Section III

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Photographic Text-Atlas of Biodynamic Skills

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Chapter 13

Preliminary Instructions and First Contact

How to View the Photographs

The intention of the photographs in this section is to provide a sense of precision for where the practitioner's hands are placed for any given location, or window, on the client's body. Precision is very important because the hands gradually change position naturally with micro movement and even periodically lift off the body due to the constant shaping of the fluid body. Thus the starting point is essential and there are many photographs that zoom in on my hands, not only on a skeleton, but also on my wife Cathy.

These photos span a period starting in 1990 and extending through the summer of 2010. The early photographs were taken during a time in my career when I was teaching biomechanical and functional approaches to craniosacral therapy. It has only been in the last decade that I have transitioned into the wholistic biodynamic approach. These photographs represent the complete way I practice and teach.

It is vitally important that the practitioner's arms and elbows have props such as a pillow or bolster underneath them during the use of certain positions. At no time should the practitioner's arms be suspended without a prop underneath them. As I say in class, the practitioner might need to stay steady for twenty minutes in one hand position, and it is difficult to predict when such a long time might be needed. The practitioner needs to have maximum comfort and ease, not only in each hand position, but also in one's posture during the entire length of every session. A good way to know this is by paying attention to one's breathing—if the practitioner's breathing is in any way restricted, the practitioner must change her posture to free the breathing.

Body alignment when seated, standing, or leaning over the client requires support and grounding for the whole body of the practitioner. One of the

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essential components of biodynamic practice is to maintain regular and almost vigilant contact with conscious somatic awareness. This is the essence of interpersonal neurobiology and, consequently, the foundation for empathy and the formation of compassionate responses that include knowing when to move one's hands to another location on the client. It is not necessary to look like a meditation expert with an upright posture whenever seated with hands on the client. I find myself frequently flexing my body forward, rolling my head or simply increasing or decreasing the lordosis in my lower back during a session while in contact with the client. In other words, it is okay to shift one's posture while hands are in contact with the client. Postural shifting needs to be done slowly and with micro movement.

It is necessary in the linear format of this book to divide the body into segments in order to present all the photographs. The sequence of the photographs as they are presented here is not necessarily a prescription or a protocol for practice. In general, I start my sessions either at the feet or in the Pietà position and try to sense the whole fluid body of the client breathing with Primary Respiration. Later in a session or subsequent session, I may address individual areas of interest in a client's body from the perspective of relating to the whole. The breathing whole is the most fundamental aspect of biodynamic practice. In addition, I rarely work on a client's head in the first several sessions. Likewise, I rarely do more than five or six hand positions in any given session.

That is the way I practice. The basic rule of thumb in the manual therapeutic arts is that one should never be a clone of one's teacher, but rather embody the work and own the work in order to keep it alive and fresh. Imitation is said to be the sincerest form of flattery and necessary at the beginning of the learning process. Then each practitioner must own the work for oneself. My suggestions are guidelines rather than statutory regulations. Find what works and discard the rest.

These photos and descriptions must only be used by practitioners with the training necessary for safe and effective practice. In no way are they intended for a beginner to practice without proper training and supervision.

Some photos only have brief references in the text and others have more detailed descriptions. As a convenience I have provided a brief description of all the photographs in Chapter 20. Some of the photo descriptions have an introduction in the following chapters. In the text I refer to hand positions as *windows.* Sometimes the hand positions are described in numbered *steps* because they take place in a sequence. Some windows are described as *variations.* Occasionally I provide more detail on the *process* involved with a particular window. Finally, I occasionally make a *summary* statement at the end of a window description.

The ground of biodynamic practice is covered in the following instructions and they apply to every hand position in this book. Periodically I repeat these basic instructions in the *process* paragraphs in the descriptions.

Preliminary Instructions Prior to Contact

Still Posture—Orienting

1. Biodynamic practice begins with the practitioner sitting still and upright with the knees slightly below the hips, feet flat on the ground, and head, neck, and shoulders in alignment. The posture is not too rigid and not too loose. I like to imagine my umbilicus, heart, and third ventricle all lined up as I sit in preparation.
2. The practitioner begins attending to her respiratory diaphragm, gradually breathing into her entire soma from head to foot as if filling up and deflating a living skin balloon. Being aware of thinking and slowing down the stream of mental thoughts by shifting attention to breathing is essential. Whenever the wandering mind goes off (and it will), simply and gently bring attention back to breathing.

   The intention is to become self aware and to find the mind of equanimity and serenity and to establish a three-dimensional (3D) sense of the environment surrounding the practitioner's fluid body. This starts by sensing the total surface of the skin from the outside and the inside. The practitioner maintains an orientation to present time with the location of attention slowly switching between breathing, one's body, and its shape determined by the skin and the environment (the zones). See Chapter 5.

This begins the practitioner's slowing and stilling process with which the client resonates through the interpersonal brain and heart systems. It establishes an embodied sense of empathy, insight, and compassion.

I like to tell the client at the beginning of a session that I am going to take a couple of minutes to settle myself. I take that time to practice these first few steps of orienting, synchronizing, and attuning to establish attention in present time.

Three-Dimensional Fluid Body—Spinal Synchronization

1. The next phase is for the practitioner to sense and image her body as a three-dimensional (3D), transparent, living fluid continuum. First, she senses the total surface volume of the skin, which establishes an orientation to her fluid

body as a single shape. The fluid body can be sensed under the skin as an ocean within and all over the surface of the skin as if being contained in an egg-shaped vessel, just as it was in the embryo being surrounded by an amniotic sac and a chorionic sac.

2. For healing to happen, both the practitioner and the client symbolically return to the undifferentiated wholeness of the original fluid body in the early embryo. This state is available in present time through the courtesy of Primary Respiration. In other words, the historical and contemporary trauma story is replaced with the origin story of love via the perception of Primary Respiration (PR) and stillness in present time through the medium of the fluid body.
3. The practitioner then begins to sense PR moving up and down the middle of her spine like an accordion lengthening and shortening every fifty seconds. The spine is imaged as a tube suspended inside the 3D fluid body. Alternatively, the practitioner may sense Primary Respiration moving three dimensionally out and back from around the respiratory diaphragm.

Heart Mirror and Third Ventricle Synchronization

1. The practitioner then imagines the space of her hands, arms, and trunk as one big heart mirror rounded like a satellite dish and extending from side to side in the trunk and abdomen and from top to bottom from the nose down to the pubic bone.

   The intention is to perceive PR coming from the client with the sternum and heart area of the practitioner rather than with the hands initially. The practitioner is sitting at the side or feet of the client using the heart mirror.
2. PR moves beyond the surface of the skin and can be felt through attention on the heart, umbilicus, or third ventricle (3V). This means that the practitioner might also sense PR moving from her 3V out to the horizon and back and then between her heart and the heart of the client. In order to bring attention to the 3V, I recommend closing the eyes and rolling the eyes up and in toward the middle of the forehead for several seconds and then relaxing the eyes. This makes it a little easier to rest attention in the third ventricle.

This begins the process of becoming receptive and yielding to the flow of PR and stillness coming from the client and/or the horizon once contact is made. During a session, the practitioner toggles back and forth from her umbilicus to her heart to her third ventricle or to her spine in order to sense PR. Usually one or the other location is prominent in any given session so it is important to

practice with all four locations to locate the most readily available access point of PR at a given time. Every session is different.

It is vitally important to sit and sense the literal movement of the heart inside one's trunk as frequently as possible in a session and between sessions.

First Touch

1. The practitioner sits by the side of the client's body to practice the Pietà window (described below). Each hand position on the client is called a *window.* It is a window of observing the activity of the fluid body at its surface. There is no intention or effort to look below the surface of the skin for biodynamic practice. Many practitioners have previous training in models of work that look inside the client's body. That has its place once the fluid body has stabilized and begun to breathe with Primary Respiration and only in small increments. This means for only several seconds or minutes in the middle of a session and only if the practitioner knows how to balance the fluid body if it has withdrawn or become compressed as a result. Everything necessary for the practitioner to know and perceive floats to the surface under the guidance of PR.
2. The practitioner verbally asks permission to make contact after sensing PR in the client with the heart mirror mentioned above. This verbal permission is usually done at least once and always at the beginning of a session.
3. Upon contact, the practitioner immediately becomes receptive and reorients and resynchronizes with her own heart and fluid body. This means removing her attention from her hands for a brief period of time in order to establish the therapeutic relationship as a circulatory system or a two-person biology. This is the cycle of attunement. The client needs to orient to the practitioner's nervous and circulatory systems first.
4. To develop afferent or sensory touch in the hands, the practitioner periodically maintains attention at the back of her hands and body while in contact with the client. The practitioner's body and hands are buoyant and transparent like a cork floating in water.
5. The initial therapeutic exploration is to sense the entire fluid body of the client as a single whole continuum breathing at the rate of PR. This is done *after* the practitioner senses her own fluid body breathing with PR.

This gives the client the space to feel safety and trust in the relationship. All normal change from a biodynamic point of view is oriented to stillness and PR.

Biodynamic palpation involves sensing systemic shape changes in the client's fluid body rather than tissue changes, although they are related. The question to be explored is whether the client's fluid body has a stronger or more amplified ability to breathe with PR at the end of a session. Consequently, its capacity to breathe with PR must be assessed at the beginning if a session.

Pietà

1. The client is supine. The practitioner sits at the side of the client with the practitioner's body perpendicular to the client opposite the client's heart and diaphragm. One hand is placed palm up under the upper arm and shoulder of the client while the opposite hand is palm up under the leg of the client, approximately under the knee depending on the arm length of the practitioner, as if holding a bowl of living water. See Figures 13.1 and 13.2.

Figure 13.1. Pietà a

Figure 13.2. Pietà b

2. Practice a cycle of attunement, detailed below. The practitioner comes into relationship with the client with the heart dish, then her hands, then back to herself, synchronizing with PR while slowly moving her attention to and from the horizon. This establishes evenly suspended attention.
3. Practitioner images wholeness and eggness as a 3D reality in present time in and around her hands, her body, and that of the client. Primary Respiration is the living movement of wholeness.

Feet

1. The client is supine. The practitioner is sitting in alignment with the spinal midline of the client at the feet. This notochordal midline in the spine shortens during inhalation and lengthens during exhalation of PR as mentioned above

in the spinal accordion perception. The practitioner practices the heart mirror to sense being moved by PR from the client's midline.

2. Then the practitioner contacts the dorsum of the feet bilaterally, or alternatively holds the heels in the palms of her hands (Figure 13.3). She reorients, resynchronizes, and practices a cycle of attunement.

Figure 13.3. Feet

3. The practitioner periodically visualizes the whole transparent fluid body in the client when she brings her attention to her hands while synchronizing with PR. This visualizing practice can happen in each window, but only for several seconds. It is important to sense whether the fluid body of the client contracts or expands with the visualization. If it contracts then it is contraindicated to visualize the client in that way at that time. The practitioner can focus on visualizing her own fluid body or go to the horizon and back with PR.

This window helps to thaw out the fight-flight response that has imploded in the interosseous membrane between the tibia and fibula. It lowers autonomic tone.

Cycle of Attunement

1. Attunement, the movement of attention, is practiced in each window. A *cycle of attunement* is the basic unit of perceptual work in a biodynamic session. This bears repeating:

   The practitioner moves her attention toward her hands and away from her hands at the tempo of PR and then expands into the stillness from one of her fulcrums such as the umbilicus, heart, or third ventricle out to the horizon (zone D) and back at the tempo of PR. This cycle of attunement is repeated periodically during a session.

2. Gradually the practitioner's attention becomes suspended between a fulcrum, especially the third ventricle, and the horizon so that very little effort is needed to move attention between those locations.

Different tempos establish structure and function in the shape of the embryo. The tempo of PR is the essential catalytic factor that modifies and generates

order and organization throughout the life span. This means that it tempers the speed and heat generated by compressive and rapid cellular forces moving in the embryo. PR provides order and organization for growth and development. Such order and/or organization is oriented to the symmetry of the initial embryonic fulcrums that become the umbilicus, heart, and third ventricle. This is why the practitioner orients to such in herself during a session.

Practitioner attunement normalizes imprinting from the preverbal time of life. This also includes the infant-mother attachment process and consequently the adult therapeutic relationship. The goal is for the practitioner to build self-regulation and integration in herself, which creates resonance for the client's nervous system to orient to and thus may stabilize the client's nervous system.

Chapter 14

Lower Extremities

Lower Extremities Supine

1. The client is supine. Practitioner is seated at the end of the table. Starting with either foot, contact each foot of the client individually with index finger and thumb of both hands holding the cuboid-navicular bone relationship. The index fingers are on the top surface of the client's foot and thumbs are below (Figures 14.1 and 14.2). It has been said in osteopathy that the cuboid-navicular relationship is analogous to the sphenoid-occiput relationship and that there is a fascial connection between the two.

   The practitioner's hands look like they are playing a flute while on the client's foot. The middle fingers or index fingers are touching together on the dorsum of one of the client's feet.

   The precise contact with the pads of these fingers is one on top of the cuboid bone and the other on top of the navicular bone. The thumb tips are

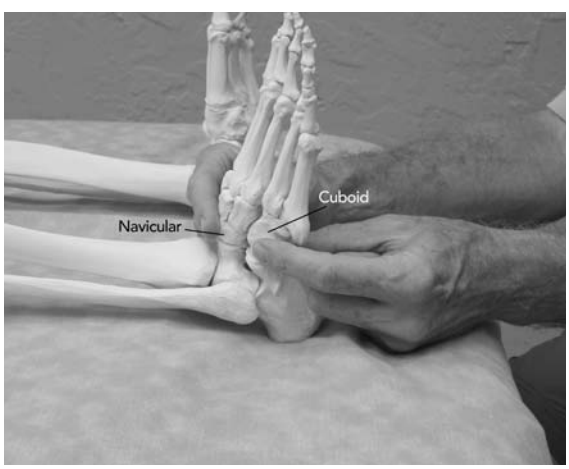

Figure 14.1. Cuboid-navicular a

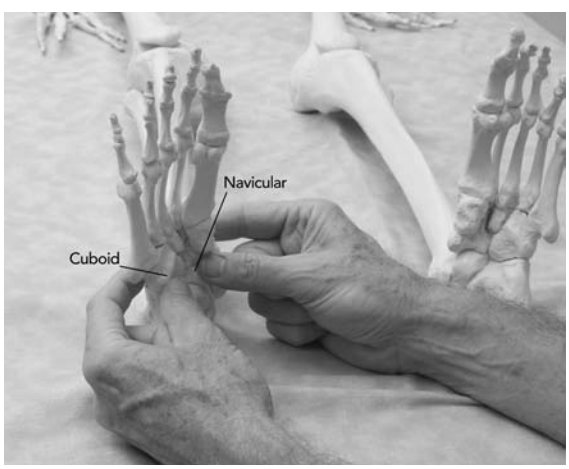

Figure 14.2. Cuboid-navicular b

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Figure 14.3. Cuboid-navicular c

touching below directly underneath the cuboid and navicular bones. See Figure 14.3.

The practitioner waits for Primary Respiration (PR) to breathe the bones until they remold or relax.

Each foot can be done or just one.

2. The next sequence for the lower extremity is also with the client supine. From the side of the table, the practitioner cradles the ankle with one hand in order to contact the medial and lateral malleoli. The other hand of the practitioner is cupping the posterior-inferior popliteal space of the knee. See Figures 14.4, 14.5, and 14.6.

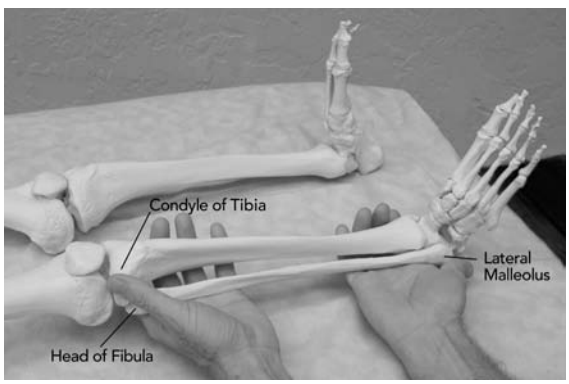

Figure 14.4. Legs supine a

Figure 14.5. Legs supine b

Figure 14.6. Legs supine c

Depending on the size of the practitioner's hands, the hand under the knee can be in contact with the head of the fibula and part of the tibial plateau. This is a noncranium vault hold in order to sense PR breathing the lower extremity through the interosseous membrane.

