

New York Open Center Windows  
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1. Still Posture – Orienting
  - a. Biodynamic practice begins by sitting still and upright with the knees slightly below the hips, feet flat on the ground, head neck and shoulders in alignment. The posture is not too tight and not too loose.
  - b. Then the practitioner begins attending to her thoracic respiration, gradually breathing into her entire soma from head to foot as if filling up and deflating a skin balloon. Being aware of thinking and slowing down the stream of mental thoughts by shifting attention to breathing is essential. The orientation is to present time.
  - c. 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. The practitioner maintains an orientation to present time with the location of attention slowly switching between breathing, one's body and environment.
  - d. This begins the practitioner's slowing and stilling process that the client resonates with through the interpersonal brain and heart systems.
  - e. 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.
  
2. 3D Fluid Body – Spinal Synchronization
  - a. The next intention is for the practitioner to sense and image her body as a 3D transparent living fluid continuum. This starts by sensing the total surface volume of the skin. This establishes an orientation to one's 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.
  - b. The embryo is a transparent living fluid body. It is 98% fluid and gradually the adult body becomes about 92% fluid. This is the original body still present.
  - c. 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 is about replacing the contemporary trauma story with the origin story of love via the perception of 1° and stillness in present time.
  - d. The practitioner then begins to sense 1° moving up and down the middle of her spine like an accordion lengthening and shortening every 50 seconds. The spine is imaged as being suspended inside the 3D fluid body.
  
3. Heart Dish – 3V Synchronization
  - a. The practitioner then imagines the space of her hands, arms and trunk as one big heart in the shape of a satellite dish from side to side and from the top of the head down to the pubic bone from top to bottom.
  - b. The intention is to perceive 1° 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 of the client and later sitting at either end (feet-head) of the client using the heart dish.

- c. 1° moves beyond the surface of the skin and can be felt through attention on the heart and third ventricle (3V). The practitioner senses 1° moving from her third ventricle out to the horizon and back and then between her heart and the heart of the client.
- d. This begins the process of becoming receptive and yielding to the flow of 1° and stillness coming from the client and the horizon once contact is made. During a session, the practitioner toggles back and forth from her heart to her third ventricle and to her spine in order to sense 1°. Usually one or the other location is prominent in any given session so it is important to practice with all three locations to locate the most readily available access point of 1° at that time.
- e. It helps to imagine someone in the practitioner's life who is (or was) incredibly loving and visualize that person sitting across from the practitioner and breathing heart to heart with 1°.

#### 4. First Touch

- a. The practitioner sits by the side of the client's body to practice the Pieta window 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. Everything necessary for the practitioner to know and perceive floats to the surface under the guidance of 1°.
- b. The practitioner asks permission to make contact verbally after sensing 1° in the client with the heart dish mentioned above. This verbal permission is usually done at least once and always at the beginning of a session.
- c. Upon contact, the practitioner immediately becomes receptive and re-orientes and re-synchronizes 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.
- d. To develop afferent or sensory touch hands, the practitioner periodically maintains attention at the surface of the client's body without physically or imaginally going into the client's body. Hands are buoyant and transparent like a cork floating in water.
- e. One therapeutic intention is to sense the entire fluid body of the client as a single whole continuum breathing at the rate of 1° after the practitioner senses her own fluid body breathing with 1°.
- f. 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 1°. Biodynamic palpation involves sensing systemic shape changes in the client's fluid body rather than tissue changes although they are related.

#### 5. Pieta

- a. The client is supine. The practitioner sits at the side of the client, one hand around the shoulder and the other hand located approximately under the knee depending on the arm length of the practitioner. The practitioners' body is perpendicular to the client opposite the client's heart.
- b. 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 as if holding a bowl of living water.
- c. Practice a cycle of attunement as detailed below. The practitioner comes into relationship with the client with the heart dish, then her hands, then back to herself, synchronizing with 1° while slowly moving her attention to and from the horizon. This establishes evenly suspended attention.
- d. The embryo is formed 3D from *outside to in* around stillness. Image wholeness and eggness as a 3D reality in present time in and around the hands.

## 6. Cycle of Attunement

- a. Attunement, the movement of attention, is practiced in each window as described above. This bears repeating:
- b. The practitioner moves her attention towards her hands and away from her hands at the tempo of 1° and then expands into the stillness from her midline out to the horizon and back at the tempo of 1°. This constitutes a *cycle of attunement* that is repeated frequently in a session.
- c. Gradually one's attention becomes suspended between the spinal midline or third ventricle and the horizon so that very little effort is needed to move attention between those locations. The work generally happens from the stillness in and around the office and the natural world with the practitioner being a silent observer.
- d. Different tempos establish structure and function in the embryo. The tempo of 1° 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. 1° provides order and organization for growth and development.
- e. 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 changes the client's nervous system.

## 7. Feet

- a. The client is supine. The practitioner is sitting in alignment with the midline of the client at the feet. This notochordal midline in the spine shortens during inhalation and lengthens during exhalation of 1° as mentioned above in the spinal accordion perception. Practice the heart dish to sense being moved by 1° from the client's midline.
- b. Then the practitioner contacts the dorsum of the feet bilaterally or alternatively holds the heels in the palms of her hands. Re-orient, re-synchronize and practice a cycle of attunement.
- c. The practitioner periodically visualizes the whole transparent fluid body in the client when she brings her attention to her hands while synchronizing with 1°. This visualizing practice can happen in each window. It is important to sense if 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.
- d. This window helps to thaw out the fight-flight response. It lowers autonomic tone.

## 8. Sacrum in Supine

- a. Client supine. One hand is contacting the sacral base and L5-L4. The 3<sup>rd</sup> finger (or longest finger or most comfortable finger of other hand contacts coccyx gently and then relaxes slightly off of the coccyx. Do not lift the sacrum. Approach from the side under the client's leg by the gluteal fold with the bottom hand and above the crest of the ileum with the other hand. Re-orient, re-synchronize and practice a cycle of attunement.
- b. The practitioner may sense the arising of the primitive streak or feel the space all around and in the sacrum breathe and come alive with 1° 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. Stay 3D. Practice several cycles of attunement.

- c. The primitive streak is crucial for embodiment, for the creation of the whole pelvis and for the generation of the heart. It induces cells to form the cardiovascular and musculoskeletal systems. It initiates the formation of the notochord which is related to the spine and cranial base.
- d. 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 equilibrium in order for 1° 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 1° will move the fluid body into deeper balance. The most important instruction for the practitioner is to wait and wait and wait.

#### 9. Still Cranium

- a. Sit at the head of the table and be still. The client is supine and the practitioner’s body is at least two feet from the client’s head.
- b. Contemplate stillness both in the practitioner’s body and in the office space and out the window with the eyes open. Alternately focus on stillness in the practitioner’s body with eyes closed.
- c. The practitioner opens her eyes and gazes at different objects in the room or outside and notices their stillness in almost a very light trance state.
- d. The practitioner connects with the earth by relaxing through her pelvis and feeling the earth 100 miles or more below her while 1° is breathing itself into the floor of the pelvis, filling the fluid body and returning back down into the earth every 50 seconds. The timing of 1° is not the most important aspect of its activity. It is just an easy way for many practitioners to enter into its healing presence. It is more important to sense 1° changing directions.
- e. Sense the client with the heart dish.
- f. If it is appropriate, the practitioner may contact the shoulders of the client bilaterally as if holding a bowl of water. Make sure you are not breathing on the client if your face is close to the face of the client. Simply turn your head slightly to one side.

