use the broad, flat part of both fists working across the entire sheath (medial cruris from the tibia to the full part of the gastrocnemius.

D. Lateral Cruris (lateral lower leg around fibula). See circles 11 and 12. Have the client sit side-saddle, giving an even, flat support to both the ankle and knee. While the model moves the ankle, use two-handed strokes to connect the lateral foot and the tissue on either side of the fibula. Continue working along the lower lateral leg, dividing tissue outward (anterior and posterior), away from the fibula (over the peroneals), while the client continues to move the ankle.

3. Connecting Fascia Cruris with Fascia Lata (whole thigh).

A. With the client lying on the side, as in medial lower leg work, use a two-handed cross stroke to connect the tissue of the medial lower leg with the tissue of the medial thigh. See circle 9. One hand will work just above the knee (across the confluence of the semitendinosus, semimembranosus, gracilis, and sartorius). Now the client’s movement can be both at the ankle and knee at the same time. Keep these strokes broad and superficial. The action of

MEN'S

FUR PAIN

ELECTRO-NERVAL STIMULATION

IT IS A SCIENTIFIC FACT THAT A LOW LEVEL VOLTAGE ELECTRIC PULSE CAN INHIBIT PAIN SIGNALS IN THE NERVOUS SYSTEM. AUTOGENIC HARMONIC PULSES TO MAXIMIZE THIS EFFECT. THIS IS CALLED THE SNSD WILL LET THE PATIENT'S BODY ELECTRICALLY CURRENT PULSES TO ENSURE THE HARMONIC EFFECTS.

AND CAN HELP YOU TO REDUCE PAIN WHILE HELPING YOU FIND THE CAUSE.

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Chiropractic

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SCIO

before/after

 Hairstyle

short/medium

FUR PAIN

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the client will help create a stretch between the lower and upper legs.

B. Client is in sidesaddle position. Connect the lateral lower leg with the tissue worked in the first session (iliotibial tract) with a two handed stroke across the knee. Now the client moves both the ankle and knee, with the kne movement beginning at the ankle. (Consult movement awareness exercises in Chapter V).

C. Use fingers or knuckles, while client is in same position, to work around the front of the knee, beginning at the bottom of the knee, and going upward, along the sides, and pincer together, under and over the rectus femoris, above the knee. The action is in ankle and knee. See circle 10.

D. With client on back, knees bent, and movement coming from the ankle, grip hands from front to popliteal fossa. Your hands pull outward across the tendons behind knees, while the knee moves. The heels of hands support the hands in front. See circle 15.

E. Do the same for the gastrocnemius, grabbing between its two parts and separating them as the foot dorsiflexes. See circle 14.

F. Hold the foot in maximum dorsiflexion and with the knuckles of both hands pull on either side of the achilles’ tendon all the way to the calcaneus. Client stretches tendon. See circle 17.

4. Connecting Posterior Fascia Lata (hamstrings) with Ischia and Buttocks. While your client is on belly and straightens and relaxes arms, spread the tissue inward and outward across both groups of hamstrings. With one hand work outward across biceps femoris while with the other stretch over the ischium — across biceps but across gluteal fascia. It is important to create plenty of length all along the back of the legs, and the back of the pelvis. This helps connect the lower posterior body to diaphragmatic breathing. See circles.

Again, as in the first session, take enough time to harmonize the parts you have already worked (lower half), with the unattended part (upper half). Help the client understand how good grounding supports and frees the upper part of the body.

PHASE II: ELONGATION

(Session 3)

GENERAL PURPOSE

We now want to loosen an intermediate layer of tissue between the pelvis, rib cage, and shoulders, mostly along the lateral torso. This is an elongation of body mind along the sides, from hips to shoulders. This lengthening gives space for the pelvis and ribcage to move more freely, independent of each other (quadratus lumborum must lengthen). It also begins the rounding of the ribcage and lifting of the 11th and 12th ribs, giving more space for posterior inhalation. Draw an imaginary line along the center of the side of the body, and divide the tissue forward and backward along this line so that the hips widen from front to back, the ribcage expands in both directions, and the shoulders settle into a central position, with the pectoralis muscles relaxing in the front and the trapezius and rhomboïd in the back. Also work for a balance between the medial (latissimus dorsi, and teres major) and lateral (teres minor, infraspinatus) rotators of the arm. We are looking for a three dimensional expansions of the person as opposed to the feeling of being a front or back, or having sides. We need fullness and flexibility throughout the whole torso. Review the artifacts of classical Greek sculpture. Read Rilke’s poem on viewing Venus de Milo.

BODY TYPE

1. Squat, short torso types whose length has been arrested during adolescence, need lots of deep work between the crest of the ilium and the twelfth rib. Many men have inflated chests but short torsos.

2. Long waisted types (many women) potentially have a great deal of flexibility but may protect themselves from what they consider excessive sensuality by tightening the sacrospinalis. The work on the latissimus dorsi should extend all the way around the torso to the spine and the sacrospinalis.

3. Burdened and Needy types may need plenty of work on the pectoralis minor in order to allow the shoulders to shift posterior. And Rigid types may need more loosening between the shoulder blades for the shoulders to shift forward.

EMOTION

In contrast with the first phase, some deeper emotions may begin to surface, but generally clients will not completely confront their deepest problems. Most of the session is along the sides of the torso and back, and will often evoke feelings of fear and vulnerability. You may also encounter sexual fear, which blocks the flowing, swinging interaction between the hips and ribs. Also the arms may be pulled around toward the front to protect the sexual organs. Going beyond these fears, of course, we can encourage the confidence of an open chest, and the sensuality of a flowing mid-body.
The sides of the body connect with the arms and help govern their position and rotation. We may hold our arms and shoulders back, rotating them out in readiness or we may hold our arms in front, rotating them inward in protection. A lot of wanting and holding back are in the arms.

**THOUGHT AND AFFIRMATION**

Our image of ourselves often involves just the front of the body, and when we begin to feel ourselves all the way around the torso, we begin to think of our environment less as something to be confronted and more of a space in which we expand simultaneously in all directions. "I claim the space behind me as well as what's in front of me."

"I am I and all that's around me." (cf Ortega y Gasset). Also "I can be long, supple and sensual, while at the same time being proud and strong." "I have a long waist and I expand my ribcage."
MANIPULATIONS

1. Depth, Speed, Distance. The angle of entry is steeper, going through the superficial layer of tissue and beginning the work on the tops of the individual envelopes. This is not the deepest work, which will penetrate to attachments, but does begin to separate and lengthen muscles. After reaching an appropriate depth, it is now important to go much slower, to wait for the deeper tissue to open, and finally, to move a shorter distance. If these strokes are well executed, you will need to cover less area than in the first phase, since any deep release will have an extensive effect in other parts of the body.

2. Since the work is not as broad as in the first phase, the points of the elbow or the knuckles, will be useful in contrast with the flat parts of the fist, or sides or backs of the hand, as used in the first sessions. Also two-handed two-directional work will be less frequent, since we are concentrating more on depth.

3. Lots of participation is needed from the client in order to get the tissue in deep, relatively inaccessible areas to move and change. For example, when working on the pectoralis minor, be sure the client moves downward and forward at the shoulder; and when sliding into the anterior part of the scapula, have your client move both arms upward until the hands touch; or when reaching the subscapularis from behind, have your client hold the arm behind the back and then flex, the rhomboids, while you slide under the scapula.

BREATHE AND ENERGY WORK

Focus less on exploring charge and discharge and more now on ways of sustaining energy. Use the connected and sustained breath techniques to maintain an even emotional and energy level, during what may be painful manipulations. We are working deeper and need to encourage the model to begin to sort out feelings and to stay with one feeling at a time — all of which calls for a sustained level of energy. Encourage breathing in the posterior ribcage (using images, and a light, guiding touch). Some helpful exercises are The Craft, Packing Fruit, The Grand Slam.

MOVEMENT AWARENESS

While interacting with your strokes, the client needs now to move carefully only certain muscles. We want to separate and isolate muscles from their neighbors. But the focus is still on extrinsic muscles, the large powerful muscles of locomotion. Halfway through the third session, have the client experiment with arm, shoulder and torso movements, comparing the released side with the untouched side. Most people don’t want to explore how far back they can move their arms and shoulders and will need a lot of encouragement and support to discover that such stiff, unconscious areas can come to life again.

MERIDIANS AND POINTS

The gall bladder and spleen meridians are important to this session. Underneath the fear we feel along the sides and back is expanding yang anger which can be released by scratching and slapping along the gall bladder meridian. Also the top of the shoulder is another important retainer of gall bladder anger. Important points: GB 25, 29, 30, also gall bladder points along the temples, Sp 21, Liv 14, Doors of Life (Gv 4, B23, B47).

CHAKRAS

This phase helps connect the navel, heart and throat chakras.

SESSION 3

(Lateral/Torso)

BODY READING

Look at the imaginary line along the side of the body to see if excessive tension is more in the front or back of the body. From front and back, look at whether one side of the waist is more contracted than the other. What is the relation of this tension, on one side of the waist, to other tensions in the shoulder, on the opposite side, or to adduction of the leg also on the other side? Help your client trace and feel these interconnections. Do the arms rotate inward or outward? Are the shoulders pulled forward or back? Remember there can be lots of fear in the cage and shoulders.

BODY AREAS

Except where indicated, this work is all done with the client lying on the side, the legs made parallel with a support (cushion).

1. Pelvic Segment (Intermediate). See circled number 1, this is a reworking of the same area as in session one, except we are working now with the envelopes of the gluteus maximus and tensor fascia lata. This deeper release will allow more expansion on both sides of the cage and help provide space for the release of the quadratus lumborum. Don’t be afraid to go fairly deep with your elbow.

2. Lower and middle Segments of Thoracic Cage. See circled numbers 3 and 4. Now we are working along the segments where we also worked in session one but are specifically pulling backward across the lattissimus dorsi (while the client rotates the arm inward) and pulling forward over the serratus anterior muscles (during deep inhalations in the chest). Work again under the diaphragmatic arch, this time going further underneath in the direction of the attachments of the diaphragm.

3. Quadratus Lumborum. See circled number 5. Work below and above, before attempting to release the quadratus lumborum with elbow, knuckles, or reinforced finger tips. Be careful not to press directly against the floating ribs. Have your client make a hip movement to the side, to activate the quadratus lumborum. At this point you should begin to see a fuller expansion of diaphragmatic breathing with the inhalations rippling down into the hips.

4. Upper Segment of Thoracic Cage. See circled numbers 6 through 10. (Client is lying on side). Here we are working below the axilla and under the pectoralis major toward front and arm rotators toward the back, along the shoulder blade. Don’t work directly in the axilla, but slide the fingertips under the lattissimus dorsi, while the client rotates the arm medially. In front slide your fingertips under the pectoralis major, while the client moves the shoulder forward and back again. While the client is on the back, we can also work directly on the pectoralis minor (circle 12) by penetrating through the major near the coracoid process. On the shoulder blade work, with the toes minor and infraspinatus, while the model rotates the arm laterally.

5. Top of shoulder and Deltoid. See circled no. 10 and 11. While the client is still on the side work along the top of the shoulder, deep in the supraspinatus with the knuckles while your client lifts the arm as a flying movement. Further along the top of the shoulder toward the neck and around the medial portion of the shoulder blade, the shoulder is lifted (levator scapula and trapezius). Now go directly to the middle fibers of the deltoid, and use the flying motion of the arm again. In the lateral and medial fibers of the deltoid use forward flexion and backward extension of the whole upper arm. The client’s deltoid can be very hard (especially in body workers) and these fibers, which do different jobs, need to be separated. The front, back top, and tip of the shoulder will begin to soften and balance with each other. You can give your client the
image of a milkmaid's yoke to help lower and stabilize the shoulder, and separate arm movements from shoulder movements.
HALFWAY READING

Have your model stand up, and now compare one side with the other. Be sure you have a large full length mirror. Take time to point out the exact changes.

SECOND HALF

Follow the above procedure of working with body areas on the other half of the body.

SYMMETRIC WORK

After work is complete on both sides of the body, there are some other possible areas for work, on both sides of the body.

1. 11th and 12th Ribs. See circled number 16. With your model on the belly, use your fingertips and the thumbs of both hands to lift up, over and in between, the 12th and then the 11th ribs. This movement encourages the rounding and opening of diaphragmatic breathing, as well as indirectly influencing the upper thoracic structures. The movement must be slow and precise, and be done sufficiently under the ribs.

2. First Rib. See circle 14. Now go to the other end of the ribcage and with the client on the back press your fingertips into the thoracic inlet and onto the first rib. Deep breathing and arm movements can help your client interact with your strokes. Another interacting movement is for the client to lift the arms from the sides of the body upward, in front, to shoulder level. The first rib is often immobile, like a frozen lock on the top of the ribcage. Together with the mobility of the 11th and 12th ribs, the free movement of the first rib can have a rippling effect throughout the whole ribcage.

3. Subscapularis. See circle 13. With fingertips, work under the shoulder blade from the front, while your client is on back. The arms are brought together with slight rotations. Careful, this can be very painful. This work is especially needed when adduction and medial rotation of the arm is too great and the shoulder blades are pulled too far forward.

4. Over The Top of the Shoulders. See circle 17. While the client is seated, use the flat part of the elbow to rake from the front of the shoulders diagonal back across the top of the shoulders and shoulder blades. Be sure the client maintains a good position with the shoulder stabilized, chin in, and neck flat. The client can assist by holding the head slightly down and rotating the head.

5. Neck and Back. Usual strokes across neck and down the back.

FINAL FINE ENERGY

Work with the feeling of wholeness and roundness. While your model is sitting or standing, brush the yin and yang meridians of the front and back (or sides) simultaneously. The image of expanding in all directions, inside a sphere, helps develop a more complete spatial feeling.
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Body Work

The SCIO device can use the Trivector and Cybersonic Loop to rectify aberrant and disharmonious energy patterns in the body. This has profound effects on all body functions but affects the corpus callosum most intensely. This means that the ability of the conscious verbal mind to relate to the subconscious is increased with the rectification process. The patient will probably not feel the effect. There will always be a positive effect. If there is a negative effect, it is because there is shielded or covert feelings or memories in the subconscious. These will cause disease if left untreated. A simple release may solve the problem.

The changes include:

1. Activate the innate intelligence to balance the body energies. This is the basic principle of chiropractic, acupuncture, and osteopathy medicine.
2. There is an easier exchange of energy and information from right brain to left brain via the corpus callosum. The corpus callosum is the largest energy form in the body and the rectification process has profound effects on stabilizing it, so it dramatically reduces switching phenomena.
3. The SCIO thereby increases the ability of the conscious to interface with the unconscious. This allows greater knowledge of self and of the higher self.
4. There is a greater memory access, a more true access of memory without emotional clouding.
5. There is a greater flexibility of connective tissue, allowing for more resilience.
6. There is a greater oxygenation and hydration ability of the body.
7. There is a smoother muscle control.
8. There is a general increase in well being that the conscious mind is so often unable to perceive. And thus there are thousands of subtle improvements to be found.
PHASE III: PELVIC RELEASE
(Sessions 4, 5, and 6)

GENERAL PURPOSE
We now want to release deep armor on the bottom, top, and back of the pelvis. We are unraveling the third level of fascia which wraps around the underside of muscles, and extends to the attachments on the periosteum. By freeing the pelvis from forward or backward imbalances, sideways tilts, and clockwise or counterclockwise twists, we help bring the head, above, and the legs, below, into a more efficient alignment and give the spine a chance to straighten itself. The floor of the pelvis can begin to move like a diaphragm, contracting evenly up and down, in combination with the breathing diaphragm. This movement of the pelvic floor (pubococcygeus) enlivens sexual response and satisfaction. The release of pelvic energy, not only makes the pelvis more alive and mobile but infuses the whole body with the vitality which has been held back because of fear and guilt.

