

Specific Indirect Techniques

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In understanding how to work motility, what we have been calling “indirect work” or, in the vernacular “going indirect” and “unwinding”, can benefit from some further clarification. I hope that the definitions and descriptions that follow can begin a more discriminating language about what we are experiencing in our indirect interventions.

Induction

The primary indirect technique is induction (also called facilitation). To begin we need to listen to or “read” the motility of the particular tissue we are concerned with. To do this we need to place our hands appropriately as much around the tissue as possible without being positioned in a manner which would also pick up the motility of other tissues. Knowing the anatomy of the area and mobilizing the tissues can help with this. We also need to be positioned in a way that does not so contain or trap the tissue that it cannot move. Often we are not able to be physically in contact with the entire area of tissue we are wanting to work with. In this case we need extend our kinesthetic field to facilitate full 3-dimensional contact with the tissue. Once again, knowing the anatomy and mobilizing the area can help. However, we need to develop the use of a kinesthetic field to perceive that which is beyond our hands. This is sometimes called “end feel”. That is, feeling that which is at the other end of what we are in contact with such as, feeling through the femur into the hip socket when grasping the femur at the knee, or like feeling through a broom handle if you were going to use it to retrieve something that is out of sight and reach. Without this 3-dimensional contact we will end up working with only part of the tissue involved in a restriction. This can produce a sheering in the area and contribute another injury to the area.

We also need to work with our level of presence or focus as well when doing Inductions. Again, we will need to be present enough to contain the tissues but not so strong as to suppress them. In reading motility a focus of just 25% of our awareness on the tissue is enough. That means that 75% of your awareness needs to be elsewhere. It can be on your own body, on the environment, on a conversation with the person, etc. But, if you are focused more than this on the tissues, it can suppress the expression of motility. When reading motility patterns, an attitude of nonchalance is the best approach.

Motility is essentially the slow expansion and contraction of the tissue. The different patterns are created by the various shapes and attachments of each particular area. With mid-tide there will be an motion expressing expansion for 10 seconds and then there will be a motion expressing contraction for 10 seconds. Then this is repeated continually each 20 seconds. For tissues that express long-tide there is expansion for 50 seconds and then contraction for 50 seconds continually repeating every 100 seconds. Restrictions in the tissues are expressed as faster than normal motion. So with a mid-tide cycle of 20 seconds, there a faster motion is very quickly felt. With long-tide tissues, there is more waiting around to find the faster motion.

It is important to remember that the fast motion always occurs as the tide (mid or long) turns from one direction to the other. So when waiting and watching long tide motion, sensing when a turn in the tide is going to occur can be very helpful. With long-tide motions it is possible to feel different qualities at different stages. With these motions we can feel qualities of not just speed but also strength or power that we can call, amplitude. The amplitude will be most clear at the height of either expansion or contraction anywhere from 15 to 30 seconds into the excursion. Prior to and after that the amplitude is weaker and so the motion is less perceptible. At about 40 seconds into the excursion the beginning of the

turn can be felt. There is less clarity of direction as well as less amplitude. When the turn does occur it can feel more quiet unless there is a restriction in the direction of the next excursion. This is when a fast, rapid movement can occur. Technically, any excursion that is less than 50 seconds would indicate a restriction. However, any notable restriction will produce excursions of 5 seconds or less. Following this rapid excursion, for the remainder of the time for that side of the tide, the tissue will be still. During this pause no motion of expansion or contraction will be felt. Then, when the tide turns, a slow progress of motion will be felt for the full 50 seconds. Then at the turn, the fast motion will occur again.

In intervening with an induction, after sensing the whole pattern of motility and finding the fast motion, we would follow this fast motion its end point and pause with the tissue waiting for the reversal. We will hold a barrier against that reversal. This barrier must be only strong enough to prevent reversal. If the barrier is too strong we will overwhelm the tissue and all motile function will cease. If the barrier is just enough, the organ will move into a new direction. This will usually first be further along the line of the fast excursion. In following tissue into restrictions it is important to truly only follow and this should be done with the 25%/75% nonchalance. When we are putting up a barrier we should start with less and add more as necessary to only prevent reversal not stop all motion. At this time our presence needs to increase. A presence of 50% focus with the person and 50% focus elsewhere is usually appropriate.

After the appropriate barrier to prevent reversal is established the tissue will move in some new direction. In the beginning of the person's experience with indirect work, after just one new excursion, the tissue will try to directly reverse its direction of excursion. We need a barrier to prevent any direct reversal. Any other motion we will follow.

When working with dense tissues, such as skeletal joints or visceral tubes, the reversal will happen when the mid-tide reverses. Which is every 10 seconds. When working with less dense tissue, such as most of the visceral organs, the reversal will come when the long tide reverses which is every 50 seconds. This requires more patience but it is worth the wait. The long tide potentiates the technique leading to more profound and system wide integrated releases. There is also a much more cooperative relationship engendered with the person receiving the work which leads to more profound and important transformations and healings.