It is here where imploded fight-flight energy can become imprinted. This is an excellent way to stabilize the ANS.

3. Once the practitioner senses PR in the lower extremity, she switches hands so the bottom hand moves from the ankle to the knee while the top hand moves to contact with the fifth lumbar vertebra (L5). L5 is the osseous fulcrum for the lower extremity. The practitioner waits to sense Primary Respiration breathing between her two hands. See Figures 14.7 and 14.8.

   Sometimes in a client with a lot of low back, pelvic, and/or extremity issues, the osseous fulcrum can shift higher up in the lumbars or lower down in the sacrum. The practitioner may need to shift her hands slightly to find the fulcrum location.

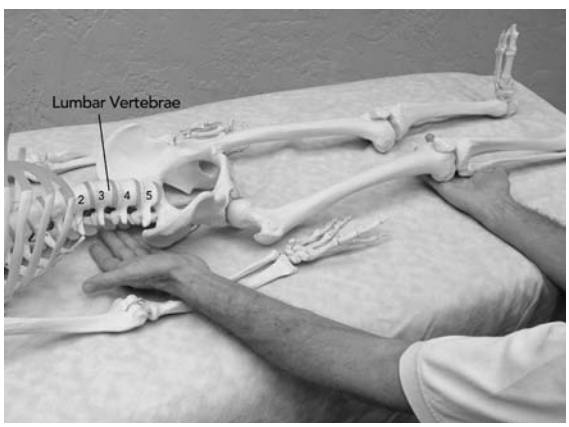

Figure 14.7. Legs supine d

Figure 14.8. Legs supine e

Lower Extremities in Sidelying

1. Practitioner starts with the cuboid-navicular window, as in the previous sequence, with the client supine (illustrated in Figures 14.1, 14.2, and 14.3). The subsequent hand positions are done with the client in sidelying.
2. The client is sidelying with the knees and feet stacked evenly upon each other and the knees slightly flexed.

   The practitioner makes contact with the head of the fibula and the lateral malleoli. The practitioner's index finger and thumb are together as if plucking a tissue out of a box of Kleenex. This style of contact is used with both hands on the proximal and distal ends of the fibula of the client. See Figures 14.9, 14.10, and 14.11.

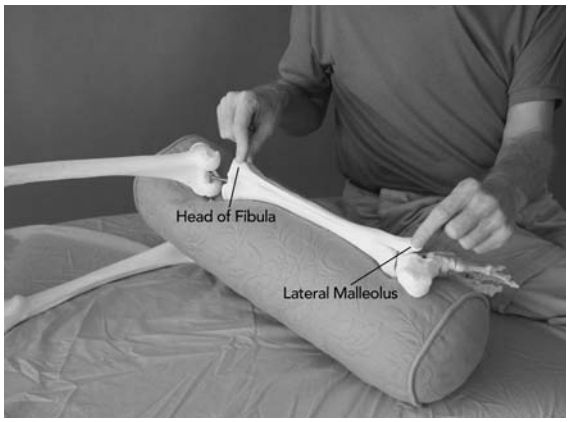

Figure 14.9. Lower extremity in sidelying a

Figure 14.10. Lower extremity in sidelying b

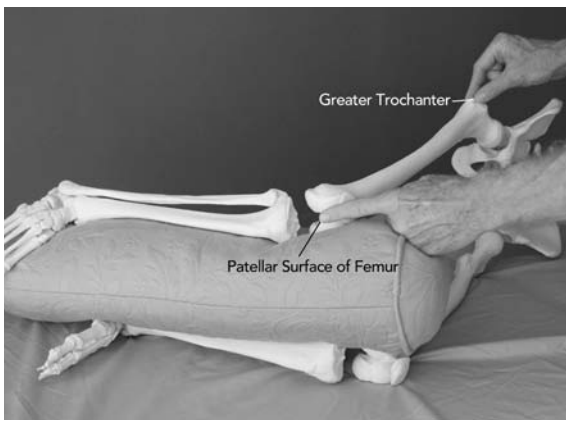

Figure 14.11. Lower extremity in sidelying c

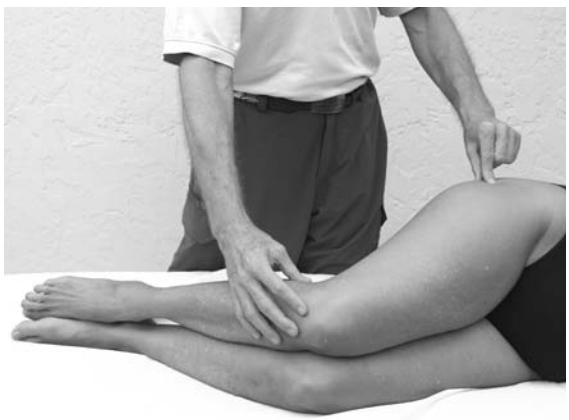

Figure 14.12. Lower extremity in sidelying d

The practitioner waits until PR begins to breathe the intraosseous fibula. Other motions especially lengthening may occur until the bone softens and becomes flexible.

3. The client is sidelying with the knees and feet stacked evenly upon each other and the knees slightly flexed.

   The practitioner makes contact with the greater trochanter and the space between the patella and tibial plateau. See Figure 14.12. The finger contact with the trochanter is the same as above in the tissue-plucking position; however, the other hand of the practitioner is simply using the pads of one or two fingers in the space between the patella and tibial plateau in order to be relatively close to the distal end of the femur.

   As above, the practitioner waits for the femur to begin breathing with PR.

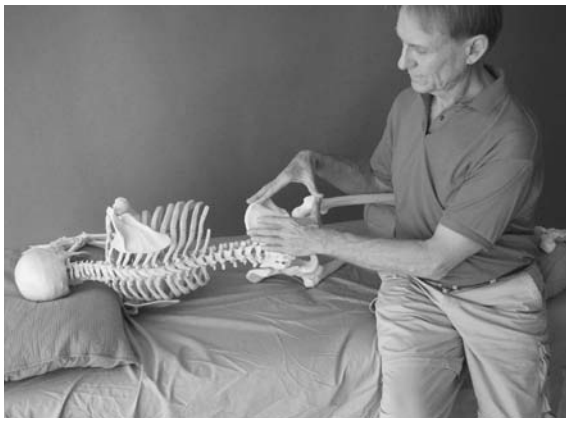

Figure 14.13. Lower extremity in sidelying e

Figure 14.14. Lower extremity in sidelying f

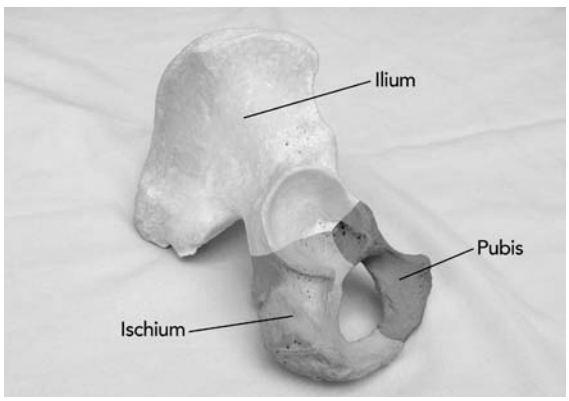

Figure 14.15. Embryological derivatives of the innominate bone

4. The client is sidelying with the knees and feet stacked evenly upon each other and the knees slightly flexed.

   The practitioner crosses her thumbs and imagines that her hands are like the wings of a bird. See Figures 14.13 and 14.14.

   The thumbs are placed over the greater trochanter of the client's hip. The practitioner's fingers spread out and span from the crest of the ilium anteriorly to the anterior superior iliac spine.

   PR will begin to breathe the three embryological derivatives of the innominate bones: the ischium, the ilium, and the pubic bone. Their fulcrum is in the acetabular fossa. See Figure 14.15. There is also a transverse midline between the two acetabular fossae that may manifest and begin to breathe with PR.

   Wait for nutation and counternutation of the innominates to normalize.

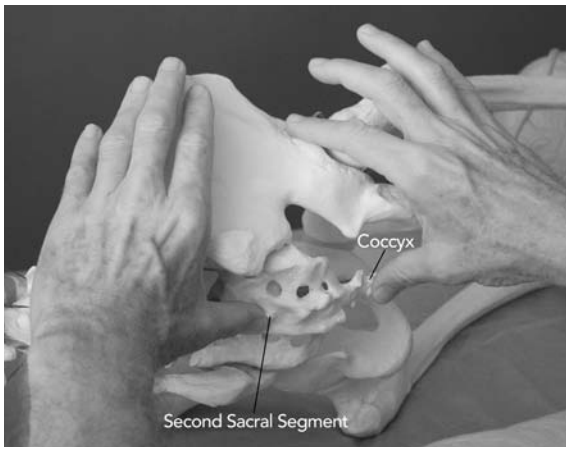

Figure 14.16. Lower extremity in sidelying g

Figure 14.17. Lower extremity in sidelying h

5. The client is sidelying with the knees and feet stacked evenly upon each other and the knees slightly flexed.

   The practitioner places the pad of one thumb on the sacral base and the pad of the opposite thumb around or near the coccyx of the client. See Figures 14.16 and 14.17.

   Wait for the sacrum to breathe with PR and normalize its motion with the spine and innominates.

Chapter 15

Abdomen and Pelvis

Developmental Movements of the Midgut

As the endoderm develops into a definitive tube by about the fourth week post-fertilization, it is divided into three distinct areas. The foregut is very large and wide and makes up all the structures or most of the face and neck because of the pharyngeal arches. This includes the esophagus, the stomach, the liver, the gall bladder, the lungs, and the pancreas. These are derived from the foregut, where the tube is the biggest and widest.

The midgut is attached to the yolk sac by means of the vitelline artery and vein. The mesenteries, the small intestine, and large intestine derive from the midgut in relationship to a substantial shaping process oriented to the superior mesenteric artery and the yolk sac.

The hindgut is slow growing and consists of the urogenital system and those respective organs. The hindgut is attached to the bony pelvis and as such is anchored to the sacrum. Consequently, both the foregut and hindgut have a hard covering around them, so to speak. That is the facial bones and pelvic bones.

For the sake of this exploration, the practitioner first must differentiate between metabolic movements involving the slow tempo of Primary Respiration (PR), then if possible the physiological and cardiovascular movements coming from the tempos in the Mid Tide, and finally the motility from the final adult form of the organ. Motility, which is a faster tempo, describes the motion present in an organ as it is held in its fascial container in relationship to adjacent structures.

1. The client is supine. Figure 15.1 shows the geography of the abdomen. It is not necessary to have skin-to-skin contact with the client by the practitioner's hands. I recommend that the practitioner sit at the side of the table with proper support for the arms and elbows. In this way, the hands are placed

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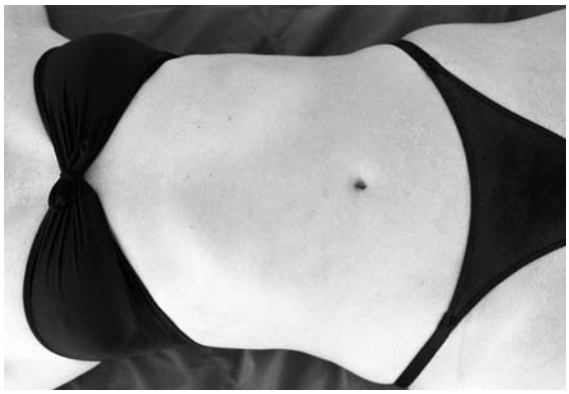

Figure 15.1. Umbilicus a

Figure 15.2. Umbilicus b

palm down above and below the umbilicus of the client, but not over the top of the client's umbilicus, as in Figure 15.2.

The first exploration is tuning in to the superior mesenteric artery. This artery originally was directly posterior to the umbilicus and it grows from posterior to anterior toward the umbilicus to innervate the intestines. Consequently, the superior mesenteric artery could be considered a horizontal midline for the development of the midgut.

The developing intestines at four weeks postfertilization begin to herniate out of the umbilicus and into the yolk sac. This is a posterior-to-anterior movement through the fulcrum of the umbilicus and caused by a differential in the coelomic space available, which is next to none in the embryo, in order to accommodate the fast-growing intestines. Consequently, they must grow out of the body initially.

In order to grow out, the intestines do it in a spiral motion following the growth of the superior mesenteric artery. This is a 90-degree counterclockwise motion around the umbilicus.

2. Next, there is a three-dimensional expansion of the intestines in all directions. This is related to a dilation field.
3. Following that, there is a retraction of the intestines toward the spine as more space becomes available in the coelomic cavity or core of the developing embryo. At this point in development, consider that the coelomic cavity is expanding and there are significant growth movements going inferiorly toward the hindgut and superiorly toward the brain. These growth movements and space are pulling the intestines back into place within the coelomic cavity. The practitioner needs to think and perceive three dimensionally.

   As the intestines retract toward the posterior abdominal wall, they do so in a continuing spiral which is a 180-degree counterclockwise motion.

This spiral motion is a result of the movement of the blood in the superior mesenteric artery. Consequently, it is important to stay attuned to this artery when working around the umbilicus.

4. Next, the intestines start to develop shearing motions three dimensionally because of the differential sizes of the small and large intestines. There may also be transverse motions and other vectors because of the rapid growth and compression of the intestines into the abdominal space. In other words, the intestines are getting compacted.

   Consequently, there will also be a strong sense of compression at this phase of development. This compression can be very similar and actually mimic the compression from the first week postfertilization.

5. During the next phase, there will be a three-dimensional expansion with a particular emphasis on an inferior vector funneling down toward the anus and coccyx. This, of course, will be the descending colon and rectum. This expansion downward toward the coccyx is done in conjunction with the growth of the genitals and the kidney-bladder system.

   At about eleven weeks, there will be a fusion of the mesenteries up against the posterior abdominal wall with condensation of the intestines as the embryo transitions into the fetal period of life. The attachment of the mesentery to the posterior abdominal wall is on a line from the ileocecal valve to the duojejunal junction. This is a diagonal line and the abdominal aorta lies right on top of it.

6. Finally, there is a very significant channel of potency moving in and out of the umbilicus. It is differentiated into both vitelline circulation coming from the yolk sac and placental circulation coming from the connecting stalk that contains the umbilical veins and arteries. Remember that Primary Respiration (PR) as it comes through the umbilical cord is associated with the quality of loving kindness.

Process: Periodically in these steps the practitioner may imagine a yolk sac as a dome over the entire ventral (front) surface of the client's body. Likewise, the amniotic sac can be imaged as a fluid-filled dome under the entire dorsal (back) surface of the client's body. Anytime the practitioner visualizes a fluid sphere around or in the client, she must be able to distinguish if the fluid body of the client expands or contracts as a reaction to the visualization. If the fluid body contracts then the visualization is contraindicated.

Summary: It must be remembered that the development of the gut tube is intimately related to the development of the cardiovascular system. Embryonic blood is produced in the yolk sac and circulates back into the embryo via the

vitelline artery and vein. The celiac artery, the superior mesenteric artery, and inferior mesenteric artery are the three major fulcrums for the midgut and lower part of the foregut and upper part of the hindgut.

First Gaze—Umbilical Cord Supine

This exploration takes into account a sequence of events spanning fetal placental development all the way up to a sequence of events immediately following birth. In general, it comes from a set of skills related to birth ignition. Birth ignition takes into account a sequence of events as mentioned in my Volume Two, immediately after the infant's body is fully out of the birth canal and has taken its first breath. The optimal sequence is:

- The first skin-to-skin contact with the mother, usually on the mother's abdomen and chest, which is called sustained skin contact (SSC), necessary to establish thermal regulation (heat distribution) and ignite the capacities of digestion, absorption, and elimination from breastfeeding
- The infant crawling up the mother's abdomen and chest to begin breastfeeding
- The first gaze of the mother at her newborn on her breast
- The first gaze of the infant at her mother's eyes from the position of the mother's breast (This mutual gazing, in conjunction with breastfeeding and sustained skin contact, allows unconditional love to be given, received, and embodied by the infant.)
- Cutting the umbilical cord
- The birth and death of the placenta

Window: This window involves the client being in supine position with a bolster under his knees. The practitioner will also need to have props for the elbows and arms, because she will place both hands palm down on the client's abdomen. The practitioner's touch is very buoyant and focused on the backs of the hands.

The practitioner is sensing the client from the back of her hands, arms, and body. If at all possible, the practitioner's hands should be able to have skin-to-skin contact with the client's abdomen. It has been my experience that some clients are very uncomfortable having their abdomen touched. In some cases, I've actually placed a towel over the client's shirt for extra covering over the abdomen.