BODY TYPE
1. Anal types may be either very tense around the anus, tucking the tail under, or so open that they expose their asses. We are dealing with a holding in of rage against authority, which can easily turn into sadistic or masochistic tendencies. You can satisfy this need for pain (initially this might create satisfaction and trust) but eventually you will need to go further, dealing with the deep need for contact and stimulation, or you can work very gently and softly, refusing to accommodate the demand for pain, showing that feeling and pleasure is possible without extreme pain.

2. When there is an extreme accumulation of tension and energy around the genitalia, we may be dealing with phallic narcissism, where the penis is used as a weapon against the parents. “You excited me but didn’t satisfy me, now I’m going to get even with you,” or with hysteria: “I want you and need you so badly that I shudder all over.” Work as above: either exhaust your client and then work gently, or keep the energy slow but aware.

3. Oral (needy) types, in concentrating their energy around the mouth and throat, these individuals may take energy away from the anus and genitals. Sometimes helping them to satisfy their oral needs (e.g., sucking their thumbs) will help them begin to pay more attention to the neglected parts of the pelvis.

4. Hysterical types can be considered a variation of oral types. The search for the love of the denied parent, contributes to an overeagerness to climax, to be completely satisfied. They are overexcited by having almost any part of Donald Duck and Pinocchio show us how the orientation of the pelvis determines character. Donald, with tilted pelvis, arched back, and splayed feet, is angry and stuck, Pinocchio, whose pelvis supports and organizes his whole structure, is open to change.
The body touched but are never satisfied. Two paths: one is to stimulate them so much that they become exhausted (this takes patience), the other is to show that you still love them, even if you say no to their demands. Work with the heart chakra.

**EMOTION**

The pelvis often holds the deepest and most hidden emotions of the whole body. When they begin to be released, they need a channel for expression. For this reason it is important during these sessions of pelvic work, to also work frequently around the eyes, in the nose, inside the mouth, with the throat and gut, in order to keep a channel open to the throat and head. If these deep pelvic feelings come to consciousness, after having been buried so long, but can’t escape their chronic armor, uncontrollable elation and depression, nervousness, etc. may follow. Don’t leave your client with this kind of unfinished business.

**MANIPULATIONS**

1. We are now reaching for the deepest layer of tissue and our movements need to be super slow. We enter and wait for the tissue to accept our pressure at a deeper level.
2. They are now reaching for the deepest layer of tissue and need to use finger and elbow points (sharper parts) to slide in between and under muscles reaching attachments on the bone.
3. Slight weaving movements with our hands or elbows can help to probe deeper through resistant layers.
4. Slight twisting or lifting moves are appropriate after the final depth has been reached.
5. Also strumming diagonally across the muscles, especially the attachments will help lengthen their structures.

**THOUGHT AND AFFIRMATION**

The pelvis is often taboo or receives too much attention. When we begin to accept our anal and genital functions as no more important than other functions of our body, we are beginning to allow our energy to distribute more equally throughout body mind. we can then say, “Every part of me gives me pleasure.” “When I have genital energy I have it; when I don’t, I don’t.” (Variation from EST: “When you’re hot you’re hot, when you’re not, you’re not”). Also: “I can enjoy the valleys as well as the peaks of pleasure.” “Ejaculatory orgasm is great, and is not necessary for completeness.”

**MANIPULATIONS**

1. We are now reaching for the deepest layer of tissue and our movements need to be super slow. We enter and wait for the tissue to accept our pressure at a deeper level.
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5. Also strumming diagonally across the muscles, especially the attachments will help lengthen their structures.

**BREATH AND ENERGY WORK**

1. When there is over eagerness and overexcitement locked in the pelvis it may be helpful to let this charge exhaust itself (with lots of fast breathing, pelvic gyrations, expressions of deep-seated pelvic anger, hard-fucking movements, masochistic clamping down in the ass hole) before turning to a softer style, helping the individual equalize this charge through the entire body. At this point gentle touching of the erogenous zones (genitals, anus, nipples, lips, roof of the mouth, inside the ears), while verbally discouraging rapid overcharge, can help establish a fine streaming.
2. In cases of deadness, unconsciousness, inability to sustain a charge in the pelvic area, begin slowly and spend a great deal of time building energy without letting it. Support and trust are important in getting this charge to happen. Eventually advanced work in the pelvis (Master PI) may be needed to activate an extreme lack of energy. Use the “connected and sustained breaths” frequently, in order to keep the energy high. Maintain a constant charge. Don’t allow your client to drift away: Direct eye contact with verbal approval and support can help overcome the negative pelvic controls, coming from mommy, daddy, and society.
3. When the individual has begun to overcome sexual taboos, encourage them to suck their thumbs, fondle their genitals and anus. These are natural parts of the body and need not have an excessive charge or be neglected, energy less parts of the self.
4. Some helpful exercises are: The Crab, Jellyfish, Spread Eagle, Barking Dog, Pelvic Drop, Pelvic Curl, Sucking, Face Stimulation, Rock and Roll, Sexual Surrender, Bottom Rub.
**MOVEMENT AWARENESS**

1. Using the pelvic curl (with inhalation and contraction of the diaphragm during upward movement), is a way of raising sexual energy and also working with fine energy at the end of the session. Let the upward curl be very slight, anything greater will involve the abdomenus rectus, which should remain relaxed. Persons who want to uncurl too far (into an overarched back, lordosis) often are exhaling too much, overworking the extrinsic muscles around the diaphragm, as well as the muscles of the back. Show them that when they drop the pelvis, the exhalation does not have to continue, does not have to be forced out.

2. Curling up on the exhalation rather than on the inhalation, is the way that most people move; you can make use of this when they need to focus on discharging an access of accumulated energy. But the above movement should also eventually be explored.

3. During streaming, the pelvis will spontaneously rock, in many directions, without one using either of the above exercises. The exercises are only a preparation, an exploration of possible movements.

4. Have your client press the knees (bent) outward, against your hands, then quickly change the pressure inward against your hands (or forearm). This changing resistance between the adductors and abductors activates lots of feeling. Try the same thing, but very gently, until there is a fine quivering throughout the legs.

5. After a session have your client walk around the room, exploring different pelvic and hip movements along with a variety of feelings and attitudes. Suggest movements which are confident, beautiful, graceful, etc.

6. Instruct your clients in internal pelvic exercises, so that they may gradually gain control over the floor of the pelvis. An inner, slow lifting of the genitals and anus, and then slow release should be practiced every day, until awareness and control of the pelvic floor is easy and complete.

**MERIDIANS AND POINTS**

Stomach 30, The doors of Life (CV 4, 3, 23, 47). Liver 10, 11 and 12, Spleen 6, Conception Vessel 1 are all powerful points for opening or calming (self-regulating) pelvic energy. Try also combining these points with points around the head, in order to balance pelvic and head energy.

**CHAKRAS**

Phase II is work with the first and second chakras. Before going to higher chakras, it is important to help your clients with grounding, with accepting their sexual energy. Try some Tantric exercises such as “Closing The Lover Gates,” in which the genitals and anus are blocked with the hands, while the individual breathes gently upward. Try, at the same time, closing the upper gates: hands over mouth and eyes, fingers over the ears. The individual can then go into an inner meditative space. Try also having your client draw the anus upward, while an inflated diaphragm presses down against this upward pull.

**SESSION 4**

*(Bottom of the Pelvis)*

**BODY READING**

1. Notice the pattern of tension. In the case of knock knees the tension is on the outside of the lower leg (peroneals), but shifts to the inside in the upper leg (adductors). In bowlegs the tension starts on the inside (tibialis posterior), but shifts to the outside of the upper leg (abductors).

2. When the adductors are overactive, this is often a part of a deep armored contraction running the length of the torso and is evident in the pelvis, diaphragm, and throat. At the pelvis the ischia are usually pulled together. Notice the connection this inward tension on the ischia has with the attachments of the psoas and psoas floor.

3. When the adductors are overactive — although the bottom, inner part of the pelvis (ischium) may be open — the tension usually moves higher into the diaphragm as a part of a continuing outside-inside pattern of tension.

4. When the tension is on the outside in the upper leg, notice that this is often connected with locked knees and that the rectus femoris and vastus lateralis may be stuck together. The rectus serves as a pulley, bringing the top of the pelvis down and contributing to lordosis. We need to lengthen the rectus so that the pelvis can settle back into an upright position.

5. Encourage your client to bend the knees, to feel weak in the knees, to even collapse into the knees. Explore the fears involved in this letting go.

6. Often there is a pattern of one hip being higher, possibly more contracted around the quadratus lumborum with excessive abduction. The other side may then be open at the quadratus lumborum and abductors, but more contracted around the adductors. Explore this possibility by having your model exaggerate the position. Often you will also discover a twist in the torso, toward the more contracted quadratus lumborum.

**BODY AREA**

Our general aim is to loosen the medial and anterior thigh, giving freedom to the bottom of the pelvis. This will allow sexual feelings moving upward and supply energy to the heart area, throat, mouth and eyes. This release is a condition of connections we will make later from the bottom to the top of the body mind core.

1. **Lower Leg**. See circled numbers 1 through 4 on illustrations. The working position is on the side, with the higher leg supported by a cushion. As a preparation for working deep on the adductors, it is important to first release the lower leg. In the case of a high arch, the invertors need to lengthen, but when the feet are flat, it will be important to also work on the outside of the lower leg (peroneals). (Much of the needed work on the outside can also be done during the sixth session, while working up the back of the leg). The work on the lower leg is now much deeper than in the second session, and is much selective. You may need to start at the arch or medial malleolus, where you can begin moving muscular envelopes which affect the upper leg. And higher, along the leg. If you can find a single effective entrance deep into the medial tibialis posterior, you can release tension which runs all the way through the medial knee to the ischium.

2. **Inversions of medial thigh.** See circled number 5. Just below the medial knee line, many tendons of the upper medial thigh muscles come together in a cluster. They are surrounded by a bursa sack (gracilis, sartorius, semitendinosus, semimembranosis). Work across and in between these tendons, since their functions tend to be undifferentiated and confused by being stuck together. You can hook the fingers or knuckles of one hand under some tendons, while working with the other hand across the top of the same tendons.
3. Sartorius. See circled number 7. The position is still with the client on the side. Notice that the sartorius (Taylor’s muscle) may be either too far forward toward the rectus femoris (especially in a leg rotated laterally) or too far backward toward the gracilis (when the knees are turned in). You can work along the gracilis, hooking around the sartorius and pulling it in the opposite direction to its malplacement. Have your client flex and laterally rotate the lower leg, during your interaction.

4. Medial Quadriceps. See circled number 6. From this position (side position with upper leg extended posterior at the hip) you can also begin to work with the medial quadriceps, i.e.; vastus medialis, vastus intermedius and medial part of the rectus. At the attachments (medial knee) the tissue is shallow, and you will have to work cautiously, but higher along these muscles you can use your elbow or penetrate deep with your fingertips. The interaction is extension of the knee.

5. Posterior Adductors. See circled number 8. Save the deep middle adductors (pectineus, adductor longus and brevis) until last. First work on the gracilis and muscles posterior to it. Keep your model on the same side but move the upper leg toward, so that it is in a flexed position. You can now work (on the lower leg) from behind your model. First separate the gracilis from the adductor magnus at several points along these muscles. Here you can probably work deep without eliciting much pain. Use your elbow, if your fingers aren’t strong enough. The interaction is adduction. (Ask your client to imagine riding a horse and squeezing with the legs).
6. Separating Flexors and Adductors. Still circled number 8. Separate the adductor magnus from the semimembranosus. Interaction is a combination of adduction and flexion of the lower leg. You can also separate the semitendinosus and semimembranosus, though this work can be handled in the 6th session.

7. Origins of Flexors and Posterior Adductors. Circled number 8a. The muscles worked within the preceding numbers 5 and 6 can be released at their origins as well. Bunching the fingers together, work along the ischium asking for either flexion or the lower leg or adduction.

8. Anterior Adductors. See circled number 9. Now change the position: the same side but the upper leg is again moved backward (extended). Work on the lower leg. You can take a position in front of the model. Imagine the three adductors forming a triangle with the adductor longus the most superficial and at the apex. Begin here between the gracilis and sartorius, weaving with your fingertips until you reach the adductor longus. Proceed toward the base of the triangle and work on the adductors. At the adductor breve, you can go even deeper. Finally at the base, try going all the way to the attachment of the pectineus. The interaction for all of these is naturally, adduction.

9. Attachment of Gracilis. See circled number 10. Now work with the attachment of the gracilis by reaching with both hands under and around it. First going straight down for enough depth, then hooking under and around the gracilis to its attachments on the pubis. Keep your client on the side, if he or she is on the back, the gracilis will be too stretched. The interaction is adduction.

**BODY READING**

Up to this point the work has been on the medial lower leg and thigh. Have your client stand so that you can see what’s happening. The inner thigh should be fuller; the line from the knee to the pubis, less wavy. Some weight may have shifted to the outside of the thigh, on which you have just worked, and to the inside of the other thigh. The medial arch of the worked leg may also be supporting more weight.

8b. Anterior and Lateral Quadriceps. See circled number 12. Now you are ready to work with the other parts of the quadriceps (rectus femoris and vastus lateralis). With the client lying on the back, work across the attachment of the rectus (especially in the case of locked knees). If the rectus is relatively free, proceed to the lateral thigh and separate the rectus and vastus lateralis. Here you can use either the flat of your elbow (not at knee, since that would prevent interacting movement of the knee, but higher along the thigh), or your fingertips or knuckles, perhaps with the knees slightly bent, and supported by a small pillow. Interaction is extension at the knee. Continue along lateral thigh. If you move a little further to the outside, you can also help free the vastus from the iliotibial tract.

11. Anterior Superior Thigh. See circled number 13. At the top work with fingertips deep on either side of the rectus. Here you will be separating the rectus and sartorius, on one side, and the rectus and vastus and vastus and tensor fascia lata, on the other side. You will need (from your client) plenty of flexion and rotation at the hip to get at this complex of envelopes.

12. Origin of Rectus. Go on to the superior process of the iliac spine. There you can work with the origin of the rectus. All this work around the rectus is extremely important in giving the pelvis a chance to lengthen in front, and thus in flattening a sway back. Of course, in the case of lordosis there is a shortening of the back as well, but the job of lengthening and broadening the lower back in the 6th session cannot be effective, unless there is sufficient lengthening of the rectus (on the front of the pelvis) in the fourth session.

**HALFWAY READING**

Be sure to look at your client after finishing one half. Look for more weight on the medial arch. Also look for an even rounding out of the whole thigh. Also the knee is often more flexible, but since the work is focused on one part of the leg, the knee, in bending more, may turn somewhat inward or outward. A balancing out of the forces acting on the knee will come as the work progresses in other sessions.