#### 10. 4 Quadrants

- a. During a complete session the practitioner circles around the client and contacts windows on the left side, the feet, the shoulders and a window on the right side of the client if possible.
- b. The practitioner sequences and locates herself on all four sides of the client during the course of the whole treatment. This mimics the four directions of the medicine wheel and thus honors the treatment as taking place in sacred space.
- c. Orienting to the cardinal directions is a fundamental growth process in the dynamic morphology of the embryo. It establishes not only the planes of the body, but also the four chambers of the heart.
- d. The intention is for the client to experience wholeness within the context of sacred space which is defined as having four directions with a midline of stillness. The client’s whole 3D fluid body is considered a midline. The starting point of biodynamic practice is to treat the client as completely whole and 3D as if one drop of living fluid.

## Level 2 Windows

### 11. The Zones

### 12. Snake Hold

- a. Client supine. Hands under thoracic spine between the scapulae. One hand above T5 and the other hand below T5. Both hands are palm up with the spinous processes of the vertebra in the fingers or in the palm, depending on the client's comfort.
- b. Coming into relationship with thoracic respiration, both structure and function first. Then sensing the ancient nature of breathing, what lies under thoracic respiration? Sensing the stillness and/or motion of the notochord either 2 dimensionally on the long axis or 3 dimensionally.
- c. Sensing the serpentine movement of the notochord. Or sensing the stillness of the notochord. Stillness is the deepest part of our embryonic core. The embryo orients its growth to the stillness, which is in the middle of the cellular structure of the notochord.
- d. Normalize ANS, breathing and cardiovascular function. By sensing the ancient function of breathing, the fluid body is able to reconnect with its origin which is essential for a client to in essence reconceive of himself or herself.

### 13. Clavicles

- a. Practitioner is seated at the head of the table. Hands are palm down, bilaterally spanning each clavicle. Finger pads make the contact and the thumbs are around the heads of R1 and the spine without any compression.
- b. To sense Primary Respiration and the midline, balanced bilateral movement of the clavicles and any intraosseous restrictions. The clavicles are the gateway to the pharyngeal arches and the heart anteriorly.
- c. 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. They are the gateway to the face and intraoral structures biodynamically
- d. The clavicles and their fascia directly relate to the cisterna chyli, the vagus nerve, the subclavian vein and arteries, as well as the carotid arteries. This can be very soothing for the ANS.

### 14. Primordial Breath

- a. Hands together under the crura of the respiratory diaphragm palm up. Aim for one hand above T-12 and one hand below. Take into consideration the floating ribs.
- b. Sense the diaphragmatic breathing of the client in 3 layers. Begin with the actual structures of the tissue and bones. Then go deeper into sensing the physiology of the ANS within the diaphragm. Then sense its origin through image. Is it a water creature or a land animal?
- c. This part of the diaphragm starts outside the body wall in the embryo along with the anterior pericardium. During the process of embryonic flexion they both come into the body in their respective locations.
- d. Induces a deep Stillpoint and opens the heart. Begins to allow client to breathe with the natural world and tune into the interface of Primary Respiration with secondary respiration. It directly relates to the Ignition process.

## Level 3 Windows

### 15. Three Fluid Spheres.

- a. Students sit in pairs leaning on each other's backs, gradually heads bowing forward and finally making an umbilical connection with the hands or belly to belly.
- b. For the student to begin to sense the three gestures of connection of the central body to the peripheral body: dorsal, sacral and umbilical. 3-D and 1° are essential. Focus on the heat.
- c. The connecting stalk is the most fundamental relationship between the two bodies of the embryo. It precedes the development of the umbilical veins and arteries.
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### 16. Bubble of Love

- a. Client is in side lying position, curled up in fetal position with head towards the knees. Practitioner's hands are spanning from the top of the head to the bottom of the feet or knees.
- b. Sensing and visualizing the client as an embryo within a large bubble of fluid, both in front, in back and around them, breathing at 1°. Wait until the entire fluid body breathes as one drop of fluid.
- c. To begin sensing the yolk sac, amniotic sac and chorionic sac as one breathing bubble of fluid.
- d. The focus is on maintaining 3-D and sensing wholeness within the client as the activity of 1°. Focus on sensing the movement and activity of heat.

### 17. RTP (Reciprocal Tension Potency of the Fluid Body)

- a. Hands together under thoracic spine of client, such that pinkies are touching.
- b. Observing the three dimensional motion of RTP and its still points. EV4 is a still point at the end of inhalation. CV4 is a still point at the end of exhalation.
- c. The RTP is the interface between 1° and the direct current or the longitudinal fluctuation of the fluid body, especially as it appears at the beginning of the third week of development.
- d. To allow the life force to permeate to every cell in the body.

### 18. Coccyx

- a. Place the pad of one finger in proximity to the client's coccyx.
- b. Sense any one of the following possibilities: 1°, intraosseous sacral movement in the Long Tide, the longitudinal fluctuation of the fluid body or the inherent motion of the neural tube.
- c. This is where the primitive streak begins at the third week post fertilization. It is associated with heart development and embodiment in general. The longitudinal fluctuation of the fluid body is what initiates the primitive streak.
- d. This position is also specific to the 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.

### 19. Cervical Heart Fulcrum.

- a. Practitioner is seated above the head of the client and places the pads of one finger on either hand under the nape of the neck (C3-C4).
- b. To sense the embryonic fulcrum of the heart and balance the space above and below the foramen magnum.

- c. This is the original fulcrum of the embryonic heart based on the position and location of the primitive node.
- d. As mentioned, this balances the head with the rest of the body when sensing 1° moving posterior to anterior through this fulcrum. This hand position precedes any work on the head itself.

#### 20. Scapular EV4

- a. Practitioner is seated above the head of the client and places the client's scapula, one in each hand bilaterally. Practitioner must remember to turn head and not breathe onto the client's face.
- b. To sense the heart and thus the parasympathetic nervous system breathing with 1° or RTP (Reciprocal Tension Potency). Please refer to sensing RTP..
- c. This is the hard covering of the back of the heart and connects the hands and arms with the heart.
- d. Frequently, the RTP will stillpoint at the endpoint of its expansion or inhalation phase. This stillpoint will then resolve into the fluid body systemically breathing with 1°. This is very beneficial for the entire ANS.