Permission for such skin-to-skin contact must be negotiated prior to making the contact itself. The client needs to be informed that skin-to-skin contact is preferable with this window before the session starts.

Process: The skill involved with this window has several extra elements associated with it. First, the practitioner considers her arms and hands to be the umbilical cord in the position shown in Figure 15.2. It is very helpful to develop a three-dimensional sense of the movement and activity of the practitioner's heart, including a pulsation down through the arms into the hands. Frequently, as the practitioner deepens into this skill, she will sense a pulsation where the hands are making contact with the client's abdomen. This indeed is the pulsation of the umbilical cord itself as two mutually interacting cardiovascular systems are speaking with each other heart to heart.

The next skill involves the practitioner visualizing herself as the mother of the client and the client as the placenta. In other words, she visualizes the entire body of the client as this gorgeous, pulsing, blood-filled, living placenta. Recent research in fetal placental development has shown that the human placenta has its own nervous system, endocrine system, immune system, and cardiovascular system. The placenta could almost be considered the fetal twin. It is 25 percent of the fetal-placental relationship by volume. This is a good reminder that the placenta should no longer be considered merely a filtration system. It is an active unique body and a vital part of our early somatic reality that dies at birth.

Periodically, in the cycle of attunement process, as the practitioner moves her attention out and back from the natural world, she will trade places with the client imaginally and become the placenta. Thus the client will then become the mother person. This role reversal is a critical part of this biodynamic skill and many others. The question becomes when is this window finished and how does the practitioner discern a change? When stillness permeates the room and the client's body or when Primary Respiration (PR) increases its potency or amplitude is when the practitioner can move on or finish the session.

Finally, the practitioner occasionally looks at the client's face and has a smile of loving kindness just as if the practitioner as mother was looking at her baby for the very first time after birth. This is called the first gaze. Likewise, when the practitioner places her hands on the client's abdomen, this can be equated with the first touch, as mentioned above. Together with the first breath, described in Volume Two, the first gaze and the first touch when coupled with PR are able to begin to normalize the harm of birth-related stress and trauma.

Umbilical Cord Prone

This particular window is designed to give the practitioner easy access to three biodynamic properties. The first is that of the fluid body. The second is that of the embryological derivatives of the midgut from the stomach to the distal end of the large intestine. Finally, the third part of this skill is balancing and restorative for the interrelationship of the respiratory diaphragm to the pelvic diaphragm.

Window: The client is in prone position, seen in Figure 15.3. If possible, the client's head needs to be supported by a face cradle inserted into the end of the treatment table. A bolster should be placed under the client's ankles. Some clients will not be able to lie prone on the table, especially during pregnancy; this position is contraindicated for these clients.

Figure 15.3. Umbilicus c

After orienting, synchronizing, and attuning, the practitioner observes the quality and three dimensionality of the client's secondary respiration. For example, when the client breathes in, does the movement of the respiratory diaphragm translate into movement of the sacrum? The next step is to negotiate permission to make contact. *Both of the practitioner's hands are palm up and go directly underneath the client's abdomen directly around the umbilicus.* The hands can cross the midline with one hand above the umbilicus and the other hand below the umbilicus. Every attempt should be made to avoid contact with the pubic symphysis and/or the xyphoid process and medial aspect of the costal arch. In other words, do not allow the hands to cover the umbilicus of the client. If at all possible, the practitioner's hands should be able to have skin-to-skin contact with the client's abdomen. The client needs to be informed that skin-to-skin contact is preferable with this window before the session begins.

Process: Now the practitioner can reorient, resynchronize, and reattune. When the practitioner attends to her hands, it is for the purpose of exploring the above intentions. The first intention is to sense the fluid body breathing three dimensionally with PR. The second intention is to notice any of the developmental movements of the midgut, discussed at the beginning of this chapter.

Summary: This skill gives the practitioner the ability to observe a new state of balance between the respiratory diaphragm and the pelvic diaphragm. These two diaphragms are designed to move reciprocally. They are interconnected via several layers of fascia. Typically, the practitioner only has to observe the movement and activity of the client's respiration because it is the strongest sensation

and movement that the hands can feel in this location. Consequently, just the hand position itself is an invitation for these two diaphragms to balance themselves together. Gradually, the practitioner will be able to sense how the client's breathing moves down into the pelvis and there will be an ignition as both diaphragms synchronize their activity.

Many clients have had surgeries affecting their pelvic floor organs, such as hysterectomies, prostatectomies, or colon resectioning. All such surgical interventions on the pelvic floor and the midgut will create adhesions in the fascial and diaphragmatic system, translating into a loss of motion and function. Such losses can also occur from food allergies and inflammatory conditions in the gut, as discussed in Chapters 1 through 4. In these cases, coming into relationship with the sacrum, as well as more specific windows around the respiratory diaphragm, will be invaluable.

Primitive Streak—Sacrum Supine

Window: Figure 15.4 shows the basic geography of the sacrum while the client is prone. Figure 15.5 shows how to palpate the sacrum with the client prone. If the new practitioner is not familiar with the sacrum, I recommend beginning to palpate it with the client prone.

Practitioner is seated perpendicular to the client. The client is supine. One hand is contacting the sacral base and the spinous processes of the fourth and fifth lumbar vertebrae (L4–L5), as shown in Figures 15.6 and 15.7. The third finger (or longest finger or most comfortable finger) of the other hand contacts the coccyx gently and then relaxes slightly off of the coccyx. The practitioner *does not lift* the sacrum. She approaches from the side under the client's leg by the gluteal fold with the bottom hand and above the crest of the ilium with the other hand, as shown in Figure 15.8. She then reorients, resynchronizes, and completes a cycle of attunement.

The practitioner may sense the space all around and in the sacrum breathe and come alive with PR, like a flower opening and closing. Other possibilities include sensing a longitudinal fluctuation of the fluid body like an electric current going up to the client's head and the movement of the neural tube itself. (The longitudinal fluctuation is discussed at length at the end of this chapter.) It is important for the practitioner to stay three-dimensional (3D). The practitioner then completes several cycles of attunement.

Summary: The primitive streak is crucial for embodiment, for creation of the whole pelvis, and for generation of the heart. It induces cells to form the cardiovascular and musculoskeletal systems. It initiates the formation of the

Figure 15.4. Sacrum a

Figure 15.5. Sacrum b

Figure 15.6. Sacrum c

Figure 15.7. Sacrum d

Figure 15.8. Sacrum e

notochord, which is related to the spine and cranial base.

This window also helps to normalize the autonomic nervous system (ANS) of the client. This means that the ANS needs to have a relative amount of disengagement from high or low tone in order for PR to express its healing priorities and allow the client to become conscious of its activity and subtlety. This event was called "idling" by Dr. Sutherland. The ANS will idle and PR will move the fluid body into deeper balance. The most important instruction for the practitioner is to wait patiently.

Liver

The liver is an extremely important organ in core regulation. As food breaks down in the intestines, it passes through the villi into the bloodstream. All of the digested and undigested food goes into the portal vein and is carried to the liver for processing. Embryologically, the liver forms the outer layer of the developing heart and itself begins as an engorgement of blood vessels. Treating the liver is a good way to explore the heart.

Figure15.9. Liver a

Figure 15.10. Liver b

Window: The client is supine and the practitioner's hands are surrounding the liver from the right side of the client, as shown in Figures 15.9, 15.10, and 15.11. Typically the left hand of the practitioner is under ribs 7–10 and the top hand is above the costal arch with the little finger and hypothenar eminence straddling the costal arch. It is important to have good support under the right arm and elbow in order to make buoyant contact with the client's rib cage.

Figure 15.11. Liver c

Process: The practitioner begins to ride the rise and fall of the client's rib cage as he is breathing. The hands simply are a cork floating on this movement.

Gradually, a deeper awareness of the liver rises to the surface above the diaphragmatic movement. The practitioner is listening for PR from the embryological vector of the liver's origin from the midgut, which would now be the juncture of approximately where the esophagus passes through the diaphragm.

The practitioner settles into a relationship with PR in the client's liver while practicing several cycles of attunement. The practitioner may encounter a very deep stillness in the liver and the possibility of this stillness expanding out to zone D.

Bladder

The bladder forms from the fourth fluid cavity in the embryo called the allantois. The other three cavities are yolk, amnion, and chorion. The allantois protrudes into the developing connecting stalk, soon to be the umbilical cord. Some embryologists say that the allantois induces the umbilical veins and arteries to form.

Figure 15.12. Bladder a (skeleton with labels)

Figure 15.13. Bladder b

Window: The client is supine. Sometimes it might help to ask the client to move his body a little closer to the edge of the table depending on the hand dominance of the practitioner. The practitioner sits on the edge of the table or stands and asks the client to point out the location of his pubic symphysis. Then the practitioner places the heel of her dominant or preferred hand on top of the pubic symphysis, with the fingers on the abdomen pointing toward the umbilicus, as shown in Figures 15.12 and 15.13.

The practitioner imagines the original allantois as a fluid-filled cavity (the bladder in this case) that comes up, around, and on top of the pubic symphysis. While attuning to PR in the bladder, the practitioner's hands have a tendency to rock forward in an arc and then back rhythmically with PR.

Once the practitioner is familiar with this hand position and the movement of the bladder with PR, she can sit at the side of the client in a chair and use the hypothenar eminence (base of the small finger) of her hand to contact the pubic symphysis. The thumb is pointing toward the umbilicus. This helps balance the support ligaments of the bladder that go up to the umbilicus.

Alternatively, the opposite hand can be placed over the costal arch (over the liver) in order to balance the bladder and liver together.

Summary: The bladder is the main support organ of the pelvic floor, with very strong attachments to the posterior border of the pubic symphysis. The prostate, uterus, and cervix are suspended from the bladder and the sacrum. This is a very important organ that facilitates core regulation in the hindgut or pelvic floor.

Small Intestine

The small intestine develops in the embryo by spiraling out of the coelomic sac (abdominal area) along with the mesenteric artery. The small intestine and large intestine actually grow into the vitelline duct and yolk sac.

Window: The client is supine and, as with the bladder, both hands are placed immediately around the umbilicus with the fingers pointing toward the rib cage, as shown in Figure 15.14. Recall that PR moves in a spiral.

Figure 15.14. Small intestine

Process: Sometimes the hands of the practitioner may feel like they are being lifted off of the body and brought back down. Sometimes the hands simply stay in buoyant contact.

As with the bladder, once the practitioner is familiar with this movement, she may sit at the side and place the hands perpendicular to the body above and below the umbilicus.

Large Intestine

The large intestine has the same developmental vector as the small intestine. I like to differentiate these two structures in the adult because of the different challenges that infants, children, adolescents, and adults face with their small intestine and large intestine. This includes everything from gluten sensitivity to constipation and complex inflammatory processes, as discussed in Chapters 1 through 4.

Window: The client is supine and, just as was done with the bladder and small intestine, the practitioner sits on the edge of the table and places her hands as laterally as possible on the belly, equidistant from the umbilicus, as shown in Figure 15.15. Sitting on the right side of the client, the practitioner's left hand

Figure 15.15. Large intestine

will be over the ascending colon of the client. The ascending colon is on the surface of the abdomen.

Process: The basic movement is that of a spiral, as noted above for the small intestine when exploring with PR. The main challenge with this window is that it is difficult to do while sitting perpendicular to the client (at the side).

The practitioner should solicit verbally any signs or signals of discomfort that the client might be having.

Summary: When exploring with these viscera in a biodynamic session, only two organs should be explored during any one session.

The Pelvic and Respiratory Diaphragms

Window: Client is supine with the practitioner sitting at the client's pelvis.

Practitioner orients, synchronizes, and attunes. She places one hand under the coccyx and waits. She places the other hand under the respiratory diaphragm. She allows the two diaphragms to synchronize their motion with PR.

The practitioner places both hands under the respiratory diaphragm from the side and imagines there is no respiratory diaphragm present, only one fluid cavity (see Figures 15.16 and 15.17). This balances the heart, the abdomen, and the pelvic floor.

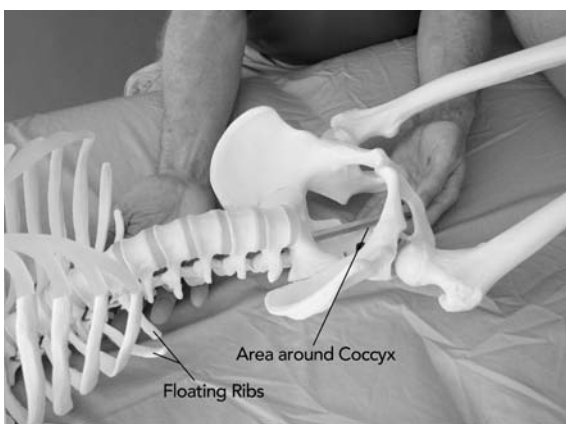

Figure 15.16. Diaphragms a

Figure 15.17. Diaphragms b

Kidneys Prone

Window: The client is prone, with head supported in a head rest if possible. The practitioner's hands are on the kidneys bilaterally, as shown in Figure 15.18. It is important to discover how the kidneys move with PR. The embryonic kidneys go all the way up to the neck and the adult kidneys expand and contract with PR on a vector toward the heart and away from the heart.

Figure 15.18. Kidneys

Hip Bones Supine

Window: Practitioner's hands are supporting the entire hip bone, as shown in Figure 15.19. The top hand has contact with the anterior superior iliac spine. The bottom hand has contact with the ischial tuberosity. The fingers do not need to be under the tuberosity, but merely touching it from the side.

Sometimes, the client needs to be asked to lift up the hip so the practitioner can make contact with the tuberosity underneath, as shown in Figure 15.20. Then instruct the client to relax the hip on top of the hand, as shown in Figure 15.21.

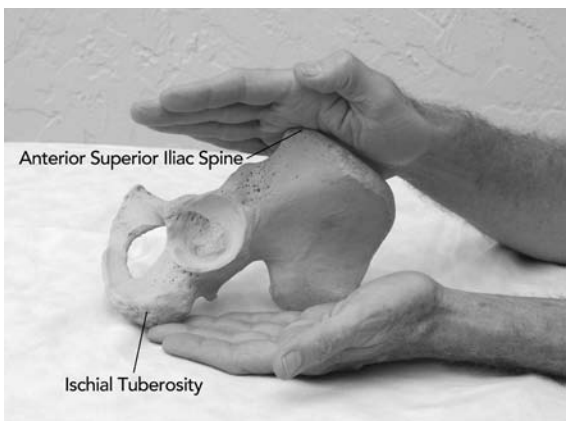

Figure 15.19. Hip bones supine a

Figure 15.20. Hip bones supine b

Figure 15.21. Hip bones supine c

The contact with the bottom hand is resting on the table. It is very important that the top hand be propped under the elbow with a pillow (just beyond the frame of Figures 15.20 and 15.21).

The practitioner's body is turned and looking diagonally toward the opposite leg and foot of the client.

Hip with Knees in Flexion

Window: The practitioner makes bilateral contact with both ischial tuberosities of the client, as shown in Figures 15.22, 15.23, and 14.24. The knees of the client need to be flexed.

The client's knees are flexed and together. The client needs to have the feet splayed out laterally in order to have the knees rest together. Sometimes if the practitioner has long enough arms, the client's legs can be cradled together with the practitioner using her shoulder and opposite arm for cradling the client's legs.

Summary: This is a wonderful way to help a pregnant woman increase the flexibility of her pelvis in preparation for birth. The practitioner is sensing the midline of the client's pelvis either through the vagina of a woman or the penis of a man breathing with Primary Respiration. This skill helps clarify the pelvic midline, especially for a woman who is pregnant (the baby becomes familiar with his or her escape route). For a man this can help the prostate breathe with Primary Respiration. As an alternative, the client can sit on the edge of

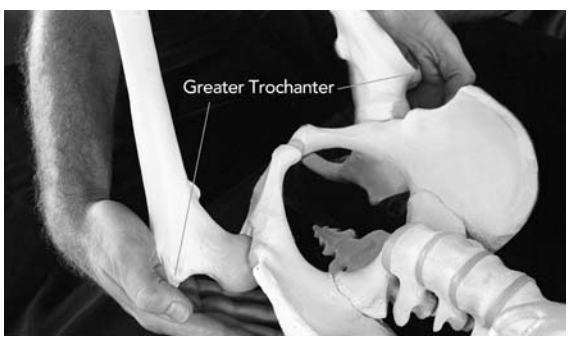

Figure 15.22. Hip in flexion a

Figure 15.23. Hip in flexion b

Figure 15.24. Hip in flexion c

the table and the practitioner can make bilateral contact with the client's ischial tuberosities from behind the client.