**OTHER HALF**

Follow the same procedure on the other leg. Although this is the more difficult (tighter, more disorganized) leg, it should be more ready to open, especially if you have encouraged the release of feelings during work of the first leg.

**NECK AND BACK:** As in other sessions.

**FINAL FINE ENERGY**

During the finishing cycles of charging and discharging breathing, make sure that the energy is not stuck along the channel from the bottom of the pelvis to the throat. Work toward an awareness of this connection of the pelvis with the throat. Images can help: threads or strings that pull gently from bottom to top; a tube of coloured energy from the genitals and anus to the throat, etc. Acceptance of the basal chakra in balance with the other body energies is the key, whether this be giving more importance to a neglected pelvis, or less importance to an overactive pelvis. Suggest that with one hand your client hold the genitals, and with the other suck the thumb.
SESSION 5
(Upper Anterior Pelvis)

BODY READING

1. When the pelvis is tilted forward (lordosis), the genitals are often hidden and protected and may store an excess of energy. Work toward the opening and expression of this energy, the acceptance of this sexual power. The extrinsic muscles need to be softened. The intrinsic muscles (e.g., psoas, obturator internus) need to be strengthened.

2. When the pelvis (top) is tilted backward, there is often a lack of energy. There can be an over thrusting forward of the genitals, and at the same time, a closing down in the anus. Work with the quieting of the sexual energy and the release of anal anger. In this case you may also find a great deal of tension in the hamstrings where they pull down on the posterior pelvis.

3. Notice (as in session 4) that a twisted pelvis involves an unevenness of strength between the right and left psoas, which in turn, may have a spinning effect on the spine, or may be involved with tension in the adductors on one side. Sometime a stringy psoas (in spasm without the capacity to function appropriately) will exert a downward pull (forward tilt at top) on one side of the pelvis, while the iliacus on the other side may contract upward, with the help of the obliques and quadratus lumborum.

4. Notice the relation between the tilt of the pelvis and tension in the abdominus rectus and thorax. When the top of the pelvis is tilted forward the chest may be high and over-inflated, and the belly damped forward, though often the abdominal wall will overcompensate in an attempt to pull the contents back inside the pelvic bowl. Often, when the top of the pelvis is tilted backward, the chest is collapsed and the abdomen flat and hard.

BODY AREAS

The main goal is to release and activate the iliopsoas. In order to make the iliopsoas available for this work, one must open and lift the chest, and lengthen the abdominal muscles.

1. Attachments of Abdominus Rectus on the Ribs. See circled number 1. Begin with the client on the back. Make sure there is enough charge or discharge and an adequate connection between diaphragmatic and upper chest breathing before beginning to work directly on these attachments. Whether done with knuckles or fingers, these strokes have to be deep and slow enough to go between and over the ribs. Working diagonally across the muscle upward toward the midline, lengths one half of the rectus at a time.
2. Attachments of Pectoralis Major. See circle 3. After working both sides of the rectus, continue working diagonally, but now across the fibers of the pectoralis where it attaches along the breast bone. This helps complete the lengthening of the abdominal rectus by encouraging the chest to lift.

3. Pectoralis Minor. In some cases you may wish to rework (after the work of session 3) the origin and insertions of the pectoralis minor. In cases where the chest is collapsed and the shoulders are rounded, work not only around the coracoid process, but also go to the insertions along the ribs. You need to be deep and exact; twist your knuckles or fingers slightly at the insertion. The shoulder is moved forward.

4. Diaphragmatic Area. See circle 2. Expansion of the entire thorax is needed (along with lengthening of the rectus abdominus) in order to give enough space to activate the psoas. Reach under the floating ribs, while
supporting their lateral side with your other hand. With your fingertips reach upward and hook inward toward the attachments of the diaphragm. Continue with similar strokes progressing toward the linea alba. The attachments of the diaphragm will be more available as you approach the sternum. If the model curls the pelvis up without contracting the belly and exhales (or pants shallow and high in the chest), your hand can more easily go under the ribs toward the diaphragm. Do the other side. If the belly is too hard, try softening the obliques and abdominus (the next two body areas) before entering the diaphragm.

5. Obliques. See circle 5. When there is a tendency toward excessive discharge (collapsing and weak in the front), not only the abdominus, but also the obliques will be tight and short. (It may seem paradoxical that in weakness there will be such a hard contraction, but these muscles are using up a lot of energy that isn’t available to the whole person). Cross your hands, back to back, using the fingertips in opposite directions to stretch the tissue toward and away from the floating ribs. This backhanded leverage will transfer the force to your fingertips, and spare the floating ribs and the ilium unnecessary pressure. You may need several of these strokes on both sides to open very blocked, lateral and posterior, diaphragmatic breathing.

6. Pubic Attachment of Abdominus (and pyramidalis). See circle 6. Before working directly with the abdominus, we loosen both ends of the rectus. We have already worked with the attachments above. We can now directly work on the pubic bone. Straddle the pelvis in a standing position. Bend in the knees, using your weight to press the fingers against the superior border of the pubic bone. As your model rocks the pelvis gently, press from side to side along the bone. Do not exert pressure against the bladder, rather work against the superior surface of the pubis, where the rectus attaches. If the model tightens the abdominus, you won’t be able to do these strokes.

7. Abdominus Rectus. See circle 4. Straddle your model, facing the feet. Bend in the knees, hooking the abdominus above the pubic hair line. After hooking (the abdominus is relatively flat), pull your fingers diagonally in large zigzags across both halves of the abdominus. You will need many such strokes to cover the entire abdominus up to the thorax. It may help to have your client curl the pelvis (without using the abdominus) as you pull upward.

8. Separate Abdominus from Transversus (scroop-di-doo). In giving more space to the belly, it’s important to ungee the abdominus from the transversus. This will allow the transversus to balloon all the way around the body during diaphragmatic breathing. Drop the elbows low enough, so that you can scoop up the abdominus with your knuckles. (Your head will have to go down to your model’s belly if you are to get enough power under your wrists).

9. Insertion of the Iliopsoas. See circle 7. Consider the pull exerted through the iliopectineus. If one side is more pulled down and the area is more closed around the lesser trochanter (e.g. there is more adduction), start with the other side, which is more open. Use the sidesaddle position. With fingers bunched together, find the area between the gracilis and sartorius, just above the insertion of the pectineus, which allows you to penetrate directly medially toward the femur. After you have gone deeper, turn slightly upward until you can feel the lesser trochanter, then press against the attachment. A rocking movement of the pelvis will help you feel movement of the tendons of the iliopectineus. The femoral nerve is in this area. Go slowly at first, but at a certain point simply do it, while encouraging your model to express the pain. Due to the sensitivity of the area, you may not be able to re-enter during this session.

10. Body of the Psoas. See circle 8. Now to wake up the psoas. We have created space around the psoas and have loosened its insertions. By directly strumming its body we can not only relax its chronic spastic condition, we can also give it a new responsiveness. With the client on the back and the opposite knee bent for support, practice a movement in which the client moves the ankle and knee, drawing the knee up to a bent position along side the other knee. When the knee is fully bent, the pelvis is rolled up, keeping the belly loose, then rolled back, and the leg is lowered (knee straightened) to the original position. Your stroke begins with the beginning of this pelvic movement; your fingers pressing across the psoas (be sure you are above the ovaries) with maximum pressure being exerted when the pelvis is rolled up. You will be interacting with the contraction and stretching of the psoas. Try different angles, to make sure you have made good contact. If there is a sharp pain as your fingers enter the abdomen, release your pressure and try again. Often there are pockets of gas in the intestines, which will move out of the way. Try the same slightly higher and closer to the ilium and you will contact the iliacus. See circle 9.

11. Lumbar Stretch With Psoas Curl. If the extrinsic are relaxed, the psoas will gently contract, without one having to arch the back. The model’s back is flat, the fingers are bent. The pelvis is gently curled, using the psoas, while simultaneously, you hook your fingers on either side of the lumbar spine and pull downward. (This means you have to reach under the torso of your model with both hands). The cooperation of the extrinsics and extrinsic allows the back to lengthen and broaden, while having a reciprocal relaxing and strengthening effect on the psoas. The stretch occurs just outside (posterior to) the origins of the psoas along the lumbar spine.


FINAL BODY READING

Notice how abdominal and thoracic breathing are more together. The front of the body will be noticeably longer, the chest much higher. If the rectus is still locked (4th session), there may be, during the 5th session, a lengthening of the belly and lifting of the chest, but the lordosis may actually be worse. This means that either the work of the 4th session has to be repeated, then followed by part of the psoas work of session 5; or that more work on the rectus can be incorporated in Session 6 and the psoas reworked at the end of session 6.

FINAL FINE ENERGY

Help connect the movement of the chest with the movement of the pelvis and head. After session four it was important to connect the pelvis and throat, without focusing too much on the mid chest. Now it is important to help your model feel a rocking release in the mid chest with each exhalation. Try out gentle sighing, until the chest and psoas can vibrate together.


**SESSION 6**  
(Posterior Pelvis)

**BODY READING**

1. Notice whether the buttocks are tucked in and the ass tight, or whether the buttocks protrude with the genitals hidden in front. Help your client to exaggerate the position and to get in touch with whatever feeling may be locked in these largely unconscious positions. When the buttocks are tucked, there may be lots of tension in the hamstrings; when the buttocks are high there will be more tension in the lower back and sacrum.

2. When the cheeks are contracted into dimples along the posterior femur, notice the connection with the iliobial tract and with the lateral gluteals. This tension in the buttock is also often connected with tension in the sacrum. You may find a little triangular patch of tissue on the sacrum which reflects the tension running through the legs and buttock, the result of a pattern of tension that shifts from inside to outside and back inside (e.g., inside the knees, outside the buttocks, inside on the sacrum).

3. When the legs are rotated laterally from the hips (not the knees), there will be tension deep in the rotators (piriformis, obturator internus and externus, gemelli, quadratus femoris). This may not always be obvious in the external form of the buttock, since the tension lies very deep. Even in the case of legs that are relatively straight or medially rotated, there may be considerable compensating, i.e., counter tension in the lateral rotators, especially after you have released a good deal of the tension in the medial rotators.

**BODY AREAS**

Sessions 4 and 5 generally lengthen the front of the body (e.g. in session 4 the rectus femoris is worked at both origin and insertion and in session 5 the abdominus rectus is lengthened, while the chest is lifted). Since the front and back of the body are in an agonistic-antagonistic relation, prior to session 6 tension will have shifted to the back of the body. Session 5, like other even sessions (excepting 4), will bring more overall balance in the body than odd sessions. After 6 the tension will shift to the neck and head, although the legs and torso will be in a relative balanced release both in front and back.

1. Preparatory Work on the Legs.

A. Peroneals and Lower Leg. See circles 1 through 4. The release of the deeper myofascial wrappings of the lower leg was begun in session 4, we continue this work, focusing on the lateral and posterior parts of the lower leg. While emphasizing the lateral part of the leg (peroneals, lateral part of soleus and gastrocnemius), you may be able to penetrate both sides of the leg, simultaneously also reworking the medial side. Here the knuckles or fingers slide in between and separate the muscles from both sides.
B. Gastrocnemius. See circle 5. Divide the gastrocnemius, using two hands (knuckles or fingertips in opposite directions), in preparation for going deeper in the region just underneath the popliteal fossa. But let this separating be in a downward direction. The plantar flexors generally need to lengthen downward, not shorten upward.

C. Back of the Knee. See circle 7. The plantaris lies one level below the gastrocnemius, and the popletius lies still a level deeper. You need direct penetrating (but slow) strokes to get sufficient depth. Work on the attachments of both these muscles and at the same time on the posterior lateral part of the knee. This is a bony area that calls for steady, powerful knuckles. Next work on the body of the plantaris with finger tips or two pointed knuckles. The interactive movement is plantar flexion. To reach the insertion of the popletius, roll the leg slightly medial and use the fingertips to press along the tibia, during medial rotation at the knee.

D. Above the Knee. See circle 6. Avoid the popliteal fossa but hook the fingertips of both hands symmetrically on the medial border of the hamstrings, and continue deep under the hamstrings to the origins of the gastrocnemius. Keep the depth and continue the stroke across the hamstrings (semitendinosus on one side and biceps femoris on the other side). The interactive movement is plantar flexion. This work will clearly open the knee in two directions: upward into the back of the legs and downward to the achilles’ tendon, (a tremendous overall lengthening of the whole leg).

E. Biceps Femoris. See circle 8 and 9. When the ass is tucked under, the hamstrings will be shortened, pulling toward their origins but also downward toward their insertions. This pattern can be connected with hyper extension of the back (over contraction of the sacrospinals) and the inability of the spine to bend forward in graceful, rolling movements. The insertion of the short head of the biceps lies along the lateral part of the leg, a few centimeters above the knee. You can use your elbow in a very short stroke, shifting and twisting slightly, while the interactive movement is straightening and relaxing the knee. (An alternative interaction is to have the knee completely bent and let the heel move back and forth toward the buttocks). You may wish to work on the body of the biceps separating its stringy fibers, or strumming across it in provoking, but lengthening movements. Finally work on its origin at the inferior ischium. The elbow will probably not reach this corner. Bunched fingertips can strum, while the knee straightens.

2. Rotators. See circles 10 through 12. The lateral rotators of the leg are obviously over contracted when the legs are splayed outward in Donald Duck, or Charlie Chaplin fashion. (The feet may be turned out from the knee, however, without the upper leg being laterally rotated). Sometimes, when the leg is relatively straight, there may be lots of mutually compensating tension in both the medial and lateral rotators. In this case be sure to rework the medial rotators after working in the sciatic notch on the lateral rotators.

A. Piriformis. It Lies in the upper part of the sciatic notch. Use the elbow to massage gently the area, gradually going deeper. When applying maximum pressure, explore different angles, since the tension is variable along the length of this muscle. Interaction is rotation of the whole leg from the hip.

B. Obturator Internus. These muscles originate deep in the pelvis and are intrinsic muscles which have a lot to do with pelvic stability and freedom of the legs to move in parallel lines from the hips. Use the same style elbow stroke with rotation. You may want also to reach the obturator internus by another stroke with the fingers high along the medial border of the ischium.

C. Quadratus Femoris. To reach these short muscles between the lateral ischium and medial femur, use the fingertips. You may have to use prying movements against the ischium or against the femur or upward toward the sciatic notch – in order to free these, not readily available, muscles.

HALFWAY BODY READING

Look at the position of the leg. Has a laterally rotated leg straightened? Also consider the shape of the buttocks. The worked on buttock may now be rounder and fuller. There may also be a visible lengthening of one side of the back.

3. Sacrum. See circle 13 and 14. Connect the sciatic notch and sacrum with strokes pulling downward over the superior edge of the notch into the notch. Next work on the sacrum. Use a great deal of pressure with a flat elbow, pulling downward and toward the midline, along the major areas of the sacrum. This thickened and hardened tissue can, with time and work, become so soft it will slide off the sacrum to which it has become glued through many years of unawareness and bunched immobility. You may want to bend your model over the table with the belly on the tabletop and knees on the floor. From this position a slight rocking movement of the pelvis can also help reorganize the tissue of the sacrum.
4. Sacrospinalis. See circle 15. It is important, before working on the coccyx, to loosen the back, at least up to the mid-thoracic hinge, perhaps even as far as the neck. Use downward diagonal strokes. Begin with the elbow flat, and as your pressure reaches the middle of the muscle, sharpen the angle of your elbow such that, finally, you use the point of the elbow next to the spine. Do one side at a time. The tissue around the sacrospinalis tends to be too spread out across the back, and holds the ribs too flat. As you work the tissue toward the spine, the sacrospinalis will come more together, becoming rounder and softer. The ribs will then be free to move at the spinal processes, rounding toward the back and front. The whole torso then is fuller and rounder and less square, less flat in front and back.