There is the possibility that from the point of greatest excursion the motion will continue in a completely different directional line. For example, at a knee we may have been tracking a left side bend as the greatest motion. At the end point of this left side bending the motion may turn and go into flexion, extension, or rotation. We can follow this new motion to its end and waiting for the next motion either further along this line or in some new direction. We are always allowing the knee joint to choose its direction, with one exception. We would not follow a motion that directly back tracks the most recent line of excursion. We would barrier any direct reversal.

The end of the induction is often experienced as a "relaxation" in the tissue. Descriptions of this relaxation will vary. In addition to the latest direction of motion no longer having any push or vitality, no new motion presents itself, and a general sense ease, softness and expansion comes into the tissues. At this point we need to change our involvement, letting our hands and focus soften as the tissue softens. There can be a period of softening which we need to wait through until the tissue begins to express motility again. We will be going from 50/50% focus to 25/75%. We can read the motility pattern again. If we perceive another rapid motion at a turn in the tide, we could do another induction. The tissue can be our guide here.

It needs to be noted that this management of all of the details of the technique is absolutely necessary when first doing inductions with someone. Their system is “investigating” the technique when you first do it. The rules of road about 3-dimensional contact, 25/75% focus, following being truly following, just the appropriate barrier and recognizing a release are very important to your being able to continue to do indirect work with this person. After the technique is understood to be beneficial (mostly this happens on a totally unconscious level for the person) then there will be much less need for putting up barriers. Your presence in following will be enough for the tissue to choose new directions of excursion and many more such excursions will occur before there is a release. There will be more room for mistakes once the body knows and trusts the process.

Balanced tension release

There is another technique that works well when there are multiple restrictions effecting one area or organ. This technique can best be described as a balanced tension release. When reading motility, if the range of motion is less than to be expected, and the amplitude of the motility is generally weak, it can be assumed that the tissue is dealing with restrictions limiting excursion in both expansion and contraction. Finding and containing a balance point for both the expansion and contraction excursion can produce a simultaneous induction of a multitude of restrictions. This technique requires that the organ or area being worked with is contained in an accurate 3-dimensional kinesthetic field. The process of induction often feels like minute popcorn being popped or a gyroscopic action with a multitude of directions. The process ends with the typical release of ease, softening and expansion and then a return to mid or long-tide motion.

To find the center point in long-tide tissues we can watch (never follow when reading motility) the motility pattern by through both sides noting the positions of furthest excursion. Then when the organ reaches the center point between those two places on its third pass we stop the motion by containing the tissue in its center point. The hold needs to be only a containment, like a barrier that is not any more than it needs to be. Our focus will be 50/50% at this time. The multidimensional releasing will start momentarily. That needs to simply be contained until a release occurs.

For mid-tide tissues like joints or major areas of myofascia we can use the same technique finding the center point in the mid-tide excursion. But we can all use mobilization of the joint or tissue. To do this begin by gently but directly mobilizing the joint to find its free range of motion. Joint restrictions will prevent a full, normal range of motion. What this test determines are the greatest points of excursion that exists for this area, not what should be normally possible. We need to test the joint or tissue in all of its functional directions. The knee, for example, has the capacity to flex, to side bend some and to shear both side to side and front to back. Some going back and forth to further range of motion is fine at this point but we should not ever try to force more motion into the joint. This will create further injury. We need to determine the center point in all the ranges of motion for the joint. Then we need to take the joint or tissue to that point and hold and contain it at that point. This hold needs gentle yet strong enough to stop any inherent motion. If the hold is correct, there can be moments of stillness. Then the many pushings and proddings of the tissue confronting restriction will be felt. These can go in several directions at once and can become fairly rapid. The technique will be complete when the entire joint or area of issue softens and expands. This release is just as it is in induction.

The choice to use induction or balanced tension is often a creative choice in the moment. The balanced tension technique can resolve more restrictions at once. But, it is difficult to master and if done incorrectly

(usually to strong of a hold), can freeze up the inherent motion for a while. This may be because, when applied incorrectly, the balanced tension technique can further traumatize the area. Usually and induction is best when first starting to work with someone so that their system can explore the technique simply at first. But also, when there is only one obvious direction of restriction, an induction is the only and best choice. Balanced tension releases work best with tissues that have multiple restrictions.

Amplification

When there are severe restrictions that aren't being freed using the methods above, there is an effective technique that can be used. Barral calls this a direct technique. Because it is entered through sensing motility, as Structural Integration practitioners we could include it in our catalogue of indirect techniques, reserving the term direct for our more forceful pressures on the connective tissue matrix. I have started calling this technique "amplification." It is most useful when the tissue has been leading into restrictions but gets bogged down, not moving and not releasing. (We need to be certain at this point that the tissue, 1, has not released and we missed that fact, or, 2, that we have not over controlled the induction and the system is in retreat.) to initiate amplification begin at the last point of the tissues excursion during the induction. At this point, make a few light thrusts along the line of excursion. This light intrusion needs to be like a slight rocking or jiggling into the restriction rather than pushing or forcing. Then, contain the area and wait to see if any further motion occurs. If and when it does, we carry on as in the induction technique, concluding when there is a release. We should let go if no new motion occurs after our thrusts.

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