Coccyx

Window: The practitioner places the pad of one finger in proximity to the client's coccyx, similar to Figure 15.7 and Figure 15.8. Except here, the practitioner's free hand rests in her lap.

She senses any one of the following possibilities: PR, intraosseous sacral movement in PR, the longitudinal fluctuation of the fluid body, or the inherent motion of the neural tube.

This is where the primitive streak begins at the third week postfertilization. The longitudinal fluctuation of the fluid body is what initiates the primitive streak.

This position is also specific to the notochordal midline of the body and therefore essential to biodynamic practice. The midline here refers to the fluid midline of the longitudinal fluctuation and the notochord that results from the primitive streak activity. This is crucial for decompressing the central nervous system.

Longitudinal Fluctuation

It is highly recommended to have a thorough intake on the client, including any history of physical or sexual abuse. Health-related issues concerning the intestines and pelvic organs should be known as well as prescribed medications currently being taken. These preexisting conditions dampen or greatly reduce the longitudinal fluctuation (LF). The LF is the midline of the fluid body and therefore crucial to its rehabilitation. Traditionally the LF is considered to be associated with the ascent of the cerebrospinal fluid starting at the coccyx going through the core link (dura mater) and ending in the third ventricle. The descent of the fluctuating cerebrospinal fluid starts at the ethmoid bone and recedes back to the coccyx. This can be sensed when using the core link window.

Because of the high concentration of organic magnetic material in the dura mater, the cerebrospinal fluid is considered to have a bioelectric magnetic field associated with it. Numerous practitioners have experienced a second avenue of descent in the LF that goes out of the head much like a fountain and then cascades down and around the skin in an envelope 15–20 inches off the skin and finally reforming at the coccyx. Perhaps this is why Dr. Sutherland called it the "direct current." The rate of the LF is very precise at two and a half cycles per minute (2.5 CPM).

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Process: The client is supine and the practitioner is sitting at the client's side at an angle, facing the client's head and neck.

The practitioner settles into an awareness of her own pelvic floor and may even initiate a few Kegel exercises in herself. A Kegel is a slight tightening of the muscles of the pelvic floor as if holding back from urinating or defecating. Alternatively, the practitioner can breathe down between the umbilicus and pubic bone in order to soften the pelvic floor and create space between the pubic bone and coccyx from anterior to posterior and the two ischial tuberosities from lateral to medial. Either way, the intention is to initiate an awareness of the LF in the practitioner first.

Practitioner synchronizes her secondary and PR and waits for zone C or D to become still.

Practitioner may sense the receding of the LF in the middle of her fluid body.

Alternatively, the practitioner visualizes her own LF from the coccyx to the third ventricle and the return in zone B as a fountain that then reforms at the coccyx.

Practitioner negotiates permission to make contact with her index or middle finger of the hand closest to the client and makes contact with the space around the coccyx and S5, as shown in Figures 15.7 and 15.8. The finger touches the bone in that area. The other hand may contact the client's sacral base (but that may be too much depending on the client's history).

The practitioner reorients, resynchronizes, and reattunes to her fluid body and the horizon.

The practitioner synchronizes attention with the health and wholeness (Primary Respiration) of the client's fluid body.

The practitioner may ask the client to visualize the anatomical space in his body from the coccyx up through the spine all the way to the middle of the brain. Rather than ask the client to sense his zone B, ask the client to sense his skin and then either the outside surface of the skin or the inside surface. Each step of the way, the practitioner must remember that there are two possibilities for the return and both are equal in therapeutic value.

The practitioner waits to sense the 2.5 CPM movement of the LF in the client. It moves twelve seconds from the coccyx to the third ventricle, returns for twelve seconds as it goes straight back down from the ethmoid or out around zone B, and starts the cycle again up from the coccyx. During the return, the practitioner waits in zone B or her own fluid body core sensing the ebb and flow of her LF.

Upon sensing the LF, the practitioner moves her attention to the central stillness within the LF. Wait for the potency and permeation of the LF to clarify and or ignite its therapeutic intention three dimensionally.

Gradually, the practitioner moves her attention out to the horizon and synchronizes with the interchange between stillness and Primary Respiration.

An alternative way to complete the exploration of the LF is to switch the client into sidelying and sense the LF via the notochord window, discussed in the next chapter.

Summary: The presence of the LF is an important evaluation in the sense that it is frequently missing in the contemporary client due to traumatic stress, lifestyle, surgery, medication, and chronic inflammatory conditions (see Chapters 1 through 4). Just as the fluid body has a pulse associated with Primary Respiration, so too the LF is the midline pulse of the fluid body with a faster tempo. Its pulse also needs to be checked early in a session and then again at the end of a session, just as an acupuncturist checks a client's meridian pulses at the beginning and end of a session. When the LF pulse is weak or unavailable, the focus is upon the pulse of the whole three-dimensional fluid body and its ability to breathe and be augmented with Primary Respiration. Then the practitioner waits for the LF to ignite by periodically returning to it in subsequent sessions by establishing a resonance in the practitioner's body, as described above.

The pulse of the fourth ventricle via the traditional CV4 window may need to be taken around the occipitomastoid suture, which Dr. Becker claimed as the premier gateway to the fourth ventricle. The pulse of the third ventricle may also need to evaluated. Both of these pulses are discussed in Chapter 18. The lateral fluctuation of the fluids in the cranium is in direct relationship with the LF. Consequently, the lateral fluctuations are an important pulse. When the lateral fluctuation in the cranium is very strong it may indicate a weakness in the LF, which means that the lateral fluctuation is overcompensating. The restoration of a balanced LF and lateral fluctuation very much depends on the overall balance of these fluid body pulses just mentioned. Practically, I would invite the clinician to become familiar with the EV4 as I outline in both Chapters 16 and 18. The EV4 is an excellent way to begin rebalancing the LF and lateral fluctuations.

Although it may seem unconventional, numerous sex therapists recommend masturbation to orgasm for both men and women as a way to reinhabit or revitalize the pelvis and thus the LF from a biodynamic point of view. An inability to orgasm (preorgasmic), painful intercourse, and generalized pain in the pelvis may not only be related to early childhood abuse but directly related to the extinguishing of the LF. Such exploration must be done with a qualified

sex therapist or psychotherapist. It is unethical for a manual therapist to explore such issues with a client.

I will also recommend a series of colonic irrigation treatments for anyone who is chronically constipated. Constipation reduces the potency of the LF and the orgasm reflex in general. Gut and pelvic floor issues are epidemic in the culture and greatly reduce the functioning of the fluid body. Many pelvic issues cannot be cured by manual therapy alone but can be greatly helped with a sensitive and well-bounded practitioner. All work around the pelvis must be done with this understanding and a great sensibility while maintaining awareness of the whole with Primary Respiration.

Chapter 16

The Spine, Trunk, and Neck

The Snake

Window: The client is supine. The practitioner sits at the side of the client and places his hands under the thoracic spine between the scapulae or below them depending on the size of one's hands (see Figures 16.1 and 16.2). Both hands are palm up around the mid to lower thoracic spine of the client with the spinous processes of the client's vertebra in the fingers or in the palm of the practitioner, depending on the client's comfort.

Process: The practitioner comes into relationship with thoracic respiration in himself and then the client. He then drops his attention to the stillness and/or motion of the client's notochord, either two dimensionally on the long axis or three dimensionally.

The practitioner senses the serpentine movement of the notochord or the stillness of the notochord. Stillness is the deepest part of the embryonic core. The embryo orients its growth to the stillness, which is in the middle of the cellular structure of the notochord and throughout the body in various tissue

Figure 16.1. Snake a

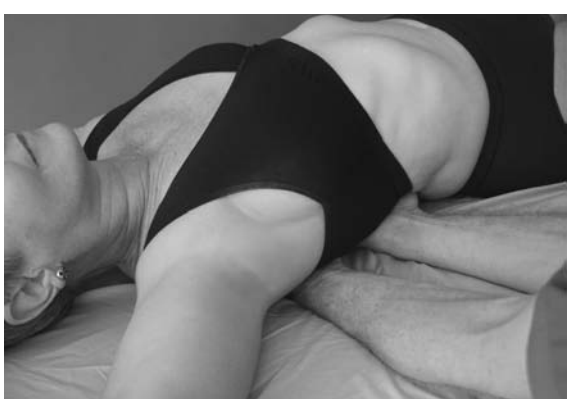

Figure 16.2. Snake b

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and vascular structures. There is a natural biological quietness throughout the human body essential to growth and development.

Summary: This process begins to normalize the ANS, breathing, and cardiovascular functions in the client. It is especially good for clients who spend a lot of time hunched over a computer.

Primordial Breath

Window: Practitioner's hands are together under the crura of the respiratory diaphragm, palm up, with one hand above T12 and one hand below. This part of the diaphragm starts inside the body wall in the embryo along with the floating ribs. It is important to take into consideration the floating ribs in the hand that is located superiorly. Figure 16.1 also illustrates the proximity of the hands, which are similar in placement as with the Snake.

Process: The practitioner senses the diaphragmatic breathing of the client in three phases:

- Beginning with the actual structures of the tissue and bones, the practitioner gets a sense of the motion present in the musculoskeletal system in that area.
- Then the practitioner moves deeper into sensing the physiology of the ANS within the diaphragm. How do the brain, heart, and lungs work together in relation to nerve impulses coming from the brain and heart and also the gut?
- Then the practitioner moves his attention to the whole three-dimensional fluid body of the client and lets go of the previous two sensibilities. The practitioner senses the primordial origin of the breathing function through an image. Is it a water creature or a land animal? The practitioner waits until an image arises in his mind's eye and then is finished.

Meanwhile, the practitioner is synchronizing Primary Respiration (PR) with his secondary respiration. It directly relates to the ignition process. It is vital that Primary and secondary respiration be synchronized.

Summary: This practice induces a deep stillness and opens the heart. It begins to allow the client to breathe with the natural world. By sensing the ancient function of breathing, the fluid body is able to reconnect with its origin, which is essential for a client to renew herself.

Lungs

Window: Figure 16.3 shows my hands bilaterally on the costal arch of the ribs. This is the way I like to sense Primary Respiration moving the lungs. Primary Respiration breathes the lungs toward its original point between the third and fifth cervical vertebra. This is where the lungs originated in the embryo. From the vantage point of the costal arch, I can sense Primary Respiration breathing the lungs back and forth from the lower cervical spine. I like to either stand for this hand position or sit on the edge of the treatment table.

Figure 16.3. Lungs

The Notochord

Window: The client is in a sidelying position, her head supported with a pillow. It does not matter whether the client is lying on her right or left side. It could be important to offer the client a choice as to which side she prefers to lie on.

The other important postural component of this exploration is that the practitioner's arms and shoulders will be slightly lower or slightly beneath the plane of the top of the treatment table. When I practice this in my office, I frequently sit on a meditation cushion on the floor so that my hands can easily contact the top and bottom of the notochord without any strain in the wrist. This will take some time to set up the right position for each individual practitioner, because the critical component is strain in the wrist and shoulder-neck tension in the practitioner. This must be avoided.

Figure 16.4. Notochord a

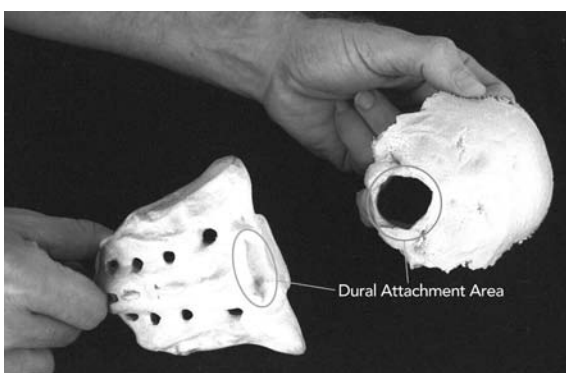

Figure 16.5. Notochord b

Process: The practitioner establishes the intersubjective field of orienting, synchronizing, and attuning. Relating with the notochord requires the practitioner to refine his skills of apprehending the inside presence of PR in his own fluid body as well as that of the client. To do this, the simplest area of concentration is on the spine. Once the practitioner has established a sense and shape or image of three-dimensional buoyancy in his own fluid body, then he brings subtle attention to the entire length of his spine from the coccyx up through the basiocciput and basisphenoid. In the osteopathic tradition, the basiocciput and basisphenoid are considered to be the top two vertebra of the spine and indeed are formed from the tip of the notochord embryologically.

PR has several two-dimensional vectors that it moves on and around the spine. The first vector sensed in the notochord of the spine comes from the top of the head straight down the spine for fifty seconds and then changes direction, coming right up from the earth through the pelvis and right through the top of the head for fifty seconds.

A second vector is one that I tend to focus on, the embryonic vector. This vector is like an accordion opening and closing for fifty seconds each way. The top of the accordion is actually the basisphenoid around the front of the face and the bottom of the accordion is the coccyx. When the accordion opens it causes a very slight sense of the spine lengthening and flexing. The head will also feel like it is slightly bowing with micro movement. Then when PR reverses itself and the notochordal midline shortens, there will be a slight sensation of the spine and head going into extension.

The structure in osteopathy called the core link is relevant to working with the notochord. The core link relates to the dural attachment around the foramen magnum of the occiput and second sacral segment, as shown in Figure 16.5. The core link, the notochord, the longitudinal fluctuation, the movement of cerebrospinal fluid, and the movement of the neural tissue itself are all valid entry points for exploring the structural midline of the client. A practitioner over time gathers the necessary experience to distinguish these various levels of motion (see Appendix) present in the client. The breathing of Primary Respiration in the notochord will not always be available to the practitioner.

That being said, the practitioner should always be ready to allow PR to teach him something he does not know. It is always willing to show the humble practitioner another dimension of its therapeutic activity of generating, repairing, and maintaining the human body.

Once the practitioner is comfortable with the inside presence of PR in his own fluid body, he requests permission to make contact with the client's occiput and sacrum.

I typically will use the back of my hands on the client's occiput and sacrum, as shown in Figure 16.4, rather than the palms of my hands. When I use the palms of my hands, it tends to bend my wrists and creates strain within seconds.

Now the practice is the same in the sense of becoming receptive and reorienting, resynchronizing, and reattuning with the interpersonal space and beyond to the natural world and back. The practitioner waits for PR to reveal which vector in the client's notochordal midline it wants to show, then attends to several cycles of Primary Respiration.

There are no photographs for this step. Once the practitioner has noticed several cycles, he will switch the hand on the occiput to a very light, single-finger contact over the glabella of the client. From this vantage point the practitioner may be able to sense the receding of the longitudinal fluctuation going back down to the coccyx.

Once the practitioner creates a bigger wing span with his arms, he will need to sit higher up than when in contact with the sacrum and occiput. Now he will need to sit in a regular chair or stool.

The glabella is the center of the forehead between the eyebrows and slightly above the bridge of the nose. Once again, he is on the very top of the notochordal midline because the sphenoid is posterior to the finger on the glabella.

The bottom hand on the sacrum switches down closer to the coccyx. In this way, the practitioner's hands span the entire length of the adult remnants of the notochordal midline. At this point, the process is the same as above. Reorient, resynchronize, and reattune until PR reveals itself once again.

It is important to solicit the comfort of the client because of the finger position on the face. The practitioner makes sure that his arms and wrists are well supported by the table or other pillows.

Summary: This is actually a great way to end the session with the client. It is not only very relaxing, but decompresses the autonomic nervous system and offers some insurance if there were any side effects from the session the client just received. It is not enough to be able to sense PR. The practitioner must also be able to establish a conscious relationship with the interchange that PR has with Dynamic Stillness that permeates the office space. It is the type of stillness that is filled with precision, clarity, and nonthought. This allows the fluid body to go into a neutral. The neutral is the way in which the fluid body pauses its motion and reestablishes its own relationship with a dynamic field of stillness that not only exists within it, but three dimensionally all around it.

Respiratory Diaphragm

Window: Practitioner is seated at the side of the table and places both hands together, palm up under the client's spine, with T12–L1 located at the junction of the right and left hand. Figures 16.1 and 16.2 illustrate this position.

The exploration is to begin to sense the relationship of PR to secondary respiration.