5. Coccyx. See circle 16. The bones of the body guide the tissue which in turn distributes the weight of the body. The coccyx is a kind of a rudder for the spine and when it is bent upward or sideways, or in rare cases comes too far posterior (is not bent enough), the distribution of weight in the tissues of the pelvis and legs is confused. Also this is a key area for introverted, stubborn feelings, and release and reorganization of the tail can bring a profound, deep-seated relaxation and feeling of well-being throughout body and mind.

6. Psoas. You may wish to rework the psoas. Often, after the release of the back, the psoas will respond even more completely to deep stimulation. You may want to combine work on the psoas in front with work on muscles in the back, e.g., obturator internus, in order to create a subtle, pelvic balance between front and back.
The two most significant changes will be the position of the legs (more parallel) and the softening of the sacrum. The sacrum accumulates stress and tends to cut itself off from the buttocks. There should now be a much more continuous flow of tissue from the hamstrings up through the sacrum. This may be evident in a diaphragmatic breath which ripples through the ribs and buttocks.

From the time of the anal stage of development, we separate our deep seated resentments from our conscious attitudes. With the expression of this repressed anger, we have a chance to let power stream through our whole body. Receptivity and assertiveness now are simply different directions for the same feeling, which we can take in or express outward through our extremities and torso. Work toward the recognition that anger is diffuse, expansive, circulating energy rather than merely repressed and contracted resentment. Connect coccyx Gv1 and occiput Gv15. Use both The Doors of Life and Windows to the Sky.

Now we want to free the cervical vertebrae, allowing the neck and head to move into alignment with the pelvis; to free the emotions around the eyes, mouth, and throat so that feelings from other parts of the body can be easily and completely expressed through the head.

Oral types accumulate either a weakness (mouth open) or over contraction (clinched jaw). We are looking for a light bite which gives boundaries to what is taken in, but also permits sucking in what is needed. Some oral types may have the chin lifted and thrust forward. Slow everything down, encourage watching what is happening.

Very Right-Sided individuals may have masculine side which controls the feminine side. Active Left sided individuals may feel guilt about conflict with the right side. During the work, encourage a Gestalt dialogue between the two sides. Remember that K27 is good for this imbalance.

Some Rigid types may have relatively straight cervical vertebrae but be extremely tight and inflexible in the anterior neck muscles. The sternocleidomastoids may be stiff and large, and the masseter clinched. There may be repressed orality, if they were weaned too early. At the right moment encourage them to feel their needs, to suck and bite.

Schizoid types have lots of energy in the head, but it is unfocused. Work with the eyes. Use eye contact and eye exercises (eyes follow the movements of a penlight or finger). Don't allow any fantasizing or drifting away; keep them present.

The head is too often the center of deliberation, consideration, and reflection. It is important to accept the head as simply another part of body mind. Thoughts then do not require effort, struggle, and lots of time; they can be easy, clear and immediate, just like the movement of a leg or arm. Try "I'm thinking with my whole self;" "My ideas are clear and complete;" "I'm certain of what I am now contacting;" "I can sit on my head;" "I can run with my ears;"

1. Depth. The neck holds a maze of muscle, many layers one over the other. This work is very deep, and very slow.

2. Precision. There are many fragile nerves and vessels in the neck and head. Be sure where and how you want to work. The fingers, being the most exact instruments of your body, will do most of the work of this session.

3. If some parts of the neck and head are too highly charged to do all the work in one session, the session can be repeated. Or if certain essential parts can be released (gums, tongue, cervical vertebrae) the postponed parts can be incorporated in sessions 8, 9, and 10.
MOVEMENT AWARENESS

Many people do not have consciousness of how the head can turn on its vertical axis. Use the Feldenkrais exercise in which the model looks with the eyes only at one shouldertip but turns the head the opposite direction. This exercise can help with getting more distance between the ears and shoulders. Work with the image of a milkmaid’s collar, holding two buckets on either side. This helps give a sense of the shoulders having a flat top, and being anchored. Also work with the idea that the chin can fall a little, while the back of the neck elongates. A lifting string attaches at the back of the head, not near the front which would lift the chin. As the chin falls and the back of the neck lengths, the chest lifts with an inhalation. Compare the needy types who collapse the chest and lift the chin in search of the unobtainable.

MERIDIANS AND POINTS

Brushing the upper yang meridians will to the neck and head. The Windows to the before, during and after this session (Csl, Twl6, B10, Gv16, L3). After working an head, be sure to reground your model by points on the lower body.

CHAKRAS

Brush a lot of energy Sky are essential Cv22, S9, Sl6, S16, entire session on the using S36 and other. Use the higher centers as enhancers of the other centers. Do not think of the third eye or uppermost chakra as an escape from the other chakras, but as their culmination. Use a tone meditation Lam, Vam, Yam, Ham, Ram, Om for ascending and descending through the chakras.

SESSION 7 (Head and Neck)

BODY READING

1. The forward angle in the cervical vertebrae will usually duplicate the angle in the lumbar vertebrae. This angle cuts off the consciousness between the head, torso, and neck. Most people do not realize that the neck can rest easily on the spine, such that there is connection all the way from the atlas and axis down to the coccyx.

2. Notice that the neck sometimes is advanced by being pulled forward to the clavicle, that is, the base of the whole neck is too far forward. This exercise is the key to opening the chest, and there may be the beginning of a dowager’s hump at the 7th cervical. Lots of work on the upper chest and clavicle will be needed. In other cases, the neck may be pulled more forward at the mid-cervical vertebrae or the chin jutted forward. In these cases more work is needed inside the mouth and with the capitis muscles, which will be short in the back of the neck.

BODY AREAS

1. Subclavicular Area. See circle 1. Preliminary reworking of the pectoralis major and minor may be necessary, before working under the clavicle. The muscles of the neck are enclosed in fascia that extends under the clavicle and is connected with the first rib. Slide your fingers against the third and second ribs and move your pressure upward under the clavicle toward the first rib. The client can turn the neck and tilt it from side to side.

2. Suprascapular Area. See circle 2. One side at a time: Using the broad part of the thumbs (one of the rare occasion that the thumbs are better than other parts of the hand), pull across the two tendons of the sternocleidomastoid, while your client turns the head. Continue with the thumb along the omohyoid, scalenus anterior, and medialis, etc. all the way out to the shoulder tip. As you get further toward the shoulder, you can exert more pressure into the anterior trapezius.


A. Begin with the usual neck strokes (usually at the end of each session) transverse to the muscles of the neck.

B. Work now to separate the longitudinal muscles of the neck. Using the fingers or knuckles, work along the muscles from the clavicle to their attachments on the head – sternocleidomastoid, omohyoid, scaleni. These strokes are not transverse but along and in between the muscles, in order to get good separation in their functions. When you work with the sternocleidomastoid, be careful, on the medial side, not to press too deeply into the trachea. Also higher at the attachment of the stern on the mastoid, be careful, on the medial side, to work slowly along the parotid glands. You can work through glands, but much more slowly than through other connective tissue. Have your client turn the neck as you progress to muscles further along the lateral neck.

C. You may need to work thoroughly across the attachments of all these muscles at the mastoid and occiput.
4. Scalp Aponeurosis. See circle 5. The scalp coordinates muscles on the posterior, lateral, and anterior skull, and you need to loosen all of it before working with the temporalis, frontalis and other muscles of the jaw and face. Beginning at the occiput, grip the scalp with an open hand, so that the force is equally distributed between the
fingers and the thumb (like playing a whole octave on the piano). While maintaining this grip, shift the whole hand a short distance. Do not pull the fingers along the scalp; move the whole scalp, otherwise you will pull the hair. You can do this with both hands simultaneously. An alternative grip is with all the knuckles and thumb. Cover the scalp in two halves, all the way from the occiput to the frontalis and temporalis, but do not yet do these latter two areas. Help your client get in touch with how the whole scalp can move; how it is connected with muscles all around the head.

5. Frontalis. See circle 6. With the fingertips (both hands) pull over the supraorbital ridge, upward toward the hairline, along the frontalis. Before beginning, have the model practice pulling the frontalis down by frowning in equal steps to the count of ten. This same muscle movement is used during your pull upward to give a counter-pull in the opposite direction. Instead of the fingers, you can also use the flat of the knuckles to pull up. Show your client how to move the frontalis with the scalp by moving the ears. This helps relieve chronic tension in the forehead and open the bunched worry and concern between the eyebrows. If there are deep vertical worry lines, try a stroke with both knuckles across the forehead, while the client counter-pulls with an inward frown.

6. Temporalis. See circle 8. Notice the fan-like origins of the temporalis around the ear and temples. There may be a lot of anger here, along the gall bladder meridian. Since the skull is thin, and delicate vessels run through these areas, work shallow and slow, beginning at the periphery of the muscle and working toward the insertion. The fingertips of both hands can be used in pushing strokes; or the flat part of the thumbs, if the pressure is not too concentrated. Use zigzagging movements, so that you are sure to pick up the

This cross section of the neck shows an outer superficial layer, an intermediate layer, and deep layer of fascia. The deep fascia is a complicated maze of myofascial sheaths (dashed lines), holding deep and intense emotions. Since the head and neck are an outlet for energy released in other parts of the body, it is important that the practitioner work frequently with their deep, intrinsic structures in the neck, 180 envelope of the temporalis. The client opens and closes the jaw, or grits the teeth slightly.

7. Muscles of the Jaw and Temporomandibular Joint. See circle 9. There is usually a concentration of anger in this area. Before beginning these strokes, you might encourage some growling and biting, to make sure the client is primed to let go of deeper anger, which may begin to come to the surface during the strokes.

A. Origin of Masseter. The masseter is more superficial than the temporalis, which passes under the zygomatic arch and attaches on the upper process of the mandible. The insertion of the masseter is available just against the zygomatic. Use the thumbs on the forehead for support (standing above the head of the model) and press the fingers upward against the bone, while the client moves the jaw open and closed.

B. Insertion of the Temporalis. Use the same position and almost the same grip with the fingers. But now drive the fingers deeper and let the pressure be, not against the cheek, but against the mandible. Use the same jaw movement.

C. Body of the Masseter. You can work directly on the masseter by inserting your first finger (with the pad lateral) between the outside of the teeth and the masseter. Push your finger as far as you can to the back of the teeth. As your client slowly grits the teeth, your finger will be pushed out against the masseter. In this way the model can regulate the pressure. A good affirmation at this point is “I create and accept my own anger.”

D. Insertion of the Masseter. Finally, work directly against the lower mandible with the fingers or thumbs. Working with both hands at the same time helps equalize the pressure. You can normally feel a large lump of developed muscle here. It needs lots of work, especially in people who hold back resentment.

8. The Tongue and Cervical Vertebrae. Large groups of muscles in the neck, head, and jaw have been released as a preparation for the most important area of this session. We want to loosen the attachments of the tongue, and then push the tongue posterior, in order to loosen the mid-cervical vertebrae. See circles 11 through 13. The Attachments of the Tongue From Outside. See circle 11. With your position still above the head of the client and somewhat to the side, reach the fingers under the mandible, using the thumb on the lateral edge of the jaw for support, press the fingers against the inner (medial) surface of the jaw and have your model extend and retract the tongue. Be especially slow here, since you will also be sliding through the submaxillary glands. Continue this work on both sides of the jaw and in front, under the chin.
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B. The Attachments of the Tongue From Inside. Examine the inside of the mouth. Notice that the formation of the teeth is probably not symmetric. The line of one side may be narrower than the other. Also the teeth may be too narrow in front or in the back. Usually the shape of the teeth reflects the shape of the pelvis. The tongue attaches along the mandible in the soft gums below the teeth. Reach with your first finger, bracing the hand with the thumb against the outside of the teeth. Move the tissue in short strokes (the pad of the finger tip) toward back of the mouth. This is the direction the tissue needs to release in order to free the back of the neck. Work both sides of the gums all the way back past the last molars. Don’t forget the front gums. The goal is to loosen the base of the tongue all along the floor of the mouth. This is usually painful. Give space for the expression of some of the most primal feelings.

C. Shifting of Tongue Posterior. The base of the tongue is connected to deep layers of tissue which wrap around the throat, and envelop the mid-cervical vertebrae. After loosening the attachments of the tongue, this whole complex can be shifted with the tongue toward the vertebrae. Position the head so that the back of the neck is flat and the chin is tucked in. One hand under the occiput will help maintain this position. With the other hand use the first two fingers to flatten the tongue against the floor of the mouth. While clamping down against the floor (don’t allow the tongue to bunch toward the back of the mouth), move the tongue backward and somewhat down into the throat. You will be pushing against a gag reflex, so your pressure needs to be secure. Before doing this explain that the breath will be cut off for a few seconds and that there may be the sensation... of gagging, but that the whole thing is very brief. Check the back of the neck before and after this work to see if it is freer and fuller.

1. Breadth of Cheeks. See circle 14. In order to be in balance with the mouth, jaw, nose and eyes, the cheeks should be wide. The zygomatic bones can actually move further apart. With the pads of both thumbs, push up and out against the cheeks. Do not drag superficial tissue; be securely against the bone. Go slowly; this can be painful. We will discover in advanced PI that the mobility of the zygomatic is important for movement of the sphenoid and freedom of the eyes.

2. Opening the Conchi of the Nose. inside the nose, on either side, there are three passages, formed by cartilaginous "conchi" (Greek for "scrolls") -- a lower, middle, 183 and upper passage. The septum separates identical structures on both sides. But often one side is more closed than the other, the conchi and septum being broken from accidents or malformed since birth. The walls of the passages may actually be collapsed or stuck together. With slow, accurate pressure, and the release of blocked emotions and thoughts, these passages can be reopened. The balance between the two sides in breathing is important for the heart, (according to both Western rhinologists and eastern yogis). Examine the structure of the nose. Sometimes the septum is deviated only at the tip of the nose; sometimes its deviation begins much higher. One side of the nose can be more collapsed or smaller. Also ask whether it is easier to breathe on one side than the other. Start your work on the side more open. Have your model wet your little finger with the mouth. Position yourself on the same side of the body as the side of the nose you are going to enter. Turn the pad of the little finger lateral away from the septum in order to be able to push out on stuck conchae. (If you want to work directly on the septum, reach across and enter the other nostril and push the pad of the little finger medial against the septum). Enter the lower concha first. Wait for the nostril to open. Suggest to your client images of opening and relaxing around your finger. Gradually advance to the second and third passage. This may require a lot of waiting. Also if the sneeze reflex is activated, do not remove your finger. You will be able to advance slightly, with the relaxation immediately following each sneeze. This work with the nose will open the eyes and make it easier to cry. Also you may reactivate memories associated with the olfactory nerve. Your client may "smell" earlier events. Work with the attendant emotions and attitudes.