#### 21. Respiratory Diaphragm 1

- a. Practitioner is seated at the side of the table and places both hands, palm up under the client's spine, with T12-L1 located at the junction of the right and left hand.
- b. To begin to sense the relationship of 1° to secondary respiration.
- c. The diaphragm is the trap door, so to speak, of the heart and can modify the behavior of the heart through the respiratory sinus arrhythmia relationship between the diaphragm and heart, which developed prenatally.
- d. The diaphragm is not only related to the heart and 1°, but also is the fulcrum for the fluid body, according to some osteopaths. Secondary respiration is always a significant consideration in every biodynamic session.

#### 22. Three Spheres

- a. This work will be in triads. One person will be the therapist. One person will be the client and the other, a witness. Sometimes the therapist will negotiate contact with the client and sometimes the witness will negotiate contact with the therapist while he/she is in contact with the client. The client will be supine and the hand contact will be under the lumbar spine of the client with palms up.
- b. Each person in the triad will rotate between being a yolk sac, a chorion and an amnion. This will include building a connecting stalk between the therapist amnion and the client chorion. Each person in the triad will rotate through these positions. In addition, different images such as chorionic blood, trophoblast and embryo will be used in order to facilitate regular role switching during a session.
- c. It is essential that a connecting stalk be made between the embryo in the second week, which consists of a yolk sac and an amniotic sac connected to the chorion and trophoblast. In the meantime, the first appearance of embryonic blood arises and surrounds the inside wall of the chorion. It contains connective tissue and a bridge or stalk must be made to connect the embryo to the surrounding trophoblast, which is embedded in the uterus.
- d. The therapeutic relationship involves the therapist being able to switch roles constantly with the client.

23. The Heart Surge.

- a. This particular exercise is for somatic concentration. It is a variation on the theme of orienting to one's soma three dimensionally. Whereas, in the early stages of the training, the focus was on getting an image of the skin and the total surface volume of our body, now we will begin to focus on the inside presence of motion and stillness.

As the practitioner sits at the side of the client, she takes a moment to orient to her body three dimensionally. Gradually the practitioner shifts her attention to the center of her chest or more focally, the area between the sternum and front and the thoracic spine in back. The intention is to be able to sustain an awareness of the movement and activity of the heart and cardiovascular system. Without taking your pulse manually at your wrist or carotid artery, is it possible to just sit still and actually feel the motion and activity of the heart and blood as it moves through and around the heart? Just like Buddhist meditation, if your mind begins to wander into past or future thinking, simply bring yourself back to your heart movement. What is the quality of the movement? How would you describe in words or with an image the activity of the heart? Does it feel like a pumping motion? Or is it more accurate to describe it as a throbbing or a pulsation? Does it feel like the blood swings through the heart space or surges through the heart?

In what way can you gradually extend your awareness of the motion present in the heart space throughout your body? Try sensing the aorta and subclavian arteries and carotid arteries. Then try sensing your abdominal aorta or even the mesenteric arteries in the floor of the pelvis. How about the femoral artery in the groin? Each time you diffuse your awareness into your body to sense the central pulsation of the heart as it exists three dimensionally in your fluid body, notice where it feels weak and where it feels strong.

- b. Now that you have spent some time focusing and maintaining your ability to concentrate on your own heart and the motion present consciously of your vascular system, it is time to put both hands on the client. Once you receive permission to make contact with your partner, slide both of your hands palm up under the low back and diaphragm. Verbally solicit the comfort level of your partner. Now immediately return your focus to your heart motion. This time, notice the surging or pulsation of the heart in your arms and hands. It is expected that there will be an increase in vascular motion, especially with the pressure on your hands from the client's body weight. See if you can synchronize the motion present in your heart space to that of the motion present in your arms and hands. Wait until you can actually feel surging and pulsation become accentuated in your hands and arms.
- c. Now begin to bring your focus and attention to that area of your client's skin and subdermal space. Allow for the pulsation and surging you are experiencing in your hands, arms, trunk and body to be matched by similar surging and pulsation localized to where your hands are on the client. Attempt to bring the surging and pulsation of both your vascular system and the client's vascular system into a synchronized wholeness. This means that it will feel like the two vascular systems are merged together and pulsing as one entity. It's likely that you will have to practice swinging your attention back to your heart and away from the client's skin and subdermal area several times. This is a variation on the theme of attunement that we have been practicing for some time now. You may even want to bring your attention up and out to the horizon.

There are several benefits to this practice. Most notably focus and concentration consciously on the motion present in the heart and vascular system can change brain structure, especially the insular cortex. This is a region of the brain that reads and

interprets emotional charge. Consequently, by just focusing on the heart activity, you can decompress your emotional body.

#### 24. Heart Tube Breathing

- a. It is not unusual at all that in the coupling of two vascular systems that either or both hearts will begin to accelerate. This is a very natural response and, in fact, may not even be an increase in heart rate, but rather an enhanced awareness of the motion present in the heart space. If the practitioner begins to sense her heart begin to beat quickly, the following breathing exercise will be helpful. This is a variation on what is called a “square breath” in the Sufi tradition. The practitioner holds the awareness of the heart activity and brings her attention to her respiratory diaphragm. First the practitioner will take a long, slow breath as if imagining that the heart is a tube and it is straightening out so that at the top of the inhalation, the top of the heart tube extends slightly above the head and the bottom of the heart tube extends down to the umbilicus. This dimension of the square breath is practiced at least three times in succession.

Then the practitioner shifts her attention to breathing the heart space between the sternum and the thoracic spine. This time the practitioner imagines that the heart is a simple sphere of fluid and can expand much like a balloon to touch the underside of the sternum and the anterior spinal column. Again, repeat this part of the breath three times. Then the practitioner breaths laterally between the two sides of the rib cage. Once again, the practitioner imagines that the heart is a fluid filled sphere and is stretching the container laterally with three successive breaths. Finally, the practitioner imagines that her whole body is the heart space and with each breath the heart expands to fill the entire undersurface of the skin throughout the body. Then the practitioner can imagine that she is breathing her heart approximately 10-12 inches outside the surface of her skin. This is practiced at least three times. For a more thorough description of this Sufi style of breathing, please refer to *Living from the Heart: Heart Rhythm Meditation for Energy, Clarity, Peace, Joy, and Inner Power* by Puran Bair.

#### 25. The Notochord.1

- a. In this window, the client will be in a side lying position. It does not make any difference whether they are lying on their right or left side. It could be important to offer the client a choice as to which side they prefer to lie on. The other important postural component of this protocol is that the practitioner’s arms and shoulders will be slightly lower or slightly beneath the plane of the top of the massage 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, because the critical component is strain in the wrist and shoulder/neck tension in the practitioner.
- b. The practitioner establishes the intersubjective field of orienting, synchronizing and attuning. This can be done with the surge as just learned above or with establishing the outside or inside presence of Primary Respiration. The term outside presence of Primary Respiration refers to the sensibility of perceiving Primary Respiration moving back and forth from the horizon into the practitioner’s awareness and attention. The term inside presence of Primary Respiration refers to the sensibility of apprehending Primary Respiration moving back and forth from the midline or fulcrum inside the practitioner’s fluid body out to the natural world and back.
- c. Relating with the notochord requires the practitioner to refine their skills of apprehending the inside presence of Primary Respiration in their 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 dimensionality in her own fluid body, then she brings subtle attention to the entire length of her spine from the coccyx and 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 top of the notochord embryologically.