The diaphragm is a door, so to speak, to the heart and can modify the behavior of the heart through the respiratory sinus arrhythmia relationship between the diaphragm and heart, which developed prenatally.

The diaphragm is not only related to the heart and PR, but also is the fulcrum for the fluid body, according to some osteopaths. Secondary respiration is always a fundamental consideration in every biodynamic session.

The practitioner might occasionally direct the client to breathe between her umbilicus and pubic bone. This is only done a couple of times in any given session.

Shoulders (Heart Holding)

Window: The practitioner sits at the head of the table. Gently negotiate permission to make contact and place the hands buoyantly over the shoulders bilaterally, as shown in Figure 16.6.

Practitioner lets PR choose which shoulder to focus on.

The practitioner then sits at the side of the table and is still. The client is supine and the practitioner's body is perpendicular to the client's shoulder.

Figure 16.6. Bilateral shoulders

Process: The practitioner contemplates stillness in his body, in the office space, and out the window with the eyes open. Alternatively, the practitioner may focus on stillness in his body with eyes closed.

The practitioner connects with the earth by relaxing through the pelvis and feeling the heat of the earth 100 miles or more below while PR is breathing itself into the floor of the pelvis, filling the fluid body and returning back down into the earth every fifty seconds.

The practitioner senses the client with the heart mirror, especially if approaching the client's left shoulder where the heart is located.

Figure 16.7. Ipsilateral shoulder a

Figure 16.8. Ipsilateral shoulder b

The practitioner makes contact with one shoulder of the client ipsilaterally, as if holding a bowl of water. One hand is under the scapula and the other is floating over the clavicle and humeral head (see Figures 16.7 and 16.8).

Allow PR to breathe through each shoulder especially through the heart when in contact with the left shoulder. This will allow the heart muscles and related ligamentous structures to decompress from traumatic impact injuries to the region of the thorax or other related shocks, such as explosions that soldiers experience in war.

Summary: The timing of PR is not the most important aspect of its activity. It is just a convenient way for some practitioners to enter into its healing presence. It is more important to sense PR changing directions to observe ignition. This is a wonderful way to relate to those clients with shoulder issues. It is helpful for upper lung freedom and the upper three ribs as well. It is also a good way to approach the head and neck. Finally, when the practitioner is on the client's left shoulder she is also holding the heart of the client and can help the heart relax and open.

Clavicles

The clavicles form in the fetal period and are a distinct human structure related to a proper cervical and lumbar curve. The clavicles are the base of the pharyngeal arches and thus are the gateway to the face biodynamically.

The clavicles and their fascia directly relate to the thoracic duct of the lymphatic system, the vagus nerve, the subclavian vein and arteries, and the carotid arteries. This can be very soothing for the autonomic nervous system (ANS) and help lymphatic drainage from the head and neck.

Figure 16.9. Clavicles a

Figure 16.10. Clavicles b

Figure 16.11. Clavicles c

Figure 16.12. Clavicles d

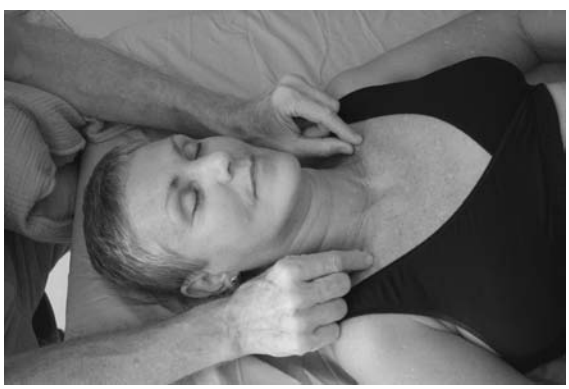

Figure 16.13. Clavicles e

Window: Practitioner is seated at the head of the table. Hands are palm down. The index, middle, and ring fingers are bilaterally spanning each clavicle, as shown in Figures 16.9 and 16.10. Only the finger pads make contact starting at midclavicle. The thumbs are resting gently around the head of first ribs and possibly the spine without any compression.

This bilateral hand configuration allows the practitioner to sense PR around the midline, as well as balanced bilateral movement of the clavicles and any intraosseous restrictions.

Gradually, the practitioner senses the lymphatic and vascular systems so close to his hands. The blood moves in spirals through

canalization zones under the clavicles and medial to the sternocleidomastoid muscles in the neck. In addition the heart was originally located in the neck and grew down into its adult placement by the end of the embryonic period. The practitioner listens to the blood and early heart located in the neck as it passes through the thoracic inlet under the clavicles.

It helps to imagine that the client's neck is like a tubular sea sponge that simply gets wider at the clavicles. In this way everything experienced inside the sea sponge can occur in the tempo of Primary Respiration.

Figure 16.11 shows my index fingers contacting the distal and proximal heads of the right clavicle. If the client has one clavicle that is more symptomatic than the other, then explore the one side as shown with Primary Respiration as it breathes between the fingers.

Following the exploration of one clavicle the practitioner reorients to both clavicles. The contact is made with the tissue-plucking hand position shown in Figures 16.12 and 16.13. The index fingers and thumbs are together and the tips of the fingers are making bilateral contact with the middle of the client's clavicles. Here the various motions of the clavicles become more readily available with PR and both clavicles have the opportunity to come into balance.

The general skill is to sense layers of the body from the outer osseous to the inner vascular component and then back out to the clavicles being breathed by Primary Respiration.

Pleura

This hand position is for contacting the cervical pleural ligament as it attaches on the pleura of the lungs. It is also the originating point of the lungs in the embryo. In the adult, the pleura is suspended from the cervical spine as high up as the third cervical vertebra in the neck.

Window: Here my fingers are located by the transverse processes of the mid to lower cervical spine, as shown in Figure 16.14. I like to wait and just sense all the tissues melting with PR. Gradually, the client's breathing will expand the upper lobes of the lungs and consequently the pleura, which can be readily sensed with the fingers.

This is the embryonic fulcrum for the lungs and a very important window to view the activity of PR in the core of the body.

Figure 16.14. Pleura

Heart Fulcrum

This exploration is to sense the embryonic fulcrum of the heart and balance the space above and below the foramen magnum. The heart starts in the neck region of the embryo around the third and fourth cervical vertebrae (C3–C4). This is the original fulcrum of the embryonic heart. The heart then grows down into the trunk as development unfolds.

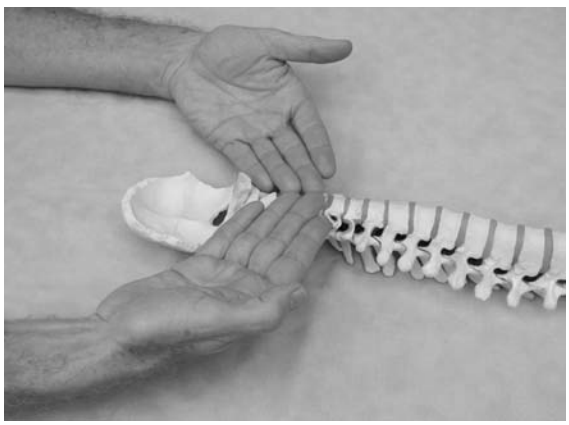

Figure 16.15. Heart fulcrum a

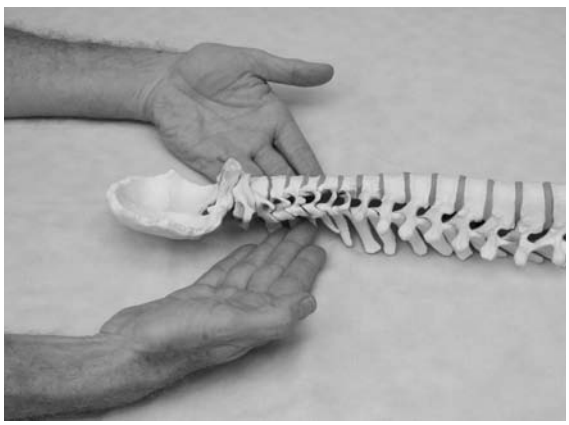

Figure 16.16. Heart fulcrum b

Figure 16.17. Heart fulcrum c

Window: The client is supine. Practitioner is seated above the head of the client and places the index and or middle fingertips together under the nape of the neck around the third and fourth cervical vertebrae (C3–C4). The hands are palm up, as shown in Figures 16.15, 16.16, and 16.17. Note that the practitioner's fingertips are touching when actually under the neck. Figure 16.15 is showing that togetherness above the neck, for visibility.

The practitioner orients to PR breathing through the heart fulcrum from posterior to anterior. In other words, the breathing proceeds from the table up to the ceiling and back rather than longitudinally up and down the midline of the spine.

Summary: This balances the head with the rest of the body via the cardiovascular system when sensing PR moving posterior to anterior through this fulcrum. This window usually precedes any exploration on the head itself. It is very calming for the client.

Scapular EV4

This exploration is to sense the heart and thus the parasympathetic nervous system breathing with PR and/or a Mid Tide tempo. The Mid Tide tempo I usually sense is about one cycle per minute (CPM).

The scapulae are the hard coverings of the back of the heart; they help connect the hands and arms with the heart.

Figure 16.18. Scapular EV4 a

Figure 16.19. Scapular EV4 b

Window: The client is supine. Practitioner is seated above the head of the client and places one of the client's scapulae in each hand, as shown in Figures 16.18, 16.19, and 16.20. The practitioner must remember to turn his head and not breathe onto the client's face.

Figure 16.20. Scapular EV4 c

Summary: Frequently, the practitioner will perceive the rate of thirty seconds of expansion and thirty seconds of contraction (1 CPM) at the scapulae. Some osteopaths have called this rate the *reciprocal tension potency* of the fluid body. When synchronized with that rate there will be a tendency in the client's fluid body to stillpoint at the end point of its expansion phase and thus the term EV4, which indicates such a stillpoint at the end of an expansion phase. There are some cases in which a stillpoint occurs at the end point of the contraction phase but that is much less frequent in the contemporary client because there is so much imprinted trauma in the client's midline. Consequently, a stillpoint in the expansion phase is much more gentle and permeates the fluid body systemically. This

stillpoint will then shift into the fluid body systemically breathing with PR. This is very beneficial for the entire ANS.

Arms and Hands

Fear in the body is regulated through a brain structure called the amygdala. This hand position helps the amygdala to reduce its fear. It helps to balance the ANS and normalize traumatic stress.

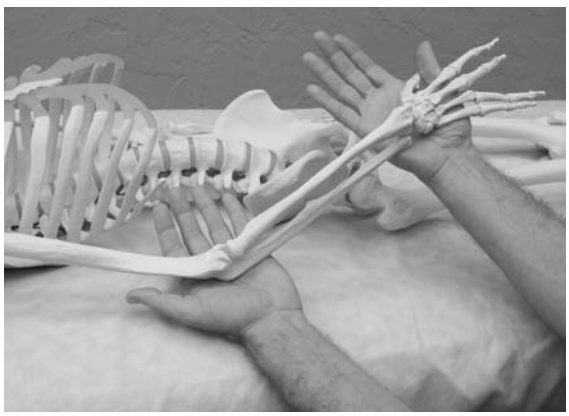

Figure 16.21. Arms and hands a

Figure 16.22. Arms and hands b

Window: Client can be seated or supine or even standing. The client's hand is placed palm down in the palm of the practitioner's hand. The free hand of the practitioner is placed under the elbow, as shown in Figures 16.21 and 16.22.

When the practitioner senses PR he moves the hand from under the elbow up to the shoulder or in back of the client's heart on the spine around T5, as shown in Figures 16.23 and 16.24. Synchronize attention again with PR.

Figure 16.23. Arms and hands c

Figure 16.24. Arms and hands d

Repeat on the other hand, arm, and shoulder of the client.

Process: The client's comfort must be solicited periodically while performing this exploration. If the client expresses any discomfort, the practitioner asks the client to grip his hand more firmly and slightly push her arm into the practitioner's hand. The practitioner offers a little resistance for fifteen to thirty seconds and then releases the arm and hand of the client and waits for the client's ANS to settle. If this does not help, this exploration must be finished.

Atlas-Occiput Space

One of the nicest effects of these atlas-occiput space (AOS) explorations is the settling of the entire autonomic nervous system. This is the principal reason I use them in clinical practice.

The point of contact is the tip of the middle fingers (or others that are a better fit for the individual) of the practitioner in the AOS between the occiput and the second cervical vertebra. In this position, the practitioner's fingers are in contact with the superior cervical sympathetic ganglion. In addition, the fascia and muscle fibers of the suboccipital triangle actually go through the occiput and insert on the dura mater that covers the brain. This fascia is located just above the foramen magnum, as shown in Figure 16.25. Thus, the AOS palpation skills are exceedingly important.

The client is supine in the exploration variations described below, with the practitioner seated at the head of the client. The client's knees are flexed and resting together without any tension. If for some reason, the client's AOS is not responsive then try having the client's legs straight out with a pillow under the knees.

Variation 1

The first step is to get the practitioner's hands together into a proper position, as shown in Figure 16.26. The practitioner's initial exploration is to slide his hands under the top of the client's neck with the pads of the pinky and ring fingers contacting the space of the suboccipital triangle of muscles and squama of the occiput. The rest of the finger pads are in the nape of the neck. The practitioner senses that whole area before getting more specific.

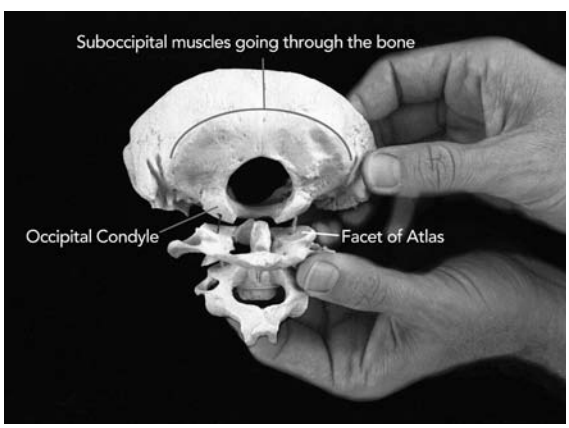

Figure 16.25. Atlas-occiput a

Figure 16.26. Atlas-occiput b

One important palpation skill for the AOS is to notice if there is any lymph edema there. It has a sense of the tissue being thick and spongy as if filled with too much fluid. This is usually the result of congestion from a whiplash injury or other types of neck or head injuries. Dr. Sutherland was in the habit of always making sure the lymphatic ducts were open in the neck and thoracic outlet area when he worked with the cranium. The practitioner must help drain the lymph before proceeding or refer the client for lymph drainage if there is such congestion in the AOS.

Variation 2

The practitioner lifts the client's head gently and rests it comfortably in his hands. The practitioner's ring and little fingers slightly overlap in such a way that the edges of the middle fingers (or, depending on the size of the practitioner's hands, the index fingers) come together. Figures 16.27, 16.28, and 16.29 show the precise finger positioning.

Figure 16.27. Atlas-occiput c

Figure 16.28. Atlas-occiput d

When placing the hands in this way under the client's head, the whole cranium of the client is cradled more or less in the medial aspects of the palms of the practitioner's hands. The *tips* of the middle fingers are used to discover the space between the occiput and the second cervical vertebra, C2. This is the center of the AOS. The atlas (C1) has no spinous process and consequently there is a gap between the occiput and C2. The *pads* of the middle fingers of

the practitioner are resting against the client's occiput.

The practitioner softly cradles the client's head with full contoured contact of the client's cranium in the palms and hands of the practitioner.

After the practitioner reorients and resynchronizes, he slightly and gently curls the tips of the middle fingers back, as shown in Figures 16.30 and 16.31. This moves the client's chin ever so slightly into extension. If the client's neck is too stiff, the chin and cranium will not go into a slight extension. This is no problem and the

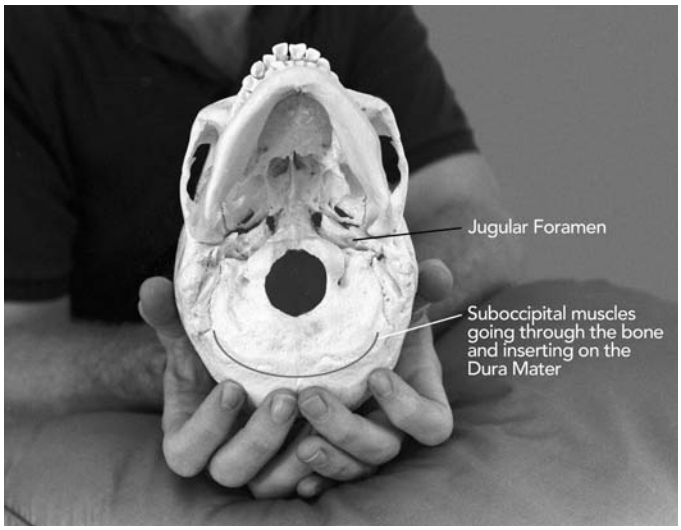

Figure 16.29. Atlas-occiput e

Figure 16.30. Atlas-occiput f

Figure 16.31. Atlas-occiput g

practitioner must not attempt to force or push the client's head into extension. In such a case I would recommend that the client have some soft-tissue work done on her neck before the next cranial session.