NECK Rework the neck as in other sessions, but now you can go deeper and shift more of the tissue of the neck posterior. Also work with your client in a semi-headstand, moving across the attachments of the capitis muscle at the occiput. This is the same stroke used in session 3, but now is deeper.

BACK Do as in previous sessions, but you may find it easier to move the sacral tissue, now that the neck is freer.

PSOAS You will also find the psoas more available now that the neck is freer. Use strokes from session 5.
FINAL BODY READING
Examine the position of both the base of the neck and the mid-cervical vertebrae. Often the shift backward is amazing, but don’t be discouraged if there seems to be little change in position. The neck is stubborn and you may need to work more on the pelvis before the neck is ready to release completely. In any case, you will find the tissue fuller and the neck more mobile.

FINAL FINE ENERGY
Focus on the connections between the cervical and lumbar vertebrae. Help your model with images which make the spine one unit from top to bottom. Try the spinal roll exercise (without any manipulations). Show how it’s
There is a tendency for the small muscles of the face to lose tone. The pull of gravity, feelings of heaviness and sadness, and chronic overcontraction to the point of weakness cause drooping of the face even in young people. As a kind of fine tuning give your model a few exercises to lift the cheeks or jowls. (These have to be done every day). These exercises are very precise and need to be studied.

PHASE V: INTEGRATION OF BODYMIND
(Sessions 8, 9, 10)

GENERAL PURPOSE

After the release of armor in individual parts of body mind -- legs, pelvis, head, etc. -- it is important to focus on bringing these parts together, getting them to function as one unit. The different layers of connective tissue are now free enough to be organized in long planes which flow the entire length of the body. Also the outside layers can be coordinated with the inside layers, such that one layer does not try to compensate for or to protect the other. The focus is also now upon the unity of emotions and thoughts, allowing one feeling or thought to complete itself and to flow into the next. Sessions 8 and 9 divide the body mind into two halves and 10 works with the whole body mind structure.

BODY TYPE

Look at the body mind in terms of symmetric parts: top-bottom, front-back, left-right.

1. Notice whether the structure is more bottom-heavy or top-heavy in deciding with which half to begin. See below decision to be made for session 8. Notice also that a person may be a mixture: partly open on top and partly open on the bottom.

2. Notice the relation of front to back. Many oral and burdened types are contracted in front, while many rigid types are contracted in back.

3. Schizoid types are asymmetric. They do not work in the same way on both sides. Nurture the neglected side.

EMOTION

1. During the release phases of the work, there may have been very explosive expression of feelings which had long been held back. During the integrative stage, the emotions are just as intense, but there may be less focus on their active expression. The focus is more on being conscious of what is felt, and the balance of one emotion with another.

2. However, in individuals who hold their feelings deep in the core, there may be, in this final stage, still some explosive moments.

3. Focus not only on the acceptance and harmonizing of old emotions, but on the exploration of new feelings. This may call for a great deal of support, encouragement and approval.

THOUGHT AND AFFIRMATION

1. As the planes of fascia between the two halves begin to connect, we also begin to open ourselves to more integrated ways of feeling and thinking. I can now say to myself, "I am expansive above, and at the same time, I can support myself below." Or, "I am well grounded, and I can soar." When we integrate ourselves in consciously identifying themselves with the movement and positions of different body parts. They can verbally express themselves from these parts, e.g., "I am now my feet; I am flat and tired; I refuse to work anymore."

2. In bringing together the above mentioned halves of ourselves, we need to recognize and accept our asymmetry. For example, my left side can say to my right side, "it's o.k. that you're more active than me, and don't forget how important I am in smoothing out and softening your actions." Or the top can say to the bottom, "I know that you've always been weaker than me; I'm not going to make lots of demands on you; I'll give you a chance to support me in your own way."

MANIPULATIONS

1. The integration, the organization of overall body mind, calls for the movement of all three layers of tissue, simultaneously. By using a stroke that is both broad and deep, you can shift more than one layer of tissue at once.

2. Use two-handed strokes which organize the tissue in different directions. The direction of movement will depend on what each person needs, but we can illustrate with two general cases. (See "Direction of Movement of Body Segments, Structure A" and "... Structure B"). The most usual structure, A, is one in which there is a pronounced sway in the back. The pelvis in this case needs to lift in the front and drop in the back. Notice arrows for Structure A. Since the lower back is compensating for the forward tilt of the pelvis, the lower back muscles are contracting downward and our direction of movement is just the opposite, up along the lower back (although down along the sacrum). Higher in the back near the shoulders, however, we want to pull tissue across the trapezius and downward in order to encourage the shoulder girdle to settle back into place (except in cases where the shoulders are already pulled too far back). Notice also that the chin is usually tilted up, being pulled from the back by downward contractions of the capsitis muscles. In this case we want to work up the mid-posterior neck, up to the occiput. In Structure B note that our work is up most of the posterior body. The hamstrings are pulling down, the ass is tucked under, the lower back muscles are hyper extending. All along the back our direction of movement is upward against these downward contractions. In the front, in contrast to Structure A, we work down the quadriceps in order to allow the anterior superior pelvis to drop forward. Our work on the belly and chest is up, as in Structure A. The legs as shown in Structure A and B are different. In A there is excessive plantar-flexion (with the heel lifting and the weight going forward onto the ball of the foot), so the arrow for our stroke is downward. But in Structure B the weight is more on the heels and there is excess dors-flexion in front. (The toes may be somewhat drawn up). Now the directions are up in back and down in the front. In the case of all these strokes you can move longitudinally along the muscle and at the same time gradually hook diagonally across the myofascial structure.
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DIRECTION OF MOVEMENT OF BODY SEGMENTS STRUCTURE A

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DIRECTION OF MOVEMENT OF BODY SEGMENTS STRUCTURE B
1. Use these two-handed strokes across major joints with interacting movements. For example, working on the medial knee, one hand will be moving down along the upper medial calf, while the other will be moving up along the vastus lateralis. Here the work is across the joint, but still respects the principle of working down on the back of the body and up on the front (the medial calf is posterior to the tibia; the vastus lateralis is anterior to the gracilis).

2. Do not overwork the halves of the body. We are now concerned with integration. If we work both on the agonists and antagonists of an imbalance, we will simply reinforce the imbalance.

**BREATH AND ENERGY WORK**

By this phase of the work, the cycle of charge and discharge should be more even than in the beginning sessions work now on sustaining the charge and sustaining the discharge. There should be less hyperventilation and its attendant tetany. There is more consciousness of being in control of one’s energy. Explore how it’s possible to breathe fast, without overexerting oneself, or how it’s possible to breathe deeply without trying. Use the “sustained” and “connected” breath frequently.

**MOVEMENT AWARENESS**

Try out movements which involve the whole body. For example, while the client is on the back with knees bent, the knees are moved by moving the feet up at the ankle. Simultaneously, the pelvis is curled with the psoas (extrinsics remain relaxed) during an inhalation. Also during the inhalation, the chin drops to meet the rising chest. During the exhalation the pelvis, feet drop and the chin lifts slightly. These movements can be used as a total body interaction of the client with your organizing strokes. You can add to the movement a pulling down of the elbows (during inhalation), while the shoulders remain stabilized by the rhomboids in back. These movements should be “empty,” zen-like images which are not goals, but merely pictures which one does not try to execute.

**MERIDIANS AND POINTS**

1. Use mostly Self Regulating points, Doors of life and Windows to the sky. There should be less need for stimulation or sedation.

2. Brush the full length of meridians. Be sure to brush both the yin and yang groups, preferably simultaneously.

**CHAKRAS**

1. As in the last phase, use mudras which allow you to move along all the chakras. Remember that in some meditations the movement of energy is not just from the basal chakra up through the head chakra, but also down from the head to the bottom. Kundalini uncoils but can also recoil.

2. Tantric closing of the gates (closing all the orifices, and entering an internal state), can help unify bodymind. Also using CV1 along with the third eye or GV1 with GV16 helps connect energies.
SESSION 8 AND 9
(Upper and Lower Halves)

CHOOSING BETWEEN TWO HALVES

The assumption in beginning this phase of the work is that the first seven sessions have been effective. If there is still major armor in some parts of bodymind, it may be necessary to return to an earlier point in the process. You may need to redo the seventh session, or even return to the fourth session. In any case, continue the sequence from the point where you rebegin, (i.e. after session 4, do 5, 6, and 7, before trying to complete the last phase). If the sequence has been effective, there will be a noticeable change in the quality of the tissue. The layers of tissue will now be even in the distribution of their tension. There will be an equal responsiveness from the superficial down to the deep layers. The two horizontal halves of our body are often very different. The upper half may be expanded and developed, while the lower half may be smaller and less developed. Or just the opposite may be the case: the upper half thin, small, maybe even collapsed; the lower broad, fleshy, and strong. This contrast is not merely a physical phenomenon, for our whole character is involved. When we use one half of ourselves to manipulate the other half, as well as other people, we develop these top-heavy or bottom-heavy disproportions. As top-heavy we may be socially manipulative, but ungrounded. As bottom-heavy we may be seductive, but socially insecure.

By the integrative stage these two halves are free of much of their armor, but need to be coordinated with each other. When working with one half of body mind, the practitioner needs to encourage movement, energy, and consciousness in the other half. Picture the body as an unopened flower bud. After the first stage of release, the petals are looser and ready to open, but either the lower or upper parts of the petals are more stuck.

One strategy for starting the connecting or opening process is to work in one session on the half which is least ready to open, that is, the half which still has comparatively more myofascial disorganization and restriction, as well as less emotional and mental consciousness. The freeing of this half of the body affects the other end of the petals in the other half as well. In the accompanying diagram, the top-heavy man provides an illustration of how his smaller, underdeveloped lower half needs to be opened first. The bottom-heavy woman provides an illustration of how her small, tight upper part needs to be opened first. I usually begin sessions 8 and 9 in the middle of the body at the level of the waist. If I have chosen to work on the lower half, I work downward into the remaining deep tensions of the pelvis and legs and thereby free fascial planes which allow the thoracic cage (upper half) to begin to lift out of the pelvis (lower half). Loosening the lower half helps unfold the upper half, and the opening process is then continued in the next session, 9, by working directly with the upper half.

When the process of deep bodywork has reached the stage of integration -sessions 8, 9, 10-- the body can be likened to a flower bud whose petals are ready to open from the middle. If the top is still relatively tight, the petals are first opened upward in session 8. If the bottom is tight, the lower half is first opened downward in session 8. The next session, 9, then completes the opening. Session 10 encourages a harmonious balance throughout the whole, now completely open, structure.

According to one of the classical explanations, pain is a conditioned response in the brain to a simple outside stimulus to the tissue. But this view does not account for the contribution which local tissue makes to the experience of pain. What we experience as pain depends on how local tissue allows the stimulus to be received; it depends on the “memory” held in the tissues. Here we see an alternative to the classical model. The nervous system is a reciprocal unit, such that changes in any one part affect every other part. The nervous system uses a complicated set of gates which open and close as stimuli pass through local receptors.
But if the top of the flower bud is tighter — that is if the diaphragm, back, chest, or neck is still too contracted at the level of the deepest layers of fascia — I again start at the waist but begin releasing the petals in the top half. In the next session I can then work with the bottom half. We can change the metaphor for a moment to an image of the last chapter: the rib cage floating like a parachute above, while the pelvis and legs dangle below. In the illustration you can see the chest being lifted by the broad distribution of body weight and tension in the upper half of the body. This happens when the myofascial network of tissue is evenly distributed around the whole rib cage, taking pressure away from individual ribs or vertebrae. This even expansion above, in turn, promotes a descending flexibility in breathing and movement down through the belly, hips, sacrum, and legs. It is worth noting that the bones are not the major support in an integrated body; rather it is the fascia, when properly organized, which really bears the body weight. When the fascia is free, the bones move easily in fine, crisp articulations with each other.

**A TEST FOR KNOWING WHICH HALF IS FIRST** If it is not visually clear which half you should work with, try the following test. Begin working at the middle of the body (lateral gluteals) and work either downward or upward in the direction you feel might be appropriate. After a few minutes of work, the release of tissue where you are working should have produced an expanding, rocking release in the movement of the breathing in the other half, on which you have not worked, either a breath upward into the cage —if you have chosen to work on the lower half— or a breath downward into the sacrum and buttocks, if you have chosen to work on the upper half.

**COMBINING THE TWO HALVES**

But it is not always the case that we are either more closed on the top or on the bottom. It may be the case that your model is partly open, and partly closed on the top — or the same may be true on the bottom half. It is possible to modify our strategy, beginning at the middle, but working in the eighth session part of the way toward the top, and part of the way toward the bottom, and in the 9th session finishing the work on both halves.

**BODY READING**

1. Consider top or bottom-heavy, or combined characteristics as discussed above. Help your models get in touch with these parts of themselves.
2. Begin looking at the long lines of the body. See how hip, knee, and ankle can function better along a straight line; how the hip, shoulder and neck work together; how the tension shifts from side to side or from front to back, etc.
3. Develop a strategy, realizing that you may have to change the strategy as you go along. You will need to look at your client in a standing position, frequently throughout the session.

**BODY AREAS (for the bottom-half)**

1. **Middle of the Body.** Begin around the gluteals, abductors, adductors, iliacus, and psoas. This part of the body has so many layers of tissue, so many connections in all directions that it is a major unravelling and release point for bodymind. Work toward the extremities, that is, first around the pelvis, the upper legs, then around the lower legs, etc.
2. **Abduction and Adduction.** Work toward alignment of the leg. Perhaps one hip will need to have its abduction lessened, while the other will need its adduction lessened. But somewhere on the same leg, the tension and disorganization will shift to the other side. If you work on the gluteus minimus and medialis, somewhere along the same leg, perhaps in the lower leg, there will be a counter pull (tibialis posterior). On the other leg there may also be a shifting of tension, but an opposite pattern: from the adductors in the upper leg to the peroneals in the lateral lower leg.

**BODY READING: See what's happening.**

3. **Intrinsics of the Pelvis.** Before working on the lower legs, return to the pelvis (principle of working from the middle toward the extremities). Pay particular attention to balancing the iliacus and the deep lateral rotators in the buttocks. Work on the attachments.
A. Work with the fingers of one hand, along the medial surface of the ischium, interacting with the obturator internus, while working with the other hand on the body of the psoas. A rocking motion of the pelvis, with external rotation, will help with the interaction.

B. Iliacus. From a sidesaddle position, reach inside the higher hip with both fingertips. Slowly penetrate deep into the iliacus, while the client rocks the pelvis. This not only releases constrictions which pull downward in the iliopsoas, but also encourages elongation of the side of the body, a lifting of the cage out of the pelvis.

C. Try working on the sacrum, while your model is lying over the edge of the table, knees on the floor, belly on the table top. It is important that the knees be elevated to a proper height. Also use a pillow or table foam to protect that part of the front of the pelvis pushing against the table. Use elbows strokes (down and in toward the midline) to organize the sacral tissue. Model rocks the pelvis.
BODY READING: Look again.