Primary Respiration has several vectors that move in and around the spine. It is always better to start with a two dimensional vector. Then Primary Respiration can direct you where it wants you to go. The two vectors that are sensed in the notochord of the spine are one that comes from the top of the head straight down the spine for 50 seconds and then changes direction, comes right up through the earth through the pelvis and right through the top of the head for 50 seconds. The other vector is one that I tend to focus on which is the embryonic vector. This vector is like an accordion opening and closing for 50 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 micromovement. Then when Primary Respiration reverses itself and the notochordal midline shortens, there will be a slight sensation of the spine and head going into extension. This will relate to the hand positions that we will be using later in this exercise.

Always be ready to allow Primary Respiration to teach you something you don't know about. It is always willing to show you another dimension of its activity. For example, as I was practicing these exercises getting ready to teach them, I noticed something quite different than just the notochordal midline flexing and extending in 100 second cycles. I simultaneously became aware in my fluid body of the downward growing motions of the embryonic gut tube and heart-liver complex. In other words, as I was sensing my spine flexing at the same time, my entire anterior fluid body was shifting downward towards the floor of the pelvis. At first, it was a very exotic sensation because of how much three dimensionality in my fluid body that it encompassed. Fortunately, I knew the embryology and could actually then sense how my embryo was moving and still is as an adult. It was actually quite relaxing for my entire gut system and vascular system. It also related the spine and nervous system to these anterior components located in the fluid body of my embryo.

- d. Once the practitioner is comfortable with the inside presence of Primary Respiration in her own fluid body, she 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 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 moments. I actually once had a student who developed carpal tunnel syndrome because of the stress that this hand position placed on her wrists. 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. Wait for Primary Respiration to reveal which vector in the client's notochordal midline that it wants to show you. Track several cycles of Primary Respiration.
- e. Once you have gone through several cycles, you will switch the hand on the occiput to a very light, single fingered contact over the glabella. The glabella is the center of the forehead between the eyebrows and slightly above the bridge of the nose. Once again, you are on the very top of the notochordal midline because the sphenoid is posterior to your finger on the glabella. The bottom hand or the sacrum switches down closer to the coccyx. In this way, your 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 Primary Respiration reveals itself once again. It is important to solicit the comfort of your client because of the finger position on the face. Make sure that your arms and wrists are well supported by the table or other pillows. Once you create a bigger wing span with your arms, you will need to sit higher up than when you had contact with the sacrum and occiput.

- f. 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 you just gave to the client. This is a very strong over focus on the midline of the client. Up until now, we have been attempting to establish a relationship with the total form and three dimensionality of the client's fluid body. This marks a significant shift in our intention with biodynamic practice. The practitioner must be mindful that when a client has a core level disturbance, the midline may be quite protected or challenged. Consequently, this side lying position should not be used in the first several sessions with a client until you have a clear sense of the client's fluid body being able to respond to the priorities of Primary Respiration. In addition, it is not enough to be able to sense Primary Respiration. The practitioner must also be able to establish a conscious relationship with a dynamic stillness that permeates the office space. It is the type of stillness that is filled with precision, clarity and non-thought. This allows the fluid body to go into what Dr. Jealous calls a neutral. The neutral is the way in which the fluid body pauses its motion and re-establishes its own relationship with a dynamic field of stillness that not only exists within it, but three dimensionally all around it.

## 26. First Breath.

- a. The first breath is defined as the synchronization of Primary inhalation with secondary inhalation or diaphragmatic breathing of an infant immediately after birth. Hence the name "first breath." In the adult client, this synchronization is designed to happen randomly. However, many clients are rarely synchronized with their first breath for many reasons. Consequently, most clients do not take a deep breath during a session.
- b. In order to be in correct relationship with first breath dynamics in a client, the biodynamic practitioner must be able to observe his own relationship with how Primary Respiration actually controls secondary respiration or diaphragmatic breathing. It is important that the practitioner meditates on this relationship privately at first and get a felt sense of how Primary Respiration manages biological breathing. To do so the practitioner must sit still in a contemplative manner and first bring his attention to the inside or outside presence of Primary Respiration.

Once the practitioner has synchronized his attention with the slow tempo of Primary Respiration, he divides some of his attention and observes the rise and fall of his breathing. I like to focus on the movement of the diaphragm in relationship to Primary Respiration. At first one's attention moves back and forth between Primary and secondary until one's attention can hold both together. Once the practitioner can hold both events simultaneously, then he can allow himself to notice how Primary Respiration is actually "in control" of secondary respiration. This may feel like a second pair of hands around the diaphragm or a more spiritual sense of being held by a greater power.

After all, Primary Respiration is not the object of our consciousness but rather we are the object of its consciousness. It is more the state of mind of yielding rather than seeking in the biodynamic practitioner. In this realization, there will be the spontaneous and sometimes sudden urge to take a deep full breath. This is synchronization of the first breath and the ground of birth ignition.

Oxygen is necessary to fuel the fire of life and the spark of the Breath of Life that occurs at the beginning of Primary inhalation now has enough oxygen to ignite the

thermal regulatory system of the infant and adult. Such synchronization returns warmth to the extremities of the client in cases of trauma.

- c. The practitioner then takes this deeply subjective quality of the self observation and contemplation of the two breaths into the treatment room and begins to watch himself, especially regarding the impulse to take a deep breath. Most contemporary clients and many practitioners are what I call impulse impaired when it comes to recognizing the need of taking a deep breath. Consequently, this is an act of self observation that takes place within the practitioner first and foremost.
- d. The practitioner then begins to practice taking a minimum of five deep, slow, full inhalations during every session with the client. Once the practitioner has taken a deep breath, he then observes if his perception of the relationship of Primary Respiration to the Stillness in himself has changed. He also observes if the client changes his respiratory pattern or takes a deep breath through the resonance of his own breathing.
- e. Once the practitioner is familiar with his own first breath and can sense the interrelationship with Primary Respiration and the respiratory diaphragm as well as the spontaneous urge to take a deep breath, he then begins to observe how and when the client takes a deep breath. As I said, many clients do not take a deep breath during a session and this is ignition related information that is important for the practitioner to know about birth dynamics, thermal regulation and whether or not the fluid body has an active, regulated midline. This can revitalize the client's midline very unobtrusively. But it must be done from a grounded awareness of the practitioner's own first breath dynamics. Otherwise, there is a risk that the midline of the client will need to defend itself and go into a defended state of stillness. In other words, the client will "play possum." This is, of course, an unconscious response and there will still be enough dynamic activity occurring in the client's soma to fool the practitioner into thinking that a positive outcome has occurred. One osteopath has called this a false fulcrum.
- f. When the practitioner is comfortable with his own first breath and clear about the client's capacity to take a deep breath or not, he informs the client before the next session begins that he will be asking the client to take one or more deep, slow, full breaths during that session.
- g. The timing of asking the client to slowly inhale is during the last ten seconds of Primary exhalation. This requires that the practitioner have a good sense of the client's Primary Respiration and especially before it changes direction. Just as Primary exhalation in the client is reversing directions to the inhalation phase, the client will then be in the mid to ending cycle of their slow deep inhalation.
- h. The slow full breath of the client will then peak at the beginning or shortly thereafter of Primary inhalation and this will augment the spark of the Breath of Life. Gradually with practice, the client can be asked to take additional breaths and be trained to recognize the impulse more directly. As I have said in class many times, the pilot light in the client's midline is out and needs to be rekindled. The spark of the Breath of Life is an event of light and quantum speed that moves from the third ventricle down the midline at the beginning of Primary inhalation. Tim Shafer calls it "the ideal impulse function." It initiates the movement of the fluid body and its longitudinal fluctuation coming from the coccyx up towards the third ventricle and intersecting at Sutherland's fulcrum.