Next, the tips of the middle fingers begin to wedge slightly into the AOS with more firmness. Again, the practitioner needs to listen locally and globally for a minute or so during each stage of this process. This is because the muscles of the suboccipital triangle will soften gradually and usually soften one side at a time and the fluid body and ANS need time to get in register with the other layers. Consequently, the practitioner must keep accommodating to the motion of the client's head when the soft tissue relaxes on both sides. In other words,

as the tissue softens the practitioner *takes up the slack* in the tissues by allowing his fingertips to move up into the AOS without excessive pressure but staying at the edge of any barriers encountered.

Variation 3

While cradling the AOS with the tips of the middle fingers, a figure eight may be explored through the fluid body of the practitioner into the suboccipital triangle of the client in the tempo of Primary Respiration. In other words, the practitioner begins to move his whole fluid body very subtly like a snake writhing or dancing in a figure eight. That motion translates through the hands of the practitioner into the AOS of the client. The practitioner periodically stops his motion and listens locally and out to the horizon. The basic motion in the fluid body is a spiral and the figure eight helps to amplify the therapeutic properties of the spiral.

The motions of the figure eight and tractioning are done with the whole hands and fluid body of the practitioner, not just the fingertips.

- Motion test with a figure eight: slightly rotate head to right not more than a one-quarter inch.
- Sidebend head to direction of ease, with micro motion.
- Repeat sequences every two minutes while waiting between sequences. Maximum is three sequences.
- Wait and sense opening and lengthening through soft tissue.

Variation 4

Gently spread the middle fingers laterally by moving the elbows together. This influences the jugular foramen and relieves pressure on the vagus nerve and jugular vein.

Variation 5

This AOS exploration involves the orienting reflex and the head-righting reflex. All of the AOS explorations have the ability to recalibrate visual and auditory attention to an external stimuli. This is a reflex located in the proprioceptors of the upper cervical spine and the cranial nerve nuclei including the fifth cranial nerve. The *head-righting reflex* is associated with being able to rest one's visual gaze on the horizon. This same reflex is also related to the ability to turn the head and orient to novel stimuli in the environment, which is the *orienting reflex.* Both of these reflexes are compromised with traumatic stress and the head becomes separate from the body in terms of perception.

Figure 16.32. Atlas-occiput h

Figure 16.33. Atlas-occiput i

The practitioner asks the client to rotate her head to the left slowly and only a short distance (a couple of inches). Then the practitioner brings the client's head back to center and asks the client to turn her head to the right.

Now ask the client to look to the left and turn the head to the left, as shown in Figure 16.32.

Repeat the sequence, with the client looking this time to the right and turning the head to the right, as shown in Figure 16.33.

Bring the client's head to the center. This sequence can start with either direction, right or left.

Now the practitioner asks the client to look right while the practitioner rotates the client's head to the left. Note restrictions or motion barriers and stop when meeting a barrier and wait for it to soften.

Repeat the sequence to the opposite side.

This is a very powerful way to work. It should be attempted only after several sessions and only if the preceding variations are ineffective.

Variation 6

Place a microgram of traction on the occiput to explore the dura mater and any tension patterns it might be holding, especially from whiplash injuries. This is a very delicate traction that is done for several seconds and then released. Figure 16.34 shows the position of the fingers on the occiput.

Figure 16.34. Atlas-occiput-dural tube traction

This variation is a visualization exploration. The practitioner visualizes the dura mater and

subarachnoid space that is filled with cerebrospinal fluid on the inside and attached to the vertebrae on the outside via the denticulate ligaments starting at the foramen magnum. Repeat several times or until the practitioner senses he is at the sacral attachment of the dura mater. It is barely an intention to traction. The tractional force is measured in nanograms!

It is also helpful to visualize the dural tube with its denticulate ligaments and subarachnoid space full of cerebrospinal fluid. In addition, the blood vascular supply to the meninges can be visualized as if the dura was pink and red.

- Offer a nanogram of traction for fifteen to thirty seconds on the occiput.
- Slowly count down the vertebrae from the first cervical all the way to the second sacral segment.
- Relax intention and wait fifteen to thirty seconds when noticing a tension or restriction in the dura mater. Practice moving attention out through the zones and back.
- Let the dura mater soften before moving on or simply go around the restriction if it chooses to remain.
- Repeat until sensing the dural tube attachment at the sacrum. In some clients I have continued down to the feet to imagine the client's body becoming like seaweed.
- Finally, fill the subarachnoid space and dura mater with a beautiful pink light from the cardiovascular system.

Caution must always be used with visualizations involving the inside of a client's body. The practitioner must be able to sense if the client is reacting to the visualization usually through a tissue contraction or the fluid body becoming tense. If softening and lengthening of the dura mater do not start occurring with a minute or two, the practitioner must abandon the visualization.

Process: One of the common mistakes is for the practitioner to relax the fingertips, whereas it is important to *take up the slack* as the suboccipital triangle softens as I mentioned. In this way, the atlas can begin to reseat itself onto the occipital condyles and a proper relationship along the whole suture line between the occiput and temporal bone can occur. Also, it is taught in the French osteopathic schools that the client's knees must be flexed for work in and around the AOS. I recommend trying both ways, with knees flexed and without, and see which is better for that client. Frequently my clients go fast asleep when my fingers are engaged in the AOS and consequently the knees must be well supported and without held tension in the legs if they are flexed.

I find that, when a client is highly toned sympathetically, if I start with an AOS exploration, it makes it much easier to sense the fluid body and tidal body. This is a judgment call on the part of the practitioner that requires skill and practice.

The biodynamic practitioner starts with the whole and in the middle of a session may move to more functional explorations if invited to do so. Nonetheless, every session begins and ends biodynamically. In other words, the best time to explore the AOS is in the middle of a session.

Summary: Contact is made with the superior cervical sympathetic ganglion in all the AOS variations. Trauma to the orienting reflex nerves may cause a person to have difficulty sensing her environment, which feels like an inability to easily turn the head or to rest attention on the horizon all the way to claustrophobic thinking and emotional breakdowns. This greatly interferes with the ability to perceive Primary Respiration from the horizon and back. It decreases one's ability to relate accurately with the environment, which is a hallmark of traumatic stress.

Finally, the occiput is the primary stress bone during a vaginal delivery. Three typical intraosseous patterns are imprinted in the occiput from birth: shelving, telescoping, and torsion. During exploration with the AOS, as well as the transverse sinus (covered in Chapter 17), it is possible to encounter these birth dynamics and normalize any intraosseous or interosseous stress imprinting from birth as long as the practitioner is synchronized with Primary Respiration.

Summary of AOS Variations

Variation 1:

- The practitioner gets a sense of the whole area of the upper neck with his finger pads.

Variation 2:

- Hands are positioned for an occiput cradle with middle fingers at AOS. Finger pads on occiput, tips of fingers toward body of atlas in soft tissue. Middle fingers are slightly curled back toward the atlas in the soft tissue area.
- Practitioner holds the head of the client like like a bowl of water and senses Primary Respiration.
- Practitioner may move fingertips to extend the client's chin very slightly if there is ease of movement.

Variation 3:

- Slowly move the whole head in a figure eight with micro movement.

Variation 4:

- The practitioner gently brings his elbows closer together to exert a lateral spreading of the fingers. This influences the client's jugular foramen to open and soften.

Variation 5:

- Client rotates head to one side, and then the other, slowly and only a couple of inches.
- Client moves eyes to right; practitioner turns head right several inches and back to midline. Repeat sequence, with client's eyes to left and moving head to left.
- Then have client look with her eyes to one side while rotating the head to the opposite side. Repeat this sequence, in the opposite direction.
- Repeat a maximum of three times or until opening and lengthening are sensed in the AOS and cervical spine down to the sacrum.

Variation 6:

- Visualize the dura mater and subarachnoid space.
- Offer a tiny bit of traction for fifteen to thirty seconds on the occiput.
- Slowly count down the vertebrae from the first cervical to the second sacral segment.
- Relax intention and wait fifteen to thirty seconds when noticing a tension or restriction in the dura mater. Practice moving attention out through the zones and back. Let the dura mater soften before moving on or simply go around the restriction if it remains.
- Repeat until sensing the dural tube attachment at the sacrum.
- Fill the subarachnoid space and dura mater with a beautiful pink light from the cardiovascular system.

Heart Tube

Window: Figures 16.35 and 16.36 show the practitioner making contact with the sternum on top and the upper thoracic spine below. The intention is to be able to sense the heart tube of the embryo expand three dimensionally and breathe with Primary Respiration. The heart tube is inside two envelopes of

fascia. The outer layer or bag that holds the lungs and heart in place is called the mediastinum. Then the heart is suspended internally by its support fascia called the pericardium that was present in the embryo. The pericardium has suspensory ligaments to the sternum and ribs that are frequently tight from stress both physical and emotional.

The practitioner's body position is very important. The left elbow needs to be supported by a pillow. In addition, if the practitioner's head, which cannot be seen in the photos, is above or near the client's head, he will need to turn his head so that when he exhales, she does not feel the practitioner's breath on her face. This can be very distracting and uncomfortable for a client.

Figure 16.35. Heart tube a

Figure 16.36. Heart tube b

Once the hands and arms are comfortable, the practitioner senses the movement of the respiratory diaphragm and how breathing moves the ribs and lungs.

Gradually, the practitioner senses the movement of the heart and toggles his attention back and forth between his heart movement and that of the client and then periodically moves attention out through the zones.

The heart tube wants to expand. That is its basic embryonic nature and the practitioner waits to sense Primary Respiration in the client's heart. This is a window that can be revisited more than once in a series of sessions.

Side effects may include a dull ache around the attachments of the suspensory ligaments of the heart to the rib cage, a general feeling of tightness in the thorax, elevated heart rate, or emotional release. These effects are usually transient and the practitioner must maintain focus on his own heart and ask the client to breathe slowly into an area of tightness.

Chapter 17

The Face

Mandible Developmental Movements

The foregut consists of the bones, muscles, and other embryological derivatives of the face, pharynx, and esophagus. In order to explore the face, a good starting position is to hold the client's mandible and sense its anterior-posterior and inferior-superior movement. The hand position recommended here will allow you to feel the two possible developmental movements of both the adult and the child. When an infant is breastfeeding the mandible moves anterior-posterior. Once a child begins to eat solid food the mandible moves inferiorly-superiorly, which persists into adulthood. Because hand size in relation to the client's face size is the determining factor in this window, remember to gauge one's hand placement accordingly.

Window: The practitioner sits at the head of the table and, after orienting, places the thenar eminences of her thumbs bilaterally on or near the condyles of the client's mandible, as shown in Figure 17.1. The tops of the thumbs are on the angle of the mandible bilaterally. The wrists and arms must be supported properly on the table to be able to relax both hands once a comfortable hand location has been found.

Figure 17.1. Mandible developmental movements

Summary: Remember to access the fluid fields of the embryo whenever on or around the face with Primary Respiration (PR). The sense of the developmental movement occurs when the anterior-posterior movements of the infant mandible balance with the inferior-superior movements of the adult mandible and typically a stillpoint is achieved. At this point, the bone itself may

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begin to breathe three dimensionally with PR. This exploration reflexes into the temporomandibular joint (TMJ) and the cranial base.

Face Seams

In these face windows, it must be remembered that throughout prenatal development and all the way through adolescence, the face is developing horizontally. Consequently, any palpation of the face is done with this sensitivity and quality of movement. Once young adulthood approaches, the face then moves into its vertical growth pattern. The face induces the heart and brain to grow as an embryo and consequently these seams are very important and usually precede exploration with the cranial base.

Practitioner has lateral contact on the client's face and neck. Practitioner's finger pads are in between the pharyngeal arch derivatives. The sequence is as follows:

- Hyoid bone (see Figures 17.2, 17.3, and 17.4)
- Mandible (see Figures 17.5, 17.6, and 17.7)
- Temporomandibular joint (TMJ) (see Figures 17.8 and 17.9)
- Maxilla (see Figures 17.10 and 17.11)

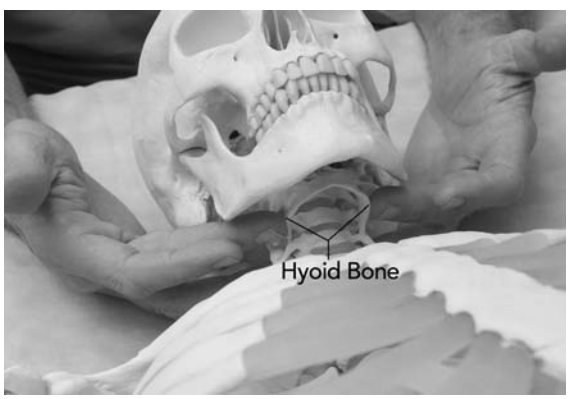

Figure 17.2. Hyoid bone a

Figure 17.3. Hyoid bone b

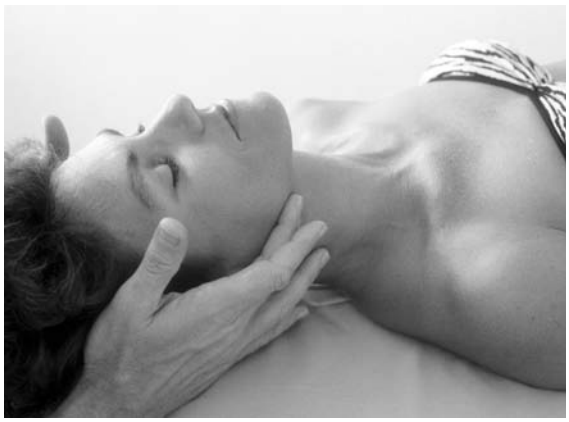

Figure 17.4. Hyoid bone c

Figure 17.5. Mandible a

Figure 17.6. Mandible b

Figure 17.7. Mandible c

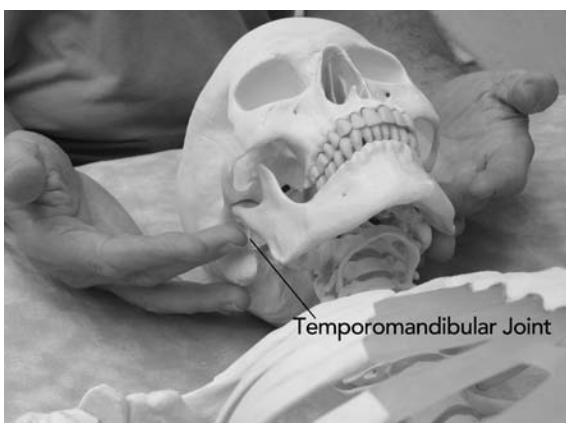

Figure 17.8. Temporomandibular joint a

Figure 17.9. Temporomandibular joint b

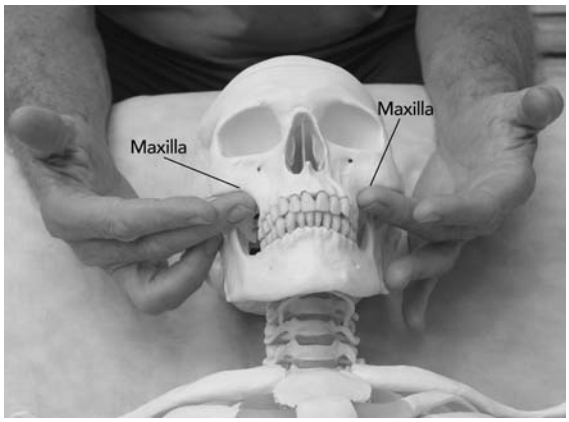

Figure 17.10. Maxilla a

Figure 17.11. Maxilla b

Process:

1. Practitioner begins with her hands six inches lateral of the client's head in zone B and synchronizes her attention with PR in or around the client.
2. Practitioner verbally negotiates contact with the first seam starting at the hyoid and going sequentially from the bottom to the top of the face.
3. Practitioner orients to the stillness under her fingers.
4. Practitioner synchronizes with lateral-medial movements of the fluid body, or by its 3D breathing in PR.
5. Practitioner observes ignition phenomena if available. Care must be taken to ensure that the practitioner's hands and arms are well supported. The practitioner must remember to have her hands open and extended rather than flexed. The exploration is done with finger pads not fingertips.