4. Knees
   A. When the entire knee is turned inward, look at the function of the popliteus (inward rotation of the tibialis), at the tension on the medial knee (gracilis, vastus medialis), and in some cases at the peroneals (collapse of the inner arch by overcontraction of lateral foot).
   B. When the entire knee is turned out, look at the contraction in the vastus lateralis and vastus lateralis (rotates and flexes the knee).
   C. Since the knee is the meeting of the femur, tibia and fibula, there can be a twisting at the knee, with part of the leg (and knee) turning in, and part turning out.
   D. Locked knees. Work to loosen the quadriceps by working on the attachments at both ends of these muscles.
   E. Flexed knees. In a few rare cases the knees are bent too far. Look for a shortened hamstrings.

BODY READING: Stand your client up again.

5. Ankles and Arches. Look at the horizontal axis passing through the two malleoli. Looking at how this line is tilted to one side or the other as well as toward the back or front, can help you see the stress in the foot. The weight of the foot should be evenly distributed along three arches:
   A. Lateral arch. When this arch is flat, the lateral peroneal muscles are overworking, and the medial supporters of the arch are weak. The adductors (gracilis) may also be stuck, preventing the lower medial muscles from contracting. Work along the fibula, which may be rotated forward, and with the adductors of the thigh.
   B. Medial arch. This arch may become overly developed as compensation for a weak lateral arch. You may also find tension underneath in the lateral plantar region.
   C. Transverse arch. When the instep is high and narrow, work not only to flatten it, by working directly on it from above, but also work with the medial plantar fascia underneath. On top the tibialis anterior and the peroneus tertius may also be involved.
   D. Notice that while the medial arch on one foot is collapsed, the medial arch on the other foot is overdeveloped. This may be part of a pattern which is seen as abduction of one thigh and adduction of the other, or elevation of one shoulder and depression of the other.


FINAL BODY READING AND FINE ENERGY Spend plenty of time helping your client feel the new directions of body organization. Alexander images, and Feldenkrais explorations are helpful. Use the above mentioned affirmations along with the body movements. Use Windows to the Sky and other points to lift energy after having worked on the lower half. Notice how the upper half of the body is lifting out of the lower half, although you have not worked on the upper half.

BODY AREA (upper half) Allow enough time to pass (two weeks minimum) for the body to begin to find a new direction, for the changes to be assimilated. An exception: if a person is very unstable and has a tendency to easily fall back into a disorganized state. In this case it might be good to do 8 and 9 a few days apart, feting one half of the body on the other, then wait a few weeks for session 10.

1. Lateral Torso. Begin at gluteals and work up along the side of the body, as in the beginning of session 3. Use cross-handed strokes to connect the torso and pelvis. On one side, the quadratus lumborum may be more contracted than on the other. It may not be necessary to work both sides. But do not work all the way to the shoulder, before...
you have returned to other parts of the pelvis. Work a little on each side, as you work toward the extremities.

**BODY READING.** Stand your client up and share the results.

2. **Abdominus Rectus.** Rework attachments, beginning at pubis. Work upward in zigzags, then do attachments on the ribs.

3. **Diaphragm.** Try to reach the attachments. Give plenty of support on the inside of the ribs with the other hand. If you have any difficulty getting into the diaphragm, rework the psoas with both hands. Reach toward its origins, high on the lumbar spine. This will help release the diaphragm, as well as the dorsal spine.

**BODY READING: Observe.**

4. **Rhomboids.** While the client is sitting, work on the rhomboids and anterior cage simultaneously. The shoulders need to be anchored, the arms moving slightly, and the inhalation full. Pull down in the back with one hand and lift in the front with the other.

5. **Arms.** Notice the rotation of the arms and consider whether to focus on lateral or medial rotation, and work under the arm or on the shoulder blade. Also, look at whether the arm is chronically flexed at the elbow. Work deep on the attachments of the biceps. Or if there is hyperextension, on the triceps at the elbow. It is important to connect and coordinate the space between the insertion of the triceps and the mid-thoracic area. There needs to be enough distance for the elbow to move forward, while the shoulder stays anchored by the rhomboids and pectoralis minor, and notice that the forward position of the arm is not always caused by the shoulder (pectoralis major) but may involve excessive pronation of the forearm. Go to the attachments of the pronators. Check out supination as well.

6. **Subscapularis.** Perhaps during the third session you were not able to reach very far under the shoulder blade in trying to contact the subscapularis. Now it should be much more available. Be sure your model is aware of how to control the position of the shoulders, while the arms move up and down and are rotated.

**BODY READING:** Again share with your model.

7. **Shoulder.** When the pectoralis minor is overcontracted, you may need to work both the origin and insertion. Notice that this is often needed on only one side. When working on the top of the shoulder (supraspinatus, trapezius, levator scapula), be sure the shoulders are anchored, and that there is awareness of the distance between the shouldertips and the ears. Rotation of the head on a perpendicular axis through the neck can help with the reorganization of the shoulders. When the shoulders are elevated, work along the top and medial upper border of the shoulder blades. You will be cutting across the levator scapula and some fibers of the trapezius. Be sure your client remains straight, not tilting one shoulder down as you work. You may have to stand on the table and support your client’s torso with your knee. Also during your stroke the shoulder blades remain stable and the client explores movements with the arm and neck (chin is dropped). This is similar to work in session 3.

**BODY READING: Stand client up.**

8. **Neck and Mouth.** If the neck is still too far forward, now is the time to again work at the attachments of the sternocleidomastoid and inside the mouth on the tongue. Also the attachment of the capitis muscles, along the occiput, can be very important.

9. **Sacral Curl, Neck, And Back.** Usual strokes.
FINAL BODY READING AND FINE ENERGY

As in the last session, use movement awareness and affirmations together. Use grounding points after having worked on the upper half. Notice how breathing descends toward the knees although you have not worked on the lower half.

SESSION 10
(Fine Tuning the Whole Structure)

The final session begins at the feet and continues to the head. It is a very selective session. Do not overwork the structure. Give a minimal number of directions for change and let the individual find his or her own integration, over a period of weeks or months. Studying several possible types of structural patterns will help organize your strategies.

1. Left-right. Example: the tension shifts from one side of the body to the other; one ankle is collapsed; the opposite hip is too high; the other shoulder down and forward.

2. Front-back. Tension in the Achilles’ tendon shifts forward into locked knees; this shifts into a swayed back; again forward to the diaphragm; into the upper shoulder blades. Or in another case the tension is in the tibialis anterior and shifts to the hamstrings.

3. Inside-outside. Flat feet (outside tension) go to knock-knees (inside), to short waist (outside), to pinched diaphragm (inside), to shoulders forward (outside). Or high arches (tension inside) to abducted hips (outside), to diaphragm (inside), to shoulders outside.

4. Repeating. The tension in the ankles can be seen again in the belly, again in the throat.

5. Twisting. When one knee is bent more than the other, this difference is part of an unequal contraction in the ilopsoas and obliques, and can be seen in a twisted neck and head.

BODY AREAS

In following these patterns of tension, it is not necessarily the case that you will want to work directly on the line of tension which you have traced from one part of the body to another. The lines of tension show where a change is needed, but you may need to work at some distance from this line of tension. For example, if the tension of knock-knee-legs moves upward from the outer ankles toward the inner knee, you may not wish to do most of your work around the knees. It may be more important to work on the upper attachments of the adductors at the pubis (gracilis, pectineus, adductor brevis). These lines of tension are merely reference points which show where the imbalance makes itself evident, but the problem probably begins in the disorganization of tissue some distance from this point. Also when following a pattern, you may not need to work every part of the pattern. In the case of a tight diaphragm, which is part of a pattern with bow legs, you might work only on the legs and not directly touch the diaphragm, although you would be judging the effectiveness of your work by degree of opening you are able to achieve in the diaphragm. Use the principle: “Work where the symptom isn’t.”

FINAL BODY READING AND FINE ENERGY

Look at the “before session 1” and “after session 10” photographs. It is important that you point out the details of the changes. It is very difficult for clients to look objectively at themselves. Also point out that without any further work there will be many changes in the following months. Often there are more changes after, than during the process. Point out the areas that need more awareness and tailor a few exercises to fit these problems; run through them at least once with your client. If the client is interested in more sessions, but has already reached a saturation point, suggest a self-integrating period of a few months, before another session 10 (or advanced work, if you are qualified). Point out that if a stressful environment hasn’t been changed, that one may be more aware of the stress, and less likely to tolerate it. Once the body has been released and reorganized, it is, of course, possible to accumulate tension and to lose part of one’s balance, but emphasize that body mind also has a greater capacity to re-release and reorganize itself. Often, simply letting go of feelings and going through some movement awareness exercises is enough to bring one back to a fine balance. One important affirmation is to work with the feelings and idea of completion. Often we burden ourselves with the idea that we never finish with our problems. If we stay with the here and now it is possible to say, “I’m complete; I’m finished.” The fact that in the next moment we have different feelings need not take away from the completeness of the present moment. Have your model explore the feeling of being finished.

NOTE: God is used as a colloquial intervention and is not meant to offend anyone.
### Spinal Flexibility & Stretching Exercises

Helps to build strong muscles to support your neck and back. STRETCHING EXERCISES increase flexibility and movement of the joints of the body and spine. Do exercises 5 to 10 times, 3 times a week, and don’t do any that cause pain.

#### LYING

**Hands & Knees**
- Bend knees, lie on back, take a deep breath, place your hands on your thighs and relax.
- Tighten your stomach and buttocks. Press your lower back onto the floor. ACTION: Stretches and strengthens stomach and back muscles.
- Turn both knees to one side while rotating your head to the opposite side. ACTION: Stretches lower back, mid back, muscles, and joints.
- Pull both knees to your chest. ACTION: Stretches lower back, buttocks and abdominal muscles.
- Slowly raise hips upward. Keep a straight line from the knees to the shoulders. Do not arch your back. ACTION: Stretches buttocks and strengthens upper leg muscles.
- Keep your neck in a normal position. Push yourself up on your forearms. ACTION: Strengthens posterior back muscles, where normal low back curve is.

**Neck Flex**
- While on your hands and knees, keep your knees directly under your hips, your hands under your shoulders, and keep abdominal muscles firm. Keep your neck raised and in its normal position, that is, with your ears in line with your shoulders.
- Slowly drop head forward and you will feel the stretch of your neck muscles.
- Slowly turn your head from side to side. Feel the stretch of the muscles on the side of your neck. Do not strain.

**Neck Strength**
- Press head to one side. This is to stretch the muscles on the side of the neck. Do not strain.

#### PRONE

**Lie on your stomach, sit one leg off the floor, while keeping the knee flexed. ACTION: Stretches lower back, abdominal and leg muscles.**

**Slowly drop head forward. Keep your head parallel to the floor. ACTION: Stretches anterior leg muscles.**

**Slowly turn your head from side to side. ACTION: Stretches neck and shoulders, abdominal, and leg muscles.**

**Body Work**

#### Shiatsu Self Massage

The colored dots indicate the approximate positions of specific pressure points. Each color refers to the following meridians: Stomach (ST), Large Intestine (SI), Spleen (SP), Bladder (BL), Liver (LV), Kidney (KI), Heart (HT), and Pericardium (PC).

**Concentration**

**Decision Making**
- 1. Push against both hands. 2. Hold hands against chin and stroke downward.

**Clear Thinking**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Discrimination**
- 1. Push fingers of both hands. 2. Hold fingers.

**Creative Thinking**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Tolerance**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Fresh Energy**
- 1. Push fingers of both hands. 2. Hold fingers.

**Headaches**
- 1. Push against both hands. 2. Hold hands against chin and stroke downward.

**Friendship**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Memory**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Metabolism**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Vitality**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Circulation**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Creativity**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Concentration**

**Memory**
- 1. Press with both hands against forehead. 2. Hold forehead.

**Energy Flow**
- 1. Press with both hands against forehead. 2. Hold forehead.
Go to http://imune.name to learn and to get your course materials. You could get a Doctorate in Wellness and an international or accredited European professional qualification in neurophysiological bioresonance and biofeedback.

The Tassel is worth the Hassel. In a world so concerned of Wellness can be yours in just 12 months of Home Study, a simple thesis, a practicum and four days of monitored supervised contact.

Big Tobacco, Big Sugar, Big Pharma, Big Oil, and Big War Industry are exempt from lay and they kill and injure, maim and cripple in the name of profit. They seek to control and dominate medicine to further build their profits.

Their money controls governments, regulators, and the small minded media. The Ultra Rich Master Echelon Computer now sees and hears all the things we say, write, and do. Rights of privacy are gone worldwide. They have taken away our rights of free speech.

The Ultra Rich control the media and refuse to tell stories that expose or offend the Ultra Rich Power. They control every movie that gets distribution, every song that hits the radio, everything that is put on the world news. They use science and psychology to control and manipulate the minds of the masses.

But medicine is controlled by Universities that teach medicine. There is now one university starting to defend Natural Medicine. IMUNE has a new 12 month home study course that can be bought with Karma and you can learn how to do natural medicine and how to break free from the Ultra Rich control.

Well, the game of Reality Monopoly is still being played all over the world. One percent of the world’s population is winning and now controls over 80% of the wealth. The law allows the game to continue till we will see one winner and 6 billion plus losers.
AWARENESS

I am aware of:

A  My love for the environment
B  My love for God
C  My love for myself
D  My love for my neighbor

If No.:
1. Develop a daily plan to help you become more aware. Write it down and follow it.
2. Develop a personal affirmation and repeat it out-loud three times a day.

EMOTIONS

I can release and control positively:

A  My anger
B  My greed
C  Lust
D  My jealousy

If No.:
1. Write yourself a letter describing how these emotions dominate you and how you can positively change them.
2. Develop a personal affirmation and repeat it out-loud three times a day.

My thoughts are filled with:

A  Sadness
B  Worry
C  Fear
D  Anxiety

If yes:
1. Write yourself a letter describing how these emotions dominate your life and how your life would change without them.
2. Develop a personal affirmation and repeat it out-loud three times a day.

BAD ATTITUDE AND NEGATIVITY

My attitude is poor concerning:

A  My body (I drink, smoke, use drugs, over-eat, abuse my body and say I don’t care)
B  My relationship (I abuse relationships, and say I don’t care)
C  My business relationships (I break promses, I do not do the best I can, and say I don’t care)
D  Life in general (nothing really matters, why bother?)

If Yes:
1. Write an essay on why your body is a temple and why you should treasure your friends and family. How can you turn this around?
2. Develop a personal affirmation for positivity and repeat it out-loud three times a day.

JUDGMENTAL

My mind is balanced because:

A  I have a good sense of humor.
B  I am light-hearted about my life and my situations.
C  I do not maliciously make fun of others.
D  I am respectful and careful of others.
E  I am not preoccupied or obsessed by anything.

If No.:
1. Write yourself a letter describing how you act. Can you stop being so judgmental?
2. Develop a personal affirmation and repeat it out-loud three times a day.
MENTAL EVALUATION AND EXERCISE EVALUATION AND EXERCISE

RESPONSIBILITY

I have accepted responsibility for:

A My health
B The consequences of my actions
C The choices I have made in my life
D Changing the things in my life that need changing

If No:
1. Write a letter to yourself explaining why you have not accepted the responsibility.
2. Develop a personal affirmation to allow you to accept responsibility of your life and repeat it out-loud three times a day.

FORGIVENESS

I forgive myself for:

A Things I have done to others
B Things I have done to myself

I forgive others for:

A Things they have done to me
B Things they have done to others

If No:
1. Write I forgive ? 70 times for seven days.
2. Develop a personal affirmation to allow you to forgive and repeat it out-loud three times a day.
3. It is human to err and to forgive divine. This is our chance as humans to be divine.