Sutherland's fulcrum is located in or around the great vein of Galen, which is between the anterior end of the straight sinus and the posterior aspect of the third ventricle, specifically the pineal recess. This is an embryological fulcrum that begins at lamina terminalis, which is the anterior border of the third ventricle. Through the different phases of growth and development in the embryo, this fulcrum automatically shifts back and forth from the more traditional location of Sutherland's fulcrum.

Sutherland's fulcrum is a tissue and osseous fulcrum whereas lamina terminalis is a fluid fulcrum. All this means is that the organizing center of brain growth shifts between these two fulcrums through life.

- i. The practitioner can ask the client to repeat the same process, but only after observing the effects echo through the whole fluid body systemically and the whole tidal body out to the horizon and back. The key is to avoid any activation of the ANS as some breathing techniques in various somatic therapies are designed to do. This skill of the first breath is quite the opposite in that asking the client to take a deep breath is done so in direct relationship with the slow tempo of Primary Respiration and not much more than three times in any one session. I have, on several rare occasions, done it more than three times with severely traumatized clients.
- j. Facilitation of the first breath is contraindicated in the first three sessions with a new client. The first three sessions with a new client are all about establishing safety and trust in the relationship and observing the client's ANS respond to afferent touch.
- k. The practitioner may need to teach the client to breathe properly which requires mechanical knowledge of the structure and function of the entire respiratory apparatus of the body. Consequently, what I frequently do is have the client take a slow deep breath before the session begins for practice, once I have informed that I will be doing this during the session.

It is important that the client have a sense of the proper bioenergetic dimensions of normal breathing. If I notice abnormal breathing dynamics such as lifting the chest up with the inhale, I know that I cannot solicit a deep breath during a session until I have taken time to coach the client into the proper biomechanics of breathing. First I cue the client's breathing seated with my hands and verbally. Then I take time to cue their breathing when lying supine on the table. It may take several sessions until the client is comfortable with a new way of breathing and should be encouraged to practice at home and report back any observations from the practice. Thus, it may be way premature to work with first breath dynamics until the client knows how to breathe normally. A good reference is *Anatomy of Breathing* by Blandine Calais-Germain.

#### Parietal Lift.

- l. 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, the second being called the temporal lift. The basic intentions are to be able to treat any side effects from the treatment that occurs with the client, especially when multiple hand positions have been used on or around the head. The anatomy is quite precise. The tentorium has two leaves to it, a superior and inferior leaf. The superior leaf has an attachment on the inferior lateral angles (ILAs) of the bilateral parietal bones. The inferior leaf has an attachment along the petrous ridge of the temporal bone. The majority of the 12 pairs of cranial nerves travel between these two leaves of the tentorium as the nerves exits the brain stem and traverses their various geographies to their end organs.
- m. Let's drop back for a moment and consider the biodynamics associated with the parietal lift. Dr. Sutherland traditionally taught any work on the cranium, first as a simple palpation of osseous motion, meningeal motion, neural tissue motion and finally, fluid motion. The practitioner's hands will initially be palm up, six inches lateral of the cranium. The practitioner imagines that she is holding a bowl of water. In this way, she can begin to sense the fluid body expanding and contracting in its relationship with Primary Respiration. Then the student slides her hands along the table towards the client's head until the little finger and hypothenar eminence make contact with the client's head underneath the ears. This is a non-specific contact point to establish a basic

palpatory relationship with the client's head. It is here where the practitioner still imagines holding a bowl of water and at the same time, begins a discovery process around the different activities and motions associated with the cranium.

- n. Once the practitioner has synchronized her attention with the fluid body, she then solicits permission to make contact with the ILAs of the client's parietal bones bilaterally. Whenever first contact is made with the head, the practitioner must solicit the comfort of the client and may even ask, "Does the contact with my fingers feel balanced from my right hand to my left hand?" The practitioner can also suggest to the client that, at any time the client senses a greater pressure coming from one hand to the other, he says something to the practitioner. This is especially true in learning this skill during a class. It is an opportunity to learn the delicate balance necessary from hand to hand, especially when cradling the client's head in any of the numerous cranial hand holds taught throughout the industry.
- o. Now that proper contact has been established bilaterally with the ILAs of the client's parietal bones, the practitioner practices several cycles of attunement and notices the quality of motion present each time she brings her attention back to her hands. Typically, I am only making contact with my client's ILAs with the pad of my 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 you use the tips of your fingers, it creates too much flexion and compression, not only in the practitioner's hands, but possibly compression into the client's cranium and nervous system.
- p. Each time the practitioner brings her attention back to her finger pads, she is waiting for the various components of the cranial mechanism to reveal themselves in whatever sequence it chooses. It is enough to just sense Primary Respiration breathing in the fluid body three dimensionally from the ILAs. As a new practitioner, this may be all that is available until this skill has been practiced for a while. 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 Delorian automobile. The pivot point for the gull wing motion is more centrally located below the superior saggital suture of the cranium and in the breathing motion, the wings under your finger pads flair out and the hinge below the superior saggital suture depresses. Then the motion reverses itself.
- q. After several cycles of observing this motion, the parietal bone may suddenly disengage within the fluid matrix that it developed in. This disengagement process 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 will feel as though the client's parietal bones are floating towards the practitioner's belly. Their nature is to float and not retract back down. If they do retract back down, then just wait several more cycles until they are able to float on their own. Finally, 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 Primary Respiration and not become over focused on the cranium, the entire midline of the client will have an opportunity to ignite biodynamically.

## 27. Temporal Lift.

- a. As mentioned previously, the first contact that I make with the client's head will generally always be at the inferior lateral angles of the parietal bones. I believe this is the safest approach for first contact with the client's cranium. It is also a skill used to treat side effects from sessions when the client feels subtly compressed in their head. If a client

expresses discomfort around their cranium at the end of a session, then the temporal lift and parietal lift plus holding the sacrum and feet are the priorities for stabilizing the client. The parietal lift, however, only works with the superior leaf of the tentorium. So it is best to follow up the parietal lift with the temporal lift.

The temporal lift, which is used to evaluate the inferior leaf of the tentorium, is done with the thumbs under the mastoid processes bilaterally. The temporal lift is performed with stacked hands. This means that the practitioner places his or her 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.