Repeat steps 2, 3, and 4 with each seam.

Summary: As a way to complete the session, the practitioner may contact the fluid body with the Pietà position and wait for the whole fluid body to breathe with Primary Respiration. The sacrum is always a good option for ending any exploration around the head.

Transverse Sinus

Window: Figure 17.12 shows the practitioner's finger pads lined up to approximate the location of the client's transverse sinus. The transverse sinus is located on a line going from lateral to medial on the inner surface of the occiput. The external location of the finger pads is along that same line with the external

occipital protuberance as the center point for the little or ring fingers depending on the size of the practitioner's hands.

The practitioner sits above the head of the client and senses softening in that area of the occiput while synchronized with PR.

The transverse sinus is formed by the superior and inferior leafs of the tentorium and consequently this is an excellent way to decompress the entire tentorium and assist the vascular system of the head to drain better.

Figure 17.12. Transverse sinus

The Anterior-Posterior Fluid Fields of the Face

These windows are related to ignition in general and specifically the importance of the face in inducing the brain and heart embryonically.

Figure 17.13. Anterior-posterior fluid fields a

Figure 17.14. Anterior-posterior fluid fields b (photographed by Robert Cutter)

Window: Client is supine. Practitioner is sitting at the side perpendicular to the client's head.

The practitioner uses the hand opposite the top of the client's head and rests the client's occiput on the palm and/or fingers of her hand, as shown in Figures 17.13 and 17.14.

The client's external occipital protuberance is situated between the ring finger and middle finger of the practitioner. In this way, the middle finger of the practitioner approximates the superior leaf of the tentorium. The ring finger approximates the inferior leaf of the client's tentorium.

It is fine for the practitioner to use other fingers depending on the size of her hand.

Process: The intention is to wait until the practitioner can sense a spreading or gapping of the superior and inferior leaves of the tentorium.

Upon sensing the spreading of the tentorium, the practitioner makes contact with the client's upper fluid field with her free hand.

The practitioner's free hand is positioned in a way that the pad of the thumb and pad of the middle finger are in light contact with the lateral portion of the frontal bone of the client. The practitioner waits to sense PR breathing between her two hands.

Then the practitioner shifts her free hand to the maxillary fluid field in order to sense the same dynamic.

Then the practitioner switches her free hand to the mandibular fluid field.

Finally, the practitioner can use her free hand to sense the hyoid fluid field from front to back.

Summary: As an alternative, the practitioner can *stand* at the side of the client and use both hands to contact the hyoid-mandible fluid fields bilaterally, the mandibular maxillary fluid fields bilaterally, and finally the maxillary-frontal fluid fields bilaterally.

Ethmoid Bone

Window: There are many ways to make contact with the ethmoid bone. This window places the practitioner's thumb over the glabella of the frontal bone, as shown in Figure 17.15. The rest of the practitioner's hand is making a very light contact. As the fluid fields of the face breathe laterally, the thumbs will depress as if the hands were like wings. When PR changes direction, the reverse of that motion will occur. The ethmoid bone will lift the thumbs and the wings of the hands will settle down closer to the face.

Process: Many clients have had facial trauma and, occasionally, I mechanically attempt to loosen the ethmoid bone before balancing it biodynamically. The practitioner's left hand is cupping the client's frontal bone. The right hand is making contact with the lacrimal bones, as shown in Figure 17.16. The practitioner then induces a very gentle torsion motion. The left hand rotates one direction while the right hand goes in the opposite with perhaps several ounces of pressure. The practitioner will do this for several seconds in each direction, and then will stop and allow the face to breathe with PR.

Figure 17.17 shows the left hand in the same position cupping the frontal bone. The thumb and index finger of the right hand are making contact with the

client's maxilla. The process is the same as in the previous paragraph. This hand position is done in conjunction with the previous one in order to get a more thorough sense of freedom in the ethmoid bone without using intraoral work.

Summary: It is important if using this type of skill to balance the fluid fields of the face with PR.

Figure 17.15. Ethmoid a (with Valerie Gora)

Figure 17.16. Ethmoid b

Figure 17.17. Ethmoid c

Intraorbital Ligament

The intraorbital ligament is responsible in prenatal development for pulling the eyes from the sides of the head into their normal anatomical position.

Window: This hand position combines a contact around the ethmoid with the pad of the left index finger and contact with the intraorbital ligament with the pad of the right index finger, as shown in Figure 17.18.

Figure 17.19 shows the practitioner's finger pads around the same position on the client's face. When synchronizing with PR at this level,

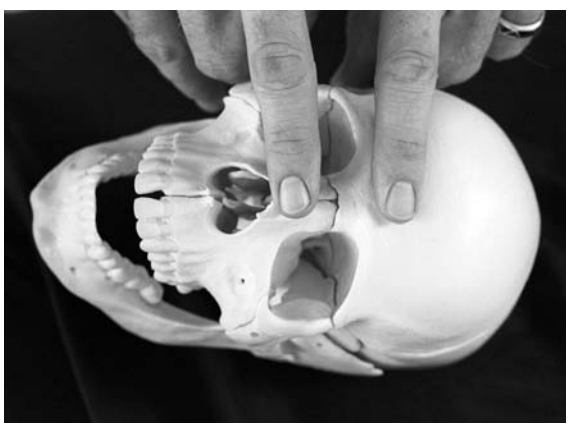

Figure 17.18. Intraorbital ligament a (photographed by Robert Cutter)

Figure 17.19. Intraorbital ligament b

one finger moves down while the other is lifted up in rhythmic periods of fifty seconds.

Summary: This is very relaxing for the eyes and the face in general. It can relieve eye strain, which is valuable in this day and age with the increased use of electronic equipment.

Figure 17.20. Frontal bone

Frontal Bone

Window: This is a beautiful hand position in which the index, middle, and ring fingers are making bilateral contact with the client's frontal bone, as shown in Figure 17.20.

Summary: Originally, the frontal bone had a suture in the middle above the nose and when the bone begins to breathe with PR, it feels as if a bird is flying. The sides of the frontal bone lift up like wings and then go back down.

Figure 17.21. Full face

Full Face

Window: This particular hand position, shown in Figure 17.21, is designed to sense the entire face breathing with PR. As with some of the previous facial hand positions, this hand position also gives a sense of a bird lifting off. Note that the practitioner's thumbs are over the ethmoid bone. It is important to sense the movement of the ethmoid bone in relationship to all the facial bones. This hand position and many others for the face are very beneficial for balancing the parasympathetic nervous system. The face is a parasympathetic organ.

Face in Sidelying

Some clients are not able to lie in the supine position for very long. As you can see in Figure 17.22, the practitioner's hands are supporting the client's face. The right hand is below the ear and left hand is above. Once again, the practitioner takes time to sense PR and allow the cranium to balance itself.

Figure 17.22. Face in sidelying

Chapter 18

The Cranial Vault and Base

Cranial Preparatory Window

As the practitioner prepares to make contact with the client's cranial vault or cranial base, I always recommend placing the hands lateral of the head, as seen in Figure 18.1. It is important to spend several minutes and imagine holding a large bowl of water that extends 15–20 inches off the client's skin. Then the practitioner can sense Primary Respiration (PR) breathing the bowl of water into his hands and back from the center of the client's cranium.

The practitioner slides his hands along the table toward the client's head until the little finger and hypothenar eminence make contact with the client's head underneath the ears. This is a nonspecific contact point to establish a basic palpatory relationship with the client's head. It is here where the practitioner, still imagining holding a bowl of water, begins a discovery process around the different activities and motions associated with the cranium if they present themselves.

Figure 18.1. Cranial preparatory window

Parietal Lift

The parietal lift is perhaps one of the safest handholds that can be done with the client's cranium. It is the first of a two-part series of windows; the second window in the series is the temporal lift, described below. The basic exploration is to be able to decompress the tentorium in the cranium. The anatomy is quite precise. The tentorium has two leaves to it, a superior and inferior leaf (as mentioned in the previous chapter regarding the transverse sinus). The superior leaf has an attachment on the inferior lateral angles (ILAs) of the bilateral parietal bones.

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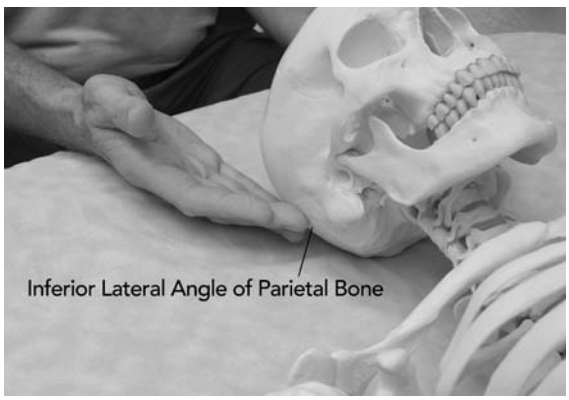

Figure 18.2. Parietal lift a

Figure 18.3. Parietal lift b

Figure 18.4. Parietal lift c

The inferior leaf has an attachment along the petrous ridge of the temporal bone. The majority of the twelve pairs of cranial nerves travel between these two leaves of the tentorium as the nerves exit the brain stem and traverse their various geographies to their end organs.

Window: Once the practitioner has synchronized his attention with the fluid body, he then solicits permission to make bilateral contact with the inferior lateral angle (ILA) of the client's parietal bones, as seen in Figures 18.2 and 18.3. Whenever first contact is made with the head, the practitioner solicits the comfort of the client. The anatomical position is quite precise and must be known by the practitioner.

Process: Now that proper contact has been established bilaterally with the ILAs of the client's parietal bones, the practitioner completes several cycles of attunement and notices the quality of motion present each time he brings his attention back to his hands.

Typically, the practitioner is only making contact with the client's ILAs with the pad of the middle finger of each hand. I like to say that this is a "one-fingered technique." It is important to use the pad of the finger rather than the tips. When the tips of the fingers are used, it creates too much flexion and compression, not only in the practitioner's hands, but possibly placing a compression into the client's cranium, brain, and nervous system.

Each time the practitioner brings his attention back to his finger pads, he is waiting for the various components of the cranial mechanism to reveal themselves in whatever sequence they choose. It is enough to just sense PR breathing in the fluid body three dimensionally from the ILAs.

Gradually, in clinical practice, the motion of the parietal bones and their relationship with the tentorium will manifest as a breathing motion much like the gull wings of the old DeLorean automobile and some Corvettes and Lamborghinis. The pivot point for the gull wing motion is more centrally located at the superior saggital suture of the cranium and in the breathing motion, the wings under the practitioner's finger pads flare out and the hinge below the superior saggital suture depresses. Then the motion reverses itself.

The practitioner may also shift the position of his hands to the parietal ridge bilaterally, as shown in Figure 18.4. From this position, the practitioner can sense the gull wing motion of the parietal bones and other movements of the cranium, such as the lateral fluctuation of the fluid body, the movement of the lateral ventricles, and even the neural tissue itself. It must be remembered that these are multiple levels of motion in the cranium (see Appendix) that appear in the practitioner's perception. Although these levels of motion are related to the layers of structure in the cranium, their appearance in a session is nonlinear.

After several cycles of observing this motion either at the ILAs or the parietal ridge, the parietal bones may move within the fluid matrix. The movement has a very clear sense of the parietal bones lifting bilaterally in a superior direction. In other words, since the practitioner is sitting at the top of the table, and consequently at the top of the client's head, it may feel as though the client's parietal bones are floating toward the practitioner's body. Their nature is to float in the direction of the practitioner's body and not retract back down. If they do retract back down, then just wait several more cycles until the bones are able to float on their own.

Summary: From a biodynamic perspective, the tentorium is actually an extension of the notochord embryologically. This means that the tentorium grew much like a sprout from the top of the notochord and spread out laterally. If the practitioner is willing to continue cycling through the attunement process with PR and not become overfocused on the cranium, holding the client's fluid body as a whole, the entire fluid body, brain, and heart of the client will have an opportunity to ignite biodynamically.

Temporal Lift

Window: The temporal lift is performed with stacked hands, as shown in Figure 18.5. This means that the practitioner places his right hand on top of the left hand and essentially cradles the client's occiput in the palm of the right hand (or the other dominant top hand) while the thumbs are free to sense the movement of the temporal bones via the mastoid tips.

Figure 18.5. Temporal lift a

The temporal lift, which is used to evaluate the inferior leaf of the tentorium, is done with the thumbs under the mastoid processes bilaterally, as shown in Figures 18.6 and 18.7.

Once the practitioner has reoriented, resynchronized, and reattuned to PR and the natural world, any attention that is brought to the hands is done with the sense of holding a bowl of water and offering complete freedom for that bowl of water to breathe in all dimensions and directions.

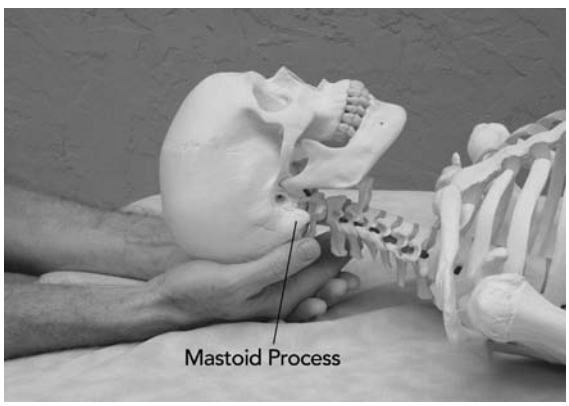

Figure 18.6. Temporal lift b

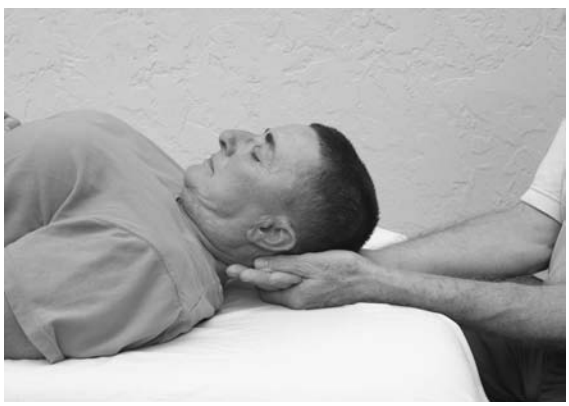

Figure 18.7. Temporal lift c
(with Valerie Gora)

Temporal Bones

The temporal bone is a highly sophisticated bone that houses the facial nerve, vestibular nerve, and acoustic nerve. These nerves generate important functions, especially associated with proprioception, somatic balance, and equilibrium. They also are associated with maintaining the head in an upright position with the eyes oriented to the horizon and the orienting reflex, as discussed in Chapter 17.

In addition, the temporomandibular joint (TMJ) is a part of the temporal bones. This bilateral joint is extremely sensitive to forces coming from the face and the function of eating and swallowing. Mandibular whiplash is a common side effect of motor vehicle accidents. This occurs when the mandible dislocates from the TMJ, which may result in damage to the TMJ and subsequent trauma to the temporal bones. Consequently, the temporal lift requires that the practitioner understand the bilateral motion dynamics of the TMJ, the motions of the

temporal bones, and the flexion and extension movement of the tentorium itself. This adds additional dimensions and layers of experience to the practitioner's perception of Primary Respiration. These movements occur three dimensionally as one unified dynamic and thus caution must be used when isolating aspects of the total movement pattern.

Window: This is a bilateral contact with the practitioner's thumbs directly on the mastoid processes of the temporal bones, as shown in Figure 18.8.

In Figure 18.9, I clearly show both of the thumbs in position over the mastoid processes.

In Figure 18.10, you can see the right hand in position on the client's temporal bone. The thumb fits snugly under the client's ear. The rest of the fingers simply rest wherever they land. The intention is to sense the external and internal rotation of the temporal bones. This occurs both through the motion of the temporal squama and mastoid process.