DESIRE

I suffer because I desire the following things to be different:

A My body and/or mind

SPINAL IMPAIRMENT RATING

Whole Man

1. Vertebral Fractures: Bodies Involved % of Compression Impairment
   - a) compression: ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )
   - b) non-union ( ) ( ) ( ) ( )

2. Reduced Subluxations: (Designate Segments)
   - by Macnab’s Line (AP) ( ) ( ) ( ) ( ) ( ) ( ) ( )
   - by Macnab’s Line (Lat.) ( ) ( ) ( ) ( ) ( ) ( ) ( )
   - by Hadley’s curve (Oblique) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )

3. Clinically established disc derangement:
   - Diagnostic Test Pos/Neg Disc Residual(s)

4. Vertebral Ankylosis: (favorable) Vertebral Ankylosis: (unfavorable)
   - Cervical 1 2 3 4 5 6 7 1 2 3 4 5 6 7
   - Dorsal 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12
   - Lumbar 1 2 3 4 5

5. Ranges of Motion: (goniometric Measurements given in degrees)
   - Cervical Spine Patient Movement Normal Limitation From “0”
     - Flexion
     - Extension
     - Right Lat. Flexion
     - Left Lat. Flexion
     - Right Rotation
     - Left Rotation
     - Dorsolumbar Spine
     - Flexion
     - Extension
     - Right Lat. Flexion
Stress Reduction

Stress is the most incipient killer of people today. Stress is responsible for 70 to 80 percent of the disease in America. Stress reduction is a must in today's society for longevity, health and happiness. Below are some simple rules for fighting this unseen killer.

1. Stress awareness begins with recognition or awareness. Our stress inventory provides insight into the amount of stress in our lives. As we become aware of stress, we can begin to deal with it. The "ostrich" technique of stress reduction never works.

2. Humans resist change. Whether change occurs in the body, mind, social, spirit or environment, most humans will resist. To learn to relax, we must learn to breathe, our old habits of stress reaction and substitute more productive reactions such as clear thinking, calm headed and relaxed understanding. To change requires perseverance, positivity, proper goals and beneficial rewards. Whether changing eating habits, exercise routines, stress reactions or social skills, change requires work, but the rewards of a healthy body and mind for you and your family are worth it.

3. Stop addictive behavior. Whether it is coffee, soda, sugar, heroin, cocaine, alcohol, etc. an addiction is an addiction. Addiction to stimulants will always rob health and always cause disease. If you care for your children, you would fight to stop them from using heroin. But so often we let them indulge in potato chips, candy bars, tobacco, etc. The seeds of addictive behavior stem from "stimulation dependency" in our youth. If we are to truly conquer drugs, then we must stop addiction to stimulation or depression early in life. To stop addiction break it's bond as early as possible. Just say no, if you really care.

4. Relax after meals. Allow at least 30 minutes after a meal to relax with comfortable music (not hard rock and roll), good spiritual books (not tax literature), good conversation (not argumentation), or some other relaxing diversion. Do not lie down. Sitting, standing or a light walk is recommended. Let your body focus on digestion for the best effect.

5. Allow one to two hours for worry or think time per day. Make this a quality think time to completely analyze your problems and concerns. Any more than 2 hours a day and your mind will distort the problem and not produce a solution. Excessive worry will produce more problem and more worry until this violent spiral results in disease. Use your quality think time to develop quality solutions you can act on to really help you solve your problems and concerns.

6. Take 30 minutes a day for relaxed prayer and silent reflection. Pray for calmness, acceptance, relaxation, health, peace, stillness, etc. Save your active prayers for later. The ones concerning needs, others, etc. Let this still time be one for producing calmness. Wear comfortable clothing, find a quiet spot and let the family know the seriousness of this time. You need the family to help provide you with this setting. This teaches them independence and maturity. At first, it is this time that your family will try to demand your attention away from your relaxation and prayer back to their needs. If your children or your spouse is not mature enough to help you with your prayer time, then include them in it. Let the family pray together, share the peace, transcend the turmoil and abound in health. During this quiet time, relax tense muscles. Breathe deeply and slowly. Visualize God's love flowing from within, surrounding you and your family and filling the universe with respect and love. Feel the magic of life in yourself and others. Calm and relax your mind as you detach yourself from the turmoil of the day. Give the troubles to God and fill your heart with joy and laughter. Use this daily experience to foster your mind and body to the health within.

7. Make a joyous noise unto the lord. Sing, dance and share the joy of living as one of God's creatures.

8. Learn the rules of health.

Okay, So I'm Under Stress. What Can I Do About It?

Since the only way to fully eliminate stress is to die, we must all learn to live with and control the stress in our lives. You can eliminate stress or reduce its effects by:

2. Improving your nutrition. Fresh and raw foods (fruits and vegetables) at least twice a day.
3. Learning to relax and to interact more effectively with people.
4. Limit self talk to one hour a day.
5. Relax during and 45 minutes after a meal. Celebrate the meal with love and care.
6. Meditate or induce deep relaxation for 30 minutes (minimum) each day.
7. Keep a positive attitude as much as possible.
8. Be patient with life.
10. Use your negativity wisely. Let it motivate and stimulate you to be the best you can be. Turn negativity around.
11. Take life lightly, have fun with your life.
12. Let stress run through you, don't hold it or fight it excessively.
How To Interpret Your Scores On Individual Sections

General Feelings
10 - 20 = Low Stress
21 - 30 = Moderate Stress
31 - 40 = High Stress
41 - 50 = Very High Stress

Work/Performance
10 - 20 = Low Stress
21 - 30 = Moderate Stress
31 - 40 = High Stress
41 - 50 = Very High Stress

Physical Symptoms
20 - 34 = Low Stress
35 - 49 = Moderate Stress
50 - 64 = High Stress
65 - 80 = Very High Stress

Interpersonal Relations
10 - 20 = Low Stress
15 - 30 = Moderate Stress
31 - 40 = High Stress
41 - 50 = Very High Stress

Total average scores below 3 are okay, but you should strive to get yourself into the 2’s. Of course, there will be periods in your life when your score will climb temporarily because you run into stressful situations that are out of your control. In many cases you can learn new ways to deal with these stressful events so that the next time you are faced with one, you will react in a more relaxed fashion.

Be careful that you don’t overreact and create a stressful event out of scoring and interpreting these scales. At one time or another, all of us are bound to have some of the symptoms listed in the four categories above. However, every one of the items on these checklists is a sign of stress if you scored yourself 4 or higher. You will probably want to look at these items to see where you can begin to make changes.

How Stressed Are You? (Interpersonal Relations)
1. I startle easily when people come up on me.
2. Around people, I can’t speak correctly.
3. I can’t stand to be around a particular person (or group).
4. I can’t stand to be around people when they are emotional.
5. I can’t tell anyone how I feel.
6. I don’t feel anything.
7. I can’t laugh at myself.
8. Down deep, I’m not happy with my sex life.
9. I don’t trust anybody.
10. I need help (food or drink) to be social.

DETERMINING THE SOURCES OF STRESS IN YOUR LIFE

Stress that is not handled properly can affect you in many ways. It can impair your ability to function mentally at home and at work. You can experience a variety of physical symptoms that can range from headaches to gastrointestinal upsets. Everyone experiences the negative effects of stress at various points in their lives. The danger lies in chronic stress overload. When your body is constantly in the fight or flight mode, you are bound to blow a fuse at your body’s weakest point. For some people the end result is a serious mental or physical illness.

This survey is designed to help you determine:
1. Your general level of stress.
2. Your level of stress at work.
3. Your physical symptoms of stress.
4. Your level of stress in interpersonal situations.

Take a look at the checklists that follow to see how stressed you are.

How Stressed Are You?
Directions: Indicate how often your feelings agree with the statements below. Scoring for each item is based on the following scale:
1 = Never feel that way
2 = Seldom feel that way
3 = Sometimes feel that way
4 = Frequently feel that way
5 = Always feel that way
How Stressed Are You? (General Feelings)
1. I worry a lot.
2. I feel unhappy.
3. All kinds of worrisome thoughts run through my mind.
4. There are times when I feel like crying for no reason.
5. I don’t know what’s the matter with me. I’m so irritable.
6. I have lost my ability just to sit around and do nothing.
7. I feel like I’m living inside a pressure cooker and about to explode.
8. Lately I’m bored with my life, job, friends and even my loved ones.
9. Deep inside, I’m dissatisfied and I don’t know why.
10. I forget things.

Total Score =

How Stressed Are You? (Work Performance)
1. I have trouble concentrating on my work.
2. It takes me forever to make decisions.
3. I can’t seem to stick to a job.
4. From the time I get there until I leave, I’m plain fidgety.
5. I overreact to things at work.
6. I let minor things get to me.
7. I procrastinate.
8. I can’t seem to get organized.
9. I’m unclear about my role at work.
10. I do a lot of paper shuffling.

Total Score =

How Stressed Are you? (Physical Symptoms)
1. My heart races or pounds.
2. I have trouble catching my breath.
3. I get diarrhea.
4. I have headaches.
5. I have to urinate frequently.
6. I get dizzy for no reason.
7. I spend my nights awake, or it takes forever to fall asleep.
8. I’m tired.
9. My throat and/or mouth is often dry.
10. My stomach is tense.
11. I have no energy.
12. I’m chilly.
13. My neck (or shoulders, eye, chest, lower back, throat, hands) is sore, stiff or painful.
14. Lately I seem to have one bug or cold after another.
15. In the afternoon I run out of steam.
16. My posture is terrible.

Total Score =

BASIC EXAMINATION FINDINGS: Per Main Complaint Area (s)
1) Observation: The patient is a year old (W)/(B)/(O)/(M)
(F) who is of (slight)/(average)/(heavy) stature, standing ‘ ”
and weighing lbs. with a blood pressure of / showing
(poor)/(fair)/(good)/(excellent) posture and (a normal)/(an
abnormal) gait. When asked to point to the center of maximum
discomfort the patient indicated the region (s). There appeared to be
(no)/(some)/(marked) asymmetry of the (spinal) - (pelvic) - (upper) -
(lower) - (trunk) - (extremities) region (s) -
(area(s) showing: (enlargement)/(swelling) of the
prominence of the .
flattening of the .
elevation of the .
depression of the end of the .
There (was) (was no) discoloration noted of the area (s). The
cervical spine showed: (no)/(right)/(left) rotation and (no)/(right)/(left)
leaning with (a) (an)/(increased)/(decreased)/(normalappearing) lordosis.
The dorsal spine showed: (no)/(right)/(left) rotation and (no)/(right)
Cranial-Sacro

Vegetables, juices, and fiber are best. Seed foods, such as legumes, nuts, rice, and grains, are rich in anticancer chemicals. Fresh and raw: plenty of foods and cholesterol-rich foods, red meat, rich sauce.

Foods as Medicine and Prevention

Appendicitis
Best: Use high-fiber foods like wheat bran that keep the stool soft and bulky. A British medical survey tagged peas, cabbage, cauliflower, green beans, brussels sprouts, and tomatoes as anti-appendicitis foods. Use vermiculge for a three-week period every year to clean out parasites.

Avoid: animal fat, low-fiber processed foods, sugar, and popcorn.

Arthritis
Rheumatoid: seafood high in omega-3 fatty acids such as salmon, sardines, lake trout, and mackerel may prevent or relieve the pain and swelling. Fish oils dramatically prevent lupus in animals. Use Lipid Liquitrophic daily.

Osteo: dairy products, all allergy-causing foods.

Asthma
Coffee: a couple of strong cups can thwart an asthma attack. Also good bronchodilators - hot pungent foods such as chili peppers, garlic, onions, mustard, horseradish. Fish oils also dramatically relieve bronchial asthma.

Avoid: processed or fried foods and cholesterol-rich foods, red meat, rich sauce.

Cancer
For overall prevention: green leafy vegetables, with emphasis on these six - broccoli, spinach, cabbage, kale, brussels sprouts and leaf lettuce. Other high-fiber vegetables, fruits, grains, and legumes. Also, radishes, chard, tomatoes, citrus fruits, dried fruits (apricots, prunes, raisins), strawberries and fish high in omega-3 fatty acids. human study showed a decrease in cancers in high-omega-3 fatty acid group. If you have ever smoked, load up on these foods. They may help prevent lung cancer years later.

Pancreatic: Citrus fruits, carrots.

Prostate: yellow and green vegetables. Carrots, tomatoes, cabbage, sunflower and pumpkin seeds, peas, broccoli, brussels sprouts, cauliflower, bee pollen. Reduce stress.

Stomach: raw carrots, coleslaw, lettuce, cabbage, tomatoes, corn, eggplant, milk, onion, sweet potatoes, squash.

Avoid: high-fat and meat diets (which predispose to cancer), sugar, processed foods, overeating. Oriental herb formulas with Depox and Depox Liquitrophic can enhance the results.

Cardiovascular System
For good cardiovascular nutrition, try fatty fish, garlic, ginger, melon, tree ear mushrooms, olive oil, onion, and kelp. Green tea, beer, wine, currants, blueberries, eggplant, and omega-3 fatty fish (salmon, sardines) will strengthen and protect arteries and capillaries from damage due to atherosclerosis or heart attack. Use Lipid Liquitrophic.

Avoid: fat, sugar, excess alcohol, stress, processed carbohydrates and excess cholesterol.

Cavities
Tea is nature’s best proved anti-cavity mouthwash. Other foods good at combatting cavity-producing bacteria: grape and black cherry juice, milk, coffee, cheese (aged cheddar cheese, bleu, Brie, Gouda, Monterey Jack, mozzarella, and Swiss). Use in a good cavity-fighting dental program. Avoid: sugar, rassis, processed carbohydrates.

Cholesterol

TO REDUCE BAD LDL (LOW-DENSITY LIPOPROTEIN) CHOLESTEROL
Best are oat bran and guar gum. Use Lipid Liquitrophic. Next, oatmeal and dried beans, including plain old baked beans. Soybeans are great for adults and kids with genetically-induced high cholesterol. Grapefruit - segments and membrane, not the juice - drives down cholesterol. Also fresh oranges, apples, yogurt, skim milk, carrots, garlic, onions, barley, ginger, eggplant, artichoke, unsripe plantain, shitake mushrooms, olive oil. Substitute seafood, including shellfish, for meat and chicken. All fruits high in pectin, which includes strawberries and bananas. Use unsaturated margarine oils instead of butter (see better butter recipe). Avoid: processed or fried foods and cholesterol-rich foods, red meat, rich sauce.

TO RAISE GOOD HDL (HIGH-DENSITY LIPOPROTEIN) CHOLESTEROL
Use strong, raw onions - at least half a medium onion a day - and garlic. Use Lipid Liquitrophic. Substitute olive oil for other vegetable oils or saturated fats. Alcoholic drinks, such as wine or spirits in moderation, one or two drinks a day - also boost HDL's. Radishes, horseradish and pepper help.