Once the practitioner has reoriented, resynchronized and reattuned to Primary Respiration 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. The temporal bone is a highly sophisticated bone that houses the facial nerve, vestibular nerve and acoustic apparatus. 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.

In addition, the temporal mandibular 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, not only of the temporal bone, but the flexion and extension of the tentorium itself. This adds additional dimensions and layers of experience to the practitioner's perception of Primary Respiration. As always, any hand position should monitor any and all of the seven levels of motion in the cranium prior to initiating a functional intention in the cranium.

## Level 5 Windows

### 28. Umbilical Cord 1

- a. 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 and 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. The client is in prone position. If at all possible, the client's head needs to be supported by a face cradle inserted into the end of the treatment table. A bolster should also be placed under the client's ankles. There are, of course, some clients who will not be able to lie prone on the table and therefore, this skill in this position is contraindicated for such a client.

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, is he or she able to have 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. 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.

Now the practitioner can reorient, resynchronize and reattune. When the practitioner attends to the hands, it is for the purpose of exploring the above intentions. The first intention is to sense the fluid body breathing three dimensionally with Primary Respiration. The second intention is to notice any of the ten developmental movements of the midgut. Please refer to my chapter on the Developmental Movements of the Midgut and review the 10 movements.

Finally, 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.

It must be stated that many clients have had surgeries affecting their pelvic floor organs, such as hysterectomies, prostatectomies, colon resectioning, etc. All such surgical interventions on the pelvic floor and the midgut will create adhesions within the fascial and diaphragmatic system. This translates into a loss of motion and a loss of function. In these cases, coming into relationship with the sacrum, as well as more specific windows around the respiratory diaphragm will be invaluable.

## 29. First Gaze – Umbilical Cord 2.

- a. This particular skill 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 at the beginning of this chapter, immediately after the infant's body is fully out of the birth canal and taken its first breath. This sequence is experienced non-linearly as: 1. the cutting of the umbilical cord, 2. the first skin to skin contact with the mother usually on the mother's abdomen and chest, which is called sustained skin contact so necessary to establish thermal regulation (heat distribution) and ignite the capacities of digestion, absorption and elimination from breast feeding, 3. the birth and death of the placenta, 4. the infant crawling up the mother's abdomen and chest to begin breast feeding, 5. the first gaze of the mother at her newborn on her breast, 6. the first gaze of the infant at her mother's eyes from the position of the mother's breast. This mutual eye gazing process in conjunction with breast feeding and sustained skin contact allows unconditional love to be given, received and embodied by the infant.

This window involves the client being in supine position with a bolster under their knees. The practitioner will also need to have props for their elbows and arms, because now the practitioner will place both hands palm down on the client's abdomen. The hand position will be exactly the same as it was located in Part 1. The touch is as usual very buoyant and focused on gamma touch. In other words, the practitioner is sensing the client from the back of the practitioner's 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 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.

The skill involved with this window has several extra elements associated with it. First, the practitioner considers their arms and hands to be the umbilical cord. 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 practitioner's arms into the hands. Frequently, as the practitioner deepens into this skill, he or 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 or himself as the mother of the client and the client as the placenta. In other words, visualize the entire body of the client as this gorgeous, pulsing, blood filled, living placenta that once was attached to the client. Recent research in fetal placental development has shown that the human placenta maintains critical functions associated with the limbic system, especially the hypothalamus, the endocrine system, in particular the adrenal glands and pancreas, the immune system and the heart and cardiovascular system. The placenta could almost be considered the fetal twin. This is a good reminder that the placenta should no longer be considered merely a filtration system. It is an active extension of our early somatic reality.

Now here is the next skill for the practitioner to learn. Periodically, in the attunement process, as the practitioner moves their attention out and back from the natural world, he or she will trade places imaginally and become the placenta. Thus the client will then become his or her own mother. This role reversal is a critical part of this biodynamic skill. The question becomes when is this window finished and how do I discern disengagement. This gets back to the notion of synchronizing Primary Respiration between the practitioner and the client into one living dynamic. This is similar to earlier skills associated with the egg of the client and the egg of the practitioner becoming one egg and breathing with Primary Respiration as a single drop of fluid.

One of the skills that can enhance this window is for the practitioner to occasionally look at the client's face and have 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 their hands on the client's abdomen, this can be equated with the first touch as mentioned above. Together with the first breath in a previous chapter, the first gaze and the first touch when coupled with Primary Respiration are able to undo the harm of birth related stress and trauma. It must also be remembered that when Primary Respiration is not available as a therapeutic reality, then the dynamic stillness must be accessible and usually is. Thus, disengagement may also include the apprehension of stillness permeating the space.

#### Mandible - Foregut Part 1.

- b. The foregut consists of the bones, muscles and other embryological derivatives of the face, pharynx and esophagus. In this particular window, as with all windows of the face, it must be remembered that throughout prenatal development and all the way up through adolescence, the face is developing horizontally. Consequently, any palpation of the face must be done with this sensitivity and quality of movement. In order to evaluate the face a good starting position is to hold the mandible and sense its horizontal and vertical movement. Once young adulthood approaches, the face then moves into its vertical

growth pattern. The hand position recommended here will allow you to feel the movement of both adult and pre-adult back to the embryo and through childhood and the teen years. Because hand size in relation to client's face size is the determining factor in this window, remember to gauge its placement accordingly.

The practitioner sits at the head of the table and after orienting to stillness places each hand on the side of the client's head so that the thumb or thenar eminence is on or near the condyles of the mandible. Some finger(s) are placed onto the ramus and another gentle finger connection over the mandible bi-laterally at the hyoid is recommended for a full sense of both movements and their rebalancing for the client in each of the horizontal and vertical vectors. The wrists and arms must be supported properly on the table. The practitioner must be able to relax both hands once he or she has found a comfortable hand location.

Remember that the muscles attaching to the hyoid bone include the floor of the mouth, up to the mastoid process at the styloid process of the temporal bone and down to the clavicle. This involves 10 muscles. So at the hyoid you have your hands on the lower face, mouth, and neck indirectly. The mouth and throat is how we express ourselves in the world and form from the pharyngeal arches of the embryo. Remember to access the fluid fields of the embryo when ever you are on or around the face. The sense of disengagement occurs when the horizontal movements of the infant mandible balance with the vertical movements of the adult mandible and typically a stillpoint is achieved. At this point, the bone itself may begin to breathe three dimensionally with Primary Respiration. This skill reflexes into the TMJ and the cranial base.

This is the first part of working with the foregut. There are many skills and windows to master when working with the foregut. These skills will be unfolded in subsequent chapters. There are two ways of approaching the face. The learning in this chapter is the biodynamic approach. The other approaches are the traditional skills of working with the face and mouth that have been handed down through the tradition of osteopathy in the cranial field. For an excellent review of the traditional skills of the face and mouth, please refer to Chapter 10, "Facial Dynamics," in *Volume 2 of Craniosacral Biodynamics: The Primal Midline and the Organization of the Body*, pp. 171-184 by Franklyn Sills, North Atlantic Books, Berkeley, CA, 2004.