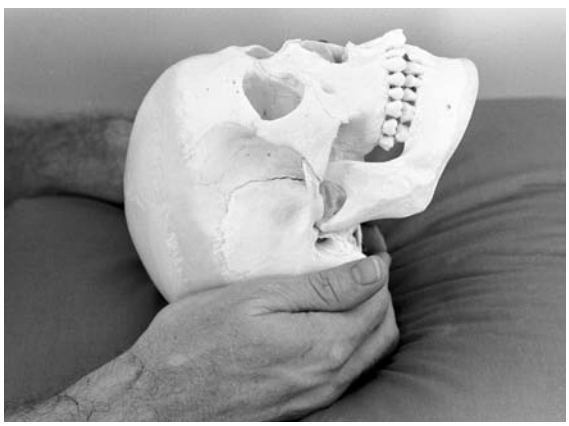

Figure 18.8. Temporal bones a

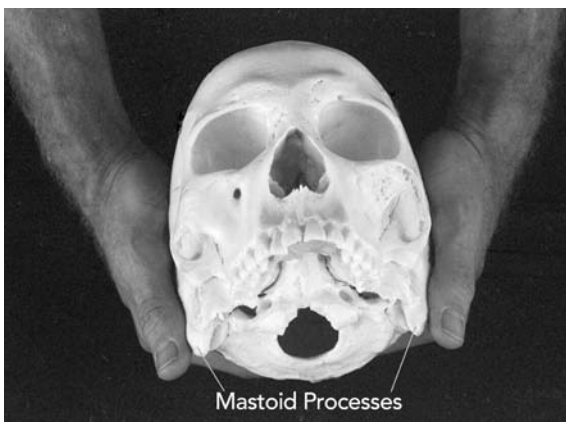

Figure 18.9. Temporal bones b

Figure 18.10. Temporal bones c

Figure 18.11. Temporal bones d

In Figure 18.11, the hands have a bilateral contact with the client's temporal bones. This is a great place to listen more directly to the fluid fields of the cranial base and how they breathe with PR.

The motion of the temporal bones may feel like a figure eight motion. In addition, it is not unusual for the temporal bones to stillpoint at the end phase of their expansion cycle. Traditionally, this was called an EV4 (expansion of the fourth ventricle). The practitioner would know that the temporal bones were in their end point of external rotation because the bilateral mastoid processes were moving medially and posteriorly while the temporal squama moved laterally. Thus it was easy to simply hold the mastoid processes in and down as long as the contact over the temporal squama allowed for external rotation.

The temporal bones seek to balance themselves by going through phases of stillpoint and motion synchronized with PR. I typically will wait for a stillpoint, especially if there is any history of head trauma, particularly one or more concussions. This is a wonderful hand position for any client who has a history of head concussions. I believe it is possible to delay or prevent chronic traumatic encephalopathy (CTE). This is a relatively new diagnosis in the field of concussions, referring to those clients who have received repeated concussions, such as football players. The temporal bones will feel like they are moving in glue. It is very important to synchronize with PR to allow the fluid body to heal itself around the brain.

Summary: Traditionally, it was taught that the temporal bones would stillpoint at the end of their phase of external rotation. From a biodynamic point of view, this may or may not happen, according to the intentions of PR.

Traditional Vault Hold

Regarding the sphenobasilar (SBJ) joint space, I have gone through an evolution of several different hand positions for it. The first hand position is, of course, the traditional Sutherland vault hold, shown in Figures 18.12, 18.13, 18.14, and 18.15.

Figures 18.12 and 18.13 show two variations for the location of the practitioner's thumbs. Figure 18.12 shows the thumbs overlapping and Figure 18.13 shows the thumbs straddling each other with the hands making more of a full-contoured contact with the client's cranium. The position of the thumbs will be determined by the size of the practitioner's hands and the size of the client's head.

Figure 18.12. Traditional vault hold a

Figure 18.13. Traditional vault hold b

Figures 18.14 and 18.15 show the following: The pads of the index fingers are on the greater wings of the sphenoid bone. The pads of the middle fingers are over the TMJ and masseter muscle. The pads of the ring fingers are under the ears. The pads of the little fingers are in contact with the occiput.

Figure 18.14. Traditional vault hold c

Figure 18.15. Traditional vault hold d

Process: The challenge with the traditional vault hold is the different sizes of practitioner's hands. The most important contact is with the greater wings of the sphenoid and if the practitioner's hands are not large, the contact with the temporal bones and occiput may strain the hands or be impossible to do. Consequently, the Becker hold, described below, is the best alternative. Alternatively, a simple thumb position for decompressing the sphenoid can be explored.

Sphenoid Decompression

I periodically use this window with some clients who have experienced severe head trauma.

Figure 18.16. Sphenoid decompression

Window: The practitioner places the pads of the thumbs bilaterally on the greater wings and the ring and pinkies around the occiput, as shown in Figure 18.16. The thumbs get a better mechanical contact on the greater wings for a lift toward the ceiling.

Becker Hold

The Becker hold is used to transition into biodynamic practice when contacting the cranial base and synchronizing with PR. In this window, the practitioner simply listens for the activity of the two metabolic fields that form the cranial base embryonically. The cranial base is made from the tip of the notochord, which becomes basiocciput and basisphenoid, as shown in Figure 18.17. The metabolic fields in question involve a three-dimensional expansion and contraction from the tip of the notochord or, in the case of the adult, the actual SBJ itself moving at the rate of PR.

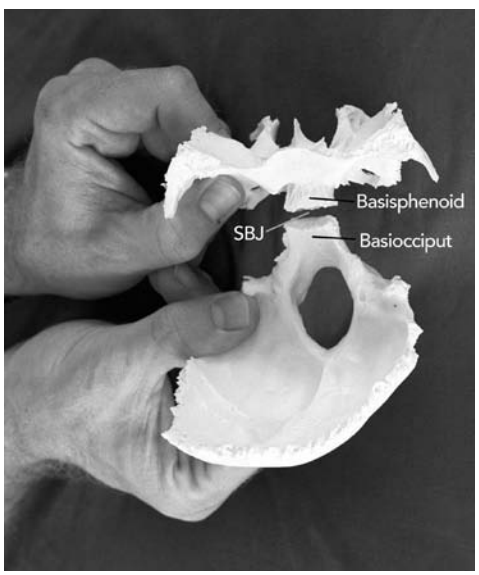

Figure 18.17. Becker hold a

The second metabolic field that forms the cranial base is a longitudinal motion perceived by the hands, much like holding a tunnel or two moving longitudinally and back between the third ventricle and the coccyx at the rate of PR. This particular window is a variation on the classical Sutherland vault hold. Over the past several decades the traditional vault hold has changed into a hand position that was used by Dr. Rollin Becker in his career. It was then subsequently taught as an alternative vault hold.

Figure 18.18. Becker hold b

Figure 18.19. Becker hold c

Window: This is a bilateral hand position with contact on the client's greater wings of the sphenoid bone and lateral masses of the occipital bone, as seen in Figure 18.18.

As with any hand position around the head, the practitioner, while seated above the client's head, places his hands six inches laterally of the client's ears and begins to imagine holding a bowl of water and sensing PR.

Once the practitioner has synchronized attention with PR, both in himself and around the client's head, the practitioner negotiates verbal permission to make contact with the side of the client's face.

Figure 18.20. Becker hold d (with Valerie Gora's hands)

The sides of the thumbs are placed buoyantly over the skin covering the greater wings of the sphenoid, as shown in Figure 18.19.

The palms of the practitioner's hands are over the ears, but not in contact with the client's ears, if possible. Figure 18.20 shows a variation with a practitioner whose hands are small in relation to a large cranium.

The practitioner uses the little fingers bilaterally to find the occiput right where it meets the table.

This particular window requires that the wrist and forearms of the practitioner be supported very securely.

Occiput CV4 (Compression of the Fourth Ventricle)

The traditional starting point to settle the whole body and nervous system is called the CV4 (compression of the fourth ventricle). As Dr. Becker said, this area has the most common sutural fixation from a vaginal birth that persists into adulthood. This is because there are important relationships between the occipitomastoid suture and the fourth ventricle, the jugular vein, and the ninth, tenth, and eleventh cranial nerves. The CV4 is birth work.

Figure 18.21. Occiput CV4 a (photographed by Robert Cutter)

Figure 18.22. Occiput CV4 b

Figure 18.23. Occiput CV4 c

Window: The palpation is done with the thenar eminences at the base of the thumbs of the practitioner. The thenar eminences are placed bilaterally on the squamous portion of the client's occiput, as shown in Figure 18.21. It is here where the occiput itself has its greatest range of motion just medial to the occipitomastoid suture.

The hands are stacked as shown in Figure 18.22. I typically use my dominant hand as the top hand in the stack.

The practitioner evaluates the movement of the occipitomastoid suture and its continuity with the occipitopetrous suture by using the hand position of the traditional CV4. The thenar eminences at the base of the thumbs are supporting the head of the client, as shown in Figure 18.23.

The practitioner lifts the client's head and may ask the client to seat it comfortably in his hands once in position. Sometimes a millimeter of movement can make this hand position extremely comfortable or uncomfortable. The practitioner also wants to make sure the hands are not pulling the client's hair.

Process: There are some important nuances with the location and activity of the practitioner's hands. When the side of the client's occipitomastoid suture that is restricted has been identified, the intention is to allow a gentle CV4. There will be a very slight amount of extra contact coming from the practitioner's hand on the side of the restriction. This is not a direct medial compression. Otherwise, the opposite hand would have to respond with an equal amount of compression or the client's head would rotate off of the midline and off the practitioner's hands.

Consequently, the hand that is offering the extra contact is gently rolling medially with its thenar eminence. It is micro movement. The rolling motion is coming from the thenar eminence at the base of the thumb. This offers a very gentle traction to open the occipitomastoid suture. As with a traditional CV4, when the occiput has reached an end point of medial motion, the practitioner holds and balances the occiput in that position until the potency builds (2–3 CPM) in the fourth ventricle and pushes the hands out.

Another nuance with the hands is important here. While the occiput is being held in a medial position, I like to use my thenar eminences of both hands to gently invite a figure eight motion into the squama of the occiput while I am waiting for the potency to build in the fourth ventricle. This rolling and alternating decompressing-compressing dynamic is done very briefly and subtly in the tempo of PR. The majority of exploration is about listening and waiting for PR to build potency in the ventricles for ignition. It is not unusual to track the lateral expansion of the occiput several times after it has pushed out in order to get a more complete normalization of movement through the suture and the fluid fields. It is not advisable to compress the occiput this way, even with a very slight compression, more than two times in the session.

Igniting the Bird in the Ventricles

Figure 18.24 is a drawing that Josefine Frind, an assistant of mine, made in Germany some years ago. The outline of the ventricles can be seen as a kind of watermark in the whole figure of the bird. Please keep this image in mind while you are practicing. This exploration requires concentration on orienting, synchronizing, and attuning.

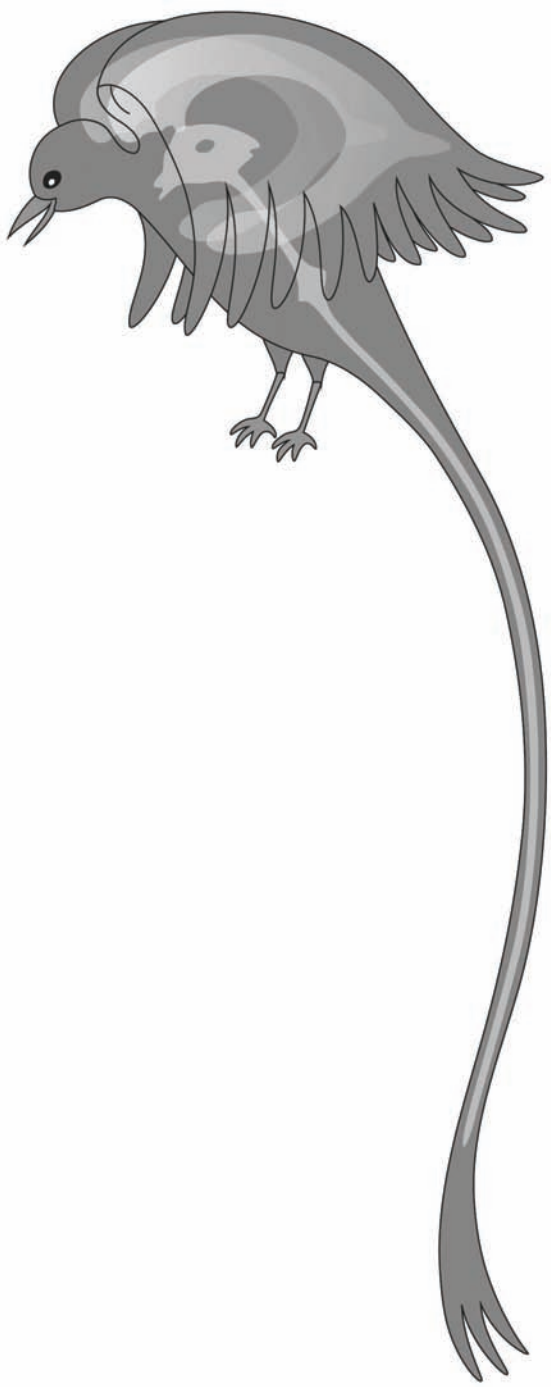

Figure 18.24. The bird in the ventricles (image by Josefine Frind, reprinted with permission)

Figure 18.25. Igniting the bird a

Figure 18.26. Igniting the bird b

Figure 18.27. Igniting the bird c (with Valerie Gora)

Window: Client is supine. Practitioner is sitting at the head of the table and rests attention in his third ventricle and central stillness at the beginning and then occasionally through the exploration.

The practitioner negotiates permission to make contact with the pads of his index and middle fingers bilaterally on the greater wings of the sphenoid. The lengths of the index fingers are positioned along the coronal suture, as shown in Figure 18.25, and the thumbs are positioned around or on top of bregma, as shown in Figures 18.26 and 18.27.

Regarding the hand position, the most important contact is over bregma with the pads of the thumbs as they are either crossed on top of one another or the tips touching one another, depending on the size of the practitioner's hands. NO pressure is placed on bregma. It is a buoyant touch with a focus on the backs of the hands.

Process: The practitioner synchronizes his attention with PR in the client's fluid body and then the cranium. The greater wings of the sphenoid will tend to move laterally for fifty seconds while bregma depresses inferiorly for fifty seconds. Then the cycle reverses itself. The perception of this motion must be precise. These are the wings of the bird in the lateral and central ventricles expressing themselves.

Bregma may begin to feel as if it is breathing on a line down through the third and fourth ventricles.

Gradually, Primary Respiration will express itself more fully and there may be a sense or an image of a bird in flight. An image of a particular bird may appear to the practitioner.

Following this hand position, the sacrum and feet must be contacted and the whole fluid body of the client allowed to amplify with PR. This includes checking the longitudinal fluctuation.

Summary: This is a powerful exploration that I only recommend trying after the third session with a client. It has the potential to recalibrate the neuroendocrine immune axis between the pineal gland in the posterior third ventricle and the pituitary gland in the anterior third ventricle. It should only be attempted once in any session. Time must be given to rebalance the fluid body as necessary afterward.

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Chapter 19

Anterior Midline

The anterior midline is an embryological seam from bregma to the pubic symphysis. It represents the last phase of closure over the ventral surface of the body, which does not take place until several months after birth. It actually does not close physically until a month after birth when the umbilicus has healed from cutting the umbilical cord.

Eight windows are described in the Process paragraphs below. The windows are:

- Bregma to intraorbital ligament (IL) (Figures 19.1 and 19.2)
- IL to upper lip (philtrum) (Figures 19.3 and 19.4)
- Philtrum to mid mandible (mentalis) (Figures 19.5 and 19.6)
- Mentalis to sternoclavicular notch (SCN) (Figures 19.7 and 19.8)
- SCN to xyphoid process (XP) (Figures 19.9 and 19.10)
- XP to umbilicus (Figures 19.11 and 19.12)
- Umbilicus to pubis (Figures 19.13 and 19.14)
- Finally, the Pietà or feet or both

Figure 19.1. Anterior midline a

Figure 19.2. Anterior midline b

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Figure 19.3. Anterior midline c

Figure 19.4. Anterior midline d

Figure 19.5. Anterior midline e

Figure 19.6. Anterior midline f

Figure 19.7. Anterior midline g

Figure 19.8. Anterior midline h

Figure 19.9. Anterior midline i

Figure 19.10. Anterior midline j

Figure 19.11. Anterior midline k

Figure 19.12. Anterior midline l

Figure 19.13. Anterior midline m

Figure 19.14. Anterior midline n