Added advice: cut back on total fat (especially saturated fats like animal-type fat, and coconut and palm oils). This enhances the effects of the above natural cholesterol-fighters. Don’t eat only cooked food; get fresh and raw foods into your diet.
### Constipation

Drink five eight-ounce glasses of good water a day. Use wheat bran, nature’s most potent bulk laxative. If that doesn’t work, add pure juice. Dried beans work wonders on some people. Most high-fiber fruits and vegetables, like carrots, cabbage, and apples, are bulk laxatives with about one quarter the effect of wheat bran. Soluble fiber foods, like oats and barley, can help. Also help: grapefruit parts and juice are helpful. Misconception: American-type rhubarb is not a true laxative. Orientaltype medicinal rhubarb is.

### Diabetes

Use foods that produce slow, steady increases in stead of rapid rises in blood sugar levels. Such foods testing best on the “glycemic index” (a measure of how quickly foods raise blood sugar) are, in order: peanuts, soybeans, lentils, kidney beans, black-eyed peas, milk, chickpeas, yogurt, ice cream, apples, and baked beans. Avoid: all processed sugars.

### Diverticular Disease

First, we encourage wheat bran. Also other foods high in fiber that give the stool bulk, such as legumes, oats, cabbage, carrots, and apples. If you already have the disease, check with a physician before loading up on high fiber.

- Avoid: strawberries, popcorn and other foods with small seeds and shells that could aggravate the condition.
- Use foods with solid A - D liquid bran. Solid grains, liquid fruit, vegetables in between.

### Diarrhea

Comfrey pepsin helps. Try yogurt with live cultures (especially if the diarrhea is caused by prescription antibiotics, such as penicillin). Also blueberries, black currents, honey 1/2 not for infants, however, because of a botulism danger). For youngsters, more acidophilus whole milk may be a cure. Too little fat in the children’s diets promotes diarrhea and other intestinal infections. Soy milk or soybeans also may help fight diarrhea-producing bacteria. Avoid: allergy-causing foods.

### Emphysema and Chronic Bronchitis

Chili peppers, pungent garlic, onions, mustard, horseradish - all kinds of hot, spicy foods. These help keep the lungs healthy by keeping mucus flowing and the bronchial tubes open. Drinking small amounts of milk has also been tied to lower rates of chronic bronchitis. Fresh, raw fruits and vegetables, and juice are helpful.

### Energy (Mental)

Caffinated drinks stimulate mental performance. Coffee is the most potent. Also tea, cola, cocoa. Also boosting mental-energy brain chemicals are high-protein, low fat foods such as shellfish, lean fish, non-fat milk, and yogurt. Include avocado, starchy beans, sprouts, and fruit juices.

- Avoid: white sugar. It makes blood sugar fluctuate too much.

### Food Work

Eat foods that produce a soft, bulky stool, reducing strain in bowel movements.

- Best: wheat bran. Other high-fiber fruits and vegetables. Radishes help liver involvement.

- Avoid: liver burdening foods, fried and fatty foods, and alcohol.

### High Blood Pressure

One tablespoon of cream of tartar in eight ounces of natural lime juice once or twice a day is an excellent formula. Mackerel - a couple of cans a week - can depress blood pressure. Also oat bran and high-fiber fruits and vegetables of all types help.

- Shown also to push down blood pressure: olive oil, garlic, seaweed (kelp), yogurt, green tea, legumes, and milk.

- Surprisingly, coffee drinking does not cause or aggravate high blood pressure except, apparently, among smokers.

- It is shown in clinical experiments that diets rich in natural potassium and low in sodium, such as fruits, vegetables and paprika, are as effective as most medications.

### Hypoglycemia

Tomatoes and potatoes can aggravate this condition, and thus should be avoided in extreme cases.

- Always avoid processed sugar. Eat complex carbohydrates, fruits and vegetables.

### Infections (General)

Yogurt and garlic are recognized antibiotic superstars. Also potent in thwarting viruses and bacteria are orange juice, apples tea, grape juice, apple juice, honey, wine, blueberries, cranberries, grapes, plums, raspberries, strawberries, peaches, and figs.

- Avoid: processed carbohydrates and sugars, stress, toxins, antibiotics.

### Insomnia

A sure bet: fruit, sugar or honey. Eat yogurt before bed.

- Misconception: milk does not put you to sleep; just the opposite, it wakes you up.

### Migraine Headache

Oils in fish (omega-3’s) can prevent the onset and severity of migraines in some cases. Use Lipid Liquitrophic and Headache formula from Dr. Recommends.

- Avoid: stimulants such as coffee, tea, and heavy foods before bed.

### Motion Sickness

Take ginger root, about half a teaspoon powdered in capsules, in tea or another beverage about a half hour before exposure to motion.

- Avoid: cold foods like ice cream, red wine, food with salicylates or other additives.

### Osteoporosis

Drinking milk when you are young makes stronger bones, less -susceptible to osteoporosis in later years. Use Osteo Liquitrophic. Green, leafy vegetables and sprouts are excellent; better if juiced.

- Avoid: all processed foods, fatty or fried foods, all processed sugars, allergy-causing foods.
Stroke
Cranial-Sacro-Chiropractic

TIPS ON FOOD AND EATING

1. Eat slowly in a relaxed atmosphere, this will aid digestion.
2. Eat small quantities of protein and vitamin-rich food instead of large helpings of over-refined food.
3. Eat a good breakfast. Include fruit juice or raw fruit, wheatgerm, and wholemeal bread.
4. Refrain from eating a large meal at the end of the day before retiring. You will sleep soundly if you avoid stimulating foods such as tea and coffee.
5. Try to cook sufficient food for one meal only, reheated food has little nutritive value.
6. The human body needs a certain amount of salt in order to function properly, but few of us are aware that most vegetables contain salt and that when cooked, they require little, if any, salt. There are varieties of salt available which have been extracted from vegetables, these are beneficial to our health.
7. Store food correctly in sealed containers. Keep perishable food in the refrigerator and non-perishable food in a dark, dry cupboard.
8. Use stainless steel or pyrex glass saucepans rather than aluminum ones, as the latter leaves traces of aluminum in the food.
9. Always rinse eating utensils with clear water after washing up with detergents.
10. Eat raw, fresh fruits and vegetables whenever possible. They are rich in vitamins and other nutrients.

Nelson Medicine
Our Contract for Health

There are many key philosophies behind Nelson medicine. The first is responsibility. The patient is encouraged to accept responsibility for their body and any disease or discomfort. The disease might have been caused by someone else or some outside imposition, but healing can only take place inside the body. Obsessing on someone else or blaming someone else is unproductive and sometimes damaging. Separation from a cause of disease is the responsibility of the diseased patient. If there is a cause of disease in your environment you can choose to change or reduce the cause, move to a new environment, or accept the conditions. Responsibility for healing is with the patient.

Many of the causes of disease that approach us are beneath our conscious awareness. Our unconscious is much more aware of the disease causing factors that come at us. Our unconscious reacts with subtle energetic changes in electrical bodies. The QXCI device is the first energetic medicine device to test reactions where the patient and doctor both do not know what is being tested. Thus the unconscious of the patient causes the reactions. The reactions are not picked by the computer but are picked by the unconscious of the patient. So we have a device that can make us aware of the unconscious. Some patients are more aware of their unconscious. These patients are likely to feel the QXCI device and recognize the reaction patterns more easily. Others will take more time, but after several visits they will become more aware of their unconscious and feel the effects more.

What is Health

Health is ease of flow.

Health is a flow of items into and out of the body. We intake nutrients, air, water, minerals, amino acids, fats, carbohydrates, thoughts, ideas, friendship, love, respect, mental stimulation, spiritual stimulation, and a host of other nutrients. We detox and excrete urine, breath exhale, stool, mucus, sweat, menses, bad feelings, fixations, addictions, Corruptions, intimations, fetish, manias, compulsions, spiritual doubts and a host of excrescences. Life is a cycle of intake, chew absorb or reject, assimilate, produce toxins, detox, and start anew. This is the need to survive. Add to this the need to reproduce and now enters our sexual needs. All of this results in a very complex flow of energies in and out, in cycles.

The levels of the person are the body, mind, spirit, social, and environmental. It is impossible to separate these or...
to know where one starts and another stops. Thus these parts cannot be reduced or analyzed separately. When there is ease of flow of things in these levels the person is in health. Health is ease of flow.

FLOW OF DISEASE

Disease starts when a stressor or intrusion causes a disruption in the flow. The ease is now dis-ease. Hans Selye outlined a medical system where disease comes into the body as some sort of stressor. This produces an ALARM reaction phase as that the body is trying to deal with the incoming stress. Thus the symptom is a sign of the ALARM reaction. If we fight the symptom not the cause we stop healing. So when our child is exposed to a stress (like a bacteria from another child) a symptom presents, such as a sore throat. The symptom is sign of a disease in flow. The immune system needs help. To fight the symptom is what allopathy does. The allopathic medical doctor fights the symptom by trying to block some other flow. He uses an anti-pyretic for fever, MAO inhibitors for depression, Serotonin uptake blockers for despair, calcium blockers for heart problems, etc.

So our child with the sore throat might have a toxin or nutritional deficiency as the deeper cause of the sore throat. The body is attempting to detox and stimulate the immune system with the symptom. The body is trying to cure itself and everything would be alright but via a unfortunate twist of fate, this child is taken to an allopath. He spots the symptom right off, and prescribes an antibiotic and an anti-inflammatory. The body’s own attempts for healing are thwarted. The disease is driven deeper. The symptom goes away but the cause lingers and another disease, more insidious than the first continues to develop.

As the stress continues the body acclimates and goes into the ADAPTATION phase. Here the symptom goes away from familiarization. But the disease progresses deeper. We now come to an ultra important conclusion that must change medicine forever. BEING SYMPTOM FREE IS NOT A SIGN OF HEALTH. In fact you can be symptom free and quite sick. Allopathy is for crisis intervention only.

Finally the system can help in finding ways to reduce symptoms thru other naturopathic means.

The causes of disease or possible stressors are:

<table>
<thead>
<tr>
<th>LACK OF AWARENESS</th>
<th>TOXICITY</th>
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<tr>
<td>STRESS</td>
<td>TRAUMA INJURY</td>
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<tr>
<td>HEREDITY</td>
<td>PATHOGENS</td>
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<tr>
<td>ALLERGY</td>
<td>DEFICIENCY OR EXCESS OF NUTRIENTS</td>
</tr>
<tr>
<td>MENTAL FACTORS</td>
<td>PERVERSE ENERGY</td>
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When these enter the body they disrupt the ease of flow. This produces the Alarm symptom. Then the body adapts, symptoms go away, but if the cause continues the disease continues. BEING SYMPTOM FREE IS NOT A SIGN OF HEALTH. The ability to restore or heal the body is based on how much life force the body has. This has an electrical component. The life force can be suppressed or obstructed. This is the SOC index in the QXCI software.

The QXCI device and Nelson medicine is based on a different treatment from allopathy. In Nelson medicine the flow of treatment is as follows:

1. Reduce or remove the cause of disease reduce the SOC index
2. Try to repair the damaged organs resulting from the disease
3. Unblock the blockages to flow of energy in the body. Chiropractic, Acupuncture, and other medical arts are dedicated to unblocking unbalances of flow.
4. Reduce the symptoms with natural methods and naturopathy
5. Deal with the constitutional make up or tendencies of the patient

The QXCI medical device is a Biofeedback / TENS device. Thus it is designed to stimulate conscious awareness of our unconscious processes. Our unconscious is aware of the initial interference in flow. And as such we all need to start our healing process with an interface with our unconscious awareness. This is the reason for the design of the QXCI.

Then with the TENS capacity of the QXCI device we can use a cybernetic link to deal with the causes of disease. The device can zap pathogens, make aware nutritional problems, stimulate repair of injury, stimulate detox, desensitize allergies, reduce stress, and more.

But the best use of the device is it’s use for unblocking the blocky in flow. The QXCI can detect faults in the acupuncture meridian flow and correct them. It can find faults in the energetic make up and correct them. It can find faults in the brain wave and correct them as well.

Finally the system can help in finding ways to reduce symptoms thru other naturopathic means.

So the primary goal of our system is to stimulate the body to heal itself. Symptom reduction is the third priority. We try to prevent the disease from slipping further. We want true healing and long term symptom reduction.

Some patients are more aware of their unconscious. These patients are likely to feel the QXCI device and recognize the reaction patterns more easily. Others will take more time, but after several visits they will become more aware of their unconscious and feel the effects more.
Perhaps you are intrigued by our new form of medicine, perhaps you are involved with this kind of path already. Let me now propose a contract. Let us agree that if you will acknowledge your own responsibility for your healing of your body, and make changes on your SOC index by reducing the blockages to disease, we at QX Ltd will make every effort to try to make our device as safe, subtle, and effective a healing device as possible.

If you and your therapist will agree on a series of visits and a path of recovery that realizes that you did not get sick in a day, but over a long period of time. Gentle long term healing and health can be yours as you and your unconscious merge to one force of healing working for your well-being.

If you will work on your health and be patient with your unconscious, we will work together for wellness.

Responsibility changes for the patient.

____________________________________________________________
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Patient_______________________  QXCI  Prof. Desire’ Dubounet

Professor Desiré Dubounet and her friends have spent over 35 million dollars to bring the world a professional and thorough course on Wellness, Naturopathy and Neuro-Electro-Physiology of Biofeedback as Bioresonance. She is such a humanitarian Angel, she lets you pay for the course videos, books and materials with Karma...

These are the TOP FIVE REASONS to get a Doctorate in Wellness PhD International Medical University degree at home.

1. Getting a degree means you will increase your earning potential. Studies have shown that at home study is just as good as attended classes.
2. Study and Complete Courses at Your Own Pace. Use this to maximize the learning.
3. Scheduling Convenience. Work when you are ready to work.
4. Teaching Faculty Who Actually Have Work Experience in Your Field of Study. Global faculty at IMUNE is with worldwide famous doctors.
5. Save Money on Travel, Parking, Childcare, and Books. You save money the world saves energy, this makes you and the world better.
6. Employer Support. Many employers offer tuition reimbursement for employees’ tuition associated with training in their fields. Employers also tend to encourage enrollment in online degree programs because they know employees will be able to go to school and still be able to be committed to their jobs. Don’t be afraid to ask your employer. Every company needs a wellness consultant.

Professor Desiré Dubounet the world’s most famous Naturopath and her friends have spent over 35 million dollars to bring the world a professional and thorough course on Wellness, Naturopathy and Neuro-Electro-Physiology of Biofeedback as Bioresonance. She is such a humanitarian Angel, she lets you pay for the course videos, books and materials with Karma... go to www.imune.name for more information.
Most of the Protestors in the World today are pointing out the Problems in the World. Few offer solutions. Mike Moore’s excellent movies like Sicko is an example...

Desiré

1. Defines the Problem
2. Thinks out a solution
3. Enacts a solution

...and because Desiré is Solution Driven, she represents the Greatest Threat to the Illuminati

THE ONE WHO BELIEVES

We must be able to detect the Geeks, Detect the Psychopaths, Detect the excessive Greedy, Detect the Prejudice, Detect the False Beliefs, and help these people to grow and to find their way. This book is just a message of how possibly to begin. Equal Economic Education is a good way to start.

Every movie I make, every musical piece I compose every song I sing, every word I write, every breath I take, is designed to help with this process. I hope that this book can touch your heart and help your mind, while calming your soul. This is the message of the Angel. To find out more go to the books, the journals, the movies, the music, and the lessons.

Only a true Angel can be too good to be true and still be true...