### Level 6 Windows

30. Face Seams - Foregut 2. (Lateral contact on the face and neck. Practitioner's fingers are in between the pharyngeal arch derivatives)
  - a. Hyoid
  - b. Angle of mandible
  - c. Zygomatic/maxilla interface
  - d. Temporal Mandibular Joint
  - e. Calvarian
  - f. Process:
    1. Begin with the hands 10-15 cm lateral of the client's head.
    2. Synchronize practitioner attention with Primary Respiration in or around the client.
    3. Verbally negotiate contact with the first seam.
    4. Orient to the stillness in the seam.
    5. Synchronize with lateral-medial movements of the fluid body, followed by 3-D breathing in 1°.
    6. Observe ignition phenomena if available.

7. Care must be taken to insure that the practitioner's hands and arms are well supported during each window.
8. The practitioner must remember to have their hands open and extended rather than flexed . The work is done with finger pads not finger tips.
9. Repeat A and B with each seam.
10. Contact the fluid body with Pieta position and wait for decompression.
11. Contact the sacrum (if appropriate).

### 31. Anterior Midline

- a. Anterior midline is an embryological seam.
- b. It is open from head to pubic bone during the embryonic time.
- c. It actually does not close physically until a month after birth when the umbilicus has healed from cutting the umbilical cord.
- d. The contact is with a single finger pad on each point mentioned below.
- e. Note that each couplet of points overlaps from the previous couplet:
- f. Bregma – interorbital ligament (IL)
- g. IL – upper lip
- h. Upper lip – mid mandible (chin)
- i. Middle chin – sternoclavicular notch (SCN)
- j. SCN – xyphoid process (XP)
- k. XP – umbilicus
- l. Umbilicus – pubis
- m. Pieta
- n. Feet
- o. Process:
  1. Orient to 3-D stillness.
  2. Synchronize with 3-D heart and blood.
  3. Let the fluid body decompress.
  4. Sense each of the 2 points connecting via 1°.

### 32. Lower Extremities.

- a. Starting at the feet, I like to hold each foot by itself with my index finger and thumb of each hand holding the navicular-cuboid bone relationship. It has been said in osteopathy that the navicular-cuboid relationship is analogous to the sphenoid-occiput relationship.
- b. The next sequence for the lower extremity is 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.
- 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. Again, this is a non-cranium vault hold in order to sense Primary Respiration breathing the lower extremity.
- d. Once the practitioner senses this possibility then he or she switches hands and the bottom hand moves from the ankle to the knee while the top hand moves to contact with the fifth lumbar vertebra. L5 is the osseous fulcrum for the lower extremity and the practitioner waits to sense Primary Respiration breathing between his or her two hands.
- e. Sometimes in a client who has a lot of low back, pelvic and/or extremity issues, the osseous fulcrum can shift higher up in the lumbar or lower down in the sacrum.

### 33. Becker Hold

- a. 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.
- b. 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.
- c. As with any hand position around the head, the practitioner, while seated above the client's head, places their hands six inches laterally of the client's ears and begins to imagine holding a bowl of water and sensing Primary Respiration.
- d. Once the practitioner has synchronized attention with Primary Respiration, both in herself and around the client's head, the practitioner negotiates verbal permission to make contact with the side of the client's face.
- e. The sides of the thumbs are placed buoyantly over the skin covering the greater wings of the sphenoid.
- f. The palms of the practitioner's hands are over the ears, but not in contact with the client's ears, if possible.
- g. The practitioner uses the little fingers bilaterally to find the occiput right where it meets the table.
- h. This particular window requires that the wrist and forearms of the practitioner be supported very securely.
- i. The sphenobasilar joint space was formed by two metabolic fields at the superior tip of the notochord. The first metabolic field involves a longitudinal movement up and down the notochord. It is sensed as a very slight compressive force with a fulcrum around the base of the sphenoid and base of the occiput.
- j. The second metabolic field is more of a radial expansion/compression moving away from the fulcrum of the cranial base and towards it. These are the basic metabolic motions of the cranial base that the practitioner seeks to come into relationship.

### 34. A-O Joint.

- a. The Atlanto-Occipital joint space is a critical area to relate with biodynamically. It is here where the suboccipital triangle of the capitis muscles are located. In addition, the jugular foramen is an important structure that allows the jugular vein to pass through along with the ninth, tenth and eleventh cranial nerves. The jugular vein allows for almost 95% of venous drainage from the head. Also, the vertebral artery winds its way through this area into the cranium where it branches into the meningeal artery. Finally, the atlas itself has a crucial interface with the occiput and can become dislocated easily.
- b. The practitioner is sitting at the head of the table and rests her hands approximately six inches laterally of the client's head. She imagines that she is holding a bowl of water and waits for Primary Respiration to begin breathing from the client's head.
- c. The practitioner negotiates permission to make contact and simply slides her hands under the A-O joint area such that the finger pads of the longest fingers are gently up against the suboccipital triangle. The practitioner can sense the proximity of the occiput and ultimately the fingers are in between the spinous process of C2 and the occiput.
- d. The next step is to get the practitioner's hands into a proper position. The practitioner's hands slightly overlap with the ring and little fingers in such a way that the edges of the middle fingers (or depending on the size of the practitioner's hands, the index fingers as well) come together. 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, thus the A-O joint space. The pads of the middle fingers of the practitioner are resting against the client's occiput. There is an attempt to softly cradle the client's head and to have full contoured contact of the client's cranium in the practitioner's hands. Then the practitioner listens for a while before the next step. The next step involves bending the tips of the middle fingers back slightly and having the client lift their chin ever so slightly. This allows for the tips of the middle fingers to wedge slightly more firmly into the A-O joint space. Again, there is a need to listen for a minute or so during each stage of the process.

There are important variations in which while cradling the A-O area with the tips of the middle fingers, a figure eight is intended into the sub-occipital triangle in slow motion. The practitioner periodically stops the motion and listens. The next variation is to gently laterally spread the middle fingers by moving the elbows together. The final variation is to place a microgram of traction of the occiput to stress the dura. This is a very delicate traction that is done for several seconds and then released. All of this work is based on the practitioner's ability to stay related with Primary Respiration. This especially includes being able to sense the bones of the cranial base breathing with Primary Respiration.

- e. One of the nicest effects of the A-O joint release is how it settles the entire autonomic nervous system. The point of contact is the tips of the middle fingers of the practitioner in the space 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 of the suboccipital triangle actually goes through the occiput between the squama and the base and inserts on the dura itself. Thus, the A-O joint release is exceedingly important. The motions described above in terms of the figure 8 and tractioning are done with the whole hands of the practitioner, not just the finger tips. One of the common mistakes is for the practitioner to relax the finger tips whereas it is important to "take up the slack" as the suboccipital triangle softens. In this way, the atlas can begin to reseat itself onto the occipital condyles.

I find that when a client is really high toned sympathetically that, if I start with an A-O joint invitation, it makes it much easier to sense the fluid body and tidal body. This is a judgment call on the part of the practitioner. As mentioned above, the biodynamic practitioner starts with the whole and in the middle of a session may move to more functional work if invited to do so. Nonetheless, every session begins and ends biodynamically. In other words I may spend the first 10 minutes orienting and synchronizing with stillness and Primary Respiration and then go to the A-O, if it seems appropriate. I cannot think of a time that I would start a session with the A-O joint hand position without orienting to the stillness first.

### 35. Cranium Levels of Motion.

- a. The palpation is based on 7 different levels of motion. The first sequence of sensing involves the basic skills of orienting to stillness three dimensionally out to the horizon. This is followed by synchronizing one's attention with Primary Respiration, also three dimensionally. The practitioner must begin with a sense of his or her own soma three dimensionally.
- b. The tidal body and Primary Respiration. This begins with the ability to sense a 100 second cycle, either inside the soma of the practitioner or moving from outside the practitioner's soma to the inside and back.
- c. The fluid body consisting of either longitudinal fluctuations or more specific to the cranium itself are lateral fluctuations. The fluid body is also a 3 dimensional drop of liquid. At the cranium, there tends to be more of a specific vector of a lateral to medial

dimension of movement. This is why the practitioner, when working around the cranium, must periodically envision the whole three dimensional soma of the client. Following this, distinctions are made regarding the longitudinal fluctuation and different aspects of the lateral fluctuations.

- d. The longitudinal fluctuation is an expression of the direct current in the fluids between the coccyx and Sutherland's third ventricle. The lateral fluctuation is a perpendicular vector of fluid movement to the Midline. The lateral fluctuation can also be an expression of stress in the fluid body if it is experienced as speeding up or a figure eight type movement that is also fast.
- e. The next level of movement is the expression of the entire dural system as it expresses what is traditionally called flexion and extension. Another way of saying this is folding and unfolding. When the practitioner is concentrating on a specific geography in the client, the terms flexion and extension are used. When the practitioner is able to concurrently manage three dimensionality, there is a different sensibility. This sensibility feels more like a global or systemic folding and unfolding.
- f. The next level of expression is the bones of the cranium which are distinguished between the vault, the base and the face. All bones breathe individually with Primary Respiration. This is called intraosseous movement. The practitioner starts with his or her hands at the interface between the tidal body and fluid body on whichever bone she has contact with. At this interface, the practitioner waits for the other levels of movement and geography to come out to this interface, which is typically right at the surface of the skin. This understanding means that the practitioner places more attention on the backs of his or her hands, rather than the palms and finger pads. This also means that the practitioner is aware of the back of the arms, the head, the spine and, in general, the whole posterior surface of his or her body.
- g. The next level of movement is the neural tissue itself. Traditionally this is called flexion as the spinal cord moves superiorly and the cortex of the brain moves posteriorly and laterally in the shape of a "ram's horn". This movement has important considerations in resolving all sorts of trauma.
- h. The last level of motion that is distinguished is that of the cerebrospinal fluid (CSF). The CSF is an interstitial fluid which is connected to all the other interstitial fluids of the body. All fluids breathe three dimensionally with Primary Respiration including the CSF.

CV4 The next levels of evaluation are with the sutures between the base and the vault and then the vault and the face and so forth. There are many sutures to consider and I can only teach what I consider to be the most significant ones in this course. Consequently, the traditional starting point is to evaluate the movement of the occipitomastoid suture and its continuity with the occipitopetrous suture by using the hand position of the traditional CV4 on the squamous portion of the occiput. It is here where the occiput itself has its greatest range of motion just medial to the occipitomastoid suture. As Dr. Becker said, this is the most common sutural fixation from a vaginal birth that persists into adulthood. This is because there are important relationships between this suture and the fourth ventricle, the jugular vein and the ninth, tenth and eleventh cranial nerves. There are also 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. 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 8 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 in the tempo of primary Respiration. The majority of work is about listening and waiting for the primary respiratory system to build potency in the ventricles. 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. It is not advisable to compress the occiput this way more than two times in the session even though it is slight.

### Core Regulation

#### 36. Liver.

- a. The liver is an extremely important organ in core regulation. As food breaks down in the intestines, it passes through the villae into the bloodstream. All of the digested food and undigested food goes into the portal vein and is carried to the liver for processing. In this particular window, the client is supine and the practitioner's hands are surrounding the liver from the right side of the client. Typically the left hand of the therapist 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.
- b. The therapist begins to ride the rise and fall of the client's rib cage as she is breathing. The hands simply are a cork floating on this movement.
- c. Gradually, a deeper awareness of the liver rises to the surface above the diaphragmatic movement. The therapist is listening for Primary Respiration 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.
- d. The therapist settles into a relationship with Primary Respiration in the client's liver while practicing several cycles of attunement. The therapist may encounter a very deep stillness in the liver and the possibility of this stillness expanding out to Zone D.

#### 37. Bladder

- a. 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 umbilical cord. Some embryologists say that the allantois induces the umbilical veins and arteries to form.
- b. The client is supine. I recommend asking the client to move her body a little closer to the left side of the table since I am right handed. The therapist sits on the edge of the table and asks the client to point out the location of their pubic symphysis. Then the therapist places the heel of her hand on top of the pubic symphysis with the fingers pointing up towards the umbilicus.
- c. The therapist imagines the original allantois as a fluid filled cavity that comes up, around and on top of the pubic symphysis. While attuning to Primary Respiration in the bladder,

the therapist's hands have a tendency to rock forward in an arc and then back rhythmically with Primary Respiration.

- d. 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 hind gut or pelvic floor.
- e. Once the therapist is familiar with this hand position and the movement of the bladder with Primary Respiration, she can sit at the side of the client in a chair and use the hypothenar eminence of her hand to contact the pubic symphysis with the thumb pointing toward the umbilicus.

### 38. Small intestine,

- a. 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.
- b. The client is supine and, as with the bladder, I like to initiate the learning of this window by having both hands placed immediately around the umbilicus with the fingers pointing up towards the rib cage. Primary Respiration moves in a spiral. Sometimes the hands of the therapist may feel like they are being lifted off of the body and brought back down. Sometimes they simply stay in buoyant contact.
- c. As with the bladder above, once the therapist is familiar with this movement, she may sit at the side and place the hands perpendicular to the body plane around the umbilicus.

### 39. Large intestine.

- a. The large intestine has the same developmental vector as the small intestine above. 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.
- b. The client is supine and just as was done with the bladder and small intestine above, the therapist sits on the edge of the table and places her hands as laterally as possible on the belly equidistant from the umbilicus. Sitting on the right side of the client, the therapist's left hand will be over the ascending colon of the client. The ascending colon is on the surface of the abdomen.
- c. The basic movement is that of a spiral as noted above in the small intestine when working with Primary Respiration. The main challenge with this window is that it is difficult to do it from the side position.
- d. In addition, when working with these viscera in a biodynamic session, only two organs should be worked with in any one session. Also, the therapist should solicit verbally any signs or signals of discomfort that the client might be having.