The Psychobiology of the Feet

With Particular Attention to Childhood Issues

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Introduction

'Psychobiology' is a term used to connect issues of the mind and biological processes. This is right up my alley, so to speak, because I've been a Rolfer for twenty-one years now, and a student (and later teacher) of the Diamond Approach, a path of consciousness work, for an equivalent amount of time (Hoff and Knight 2017). Keystones of psychology and consciousness – who we take ourselves to be (sense of self, self-image), how we interact with others (object relations), what meaning we attribute to different experiences – are intricately interrelated with our sense of the body because the mind and body develop in tandem in infancy. In Rolfing® Structural Integration (SI) we often use the term 'embodiment'. To me the state of embodiment is mind/psyche/consciousness well-integrated with body in a way that expresses the maturity and presence of the individual at his/her current age and life stage. This will hopefully become clearer in the course of this article.

Framing the Territory

Psychobiological material can weave into a Rolfing session for better or worse. Recognizing when it arises, and allowing it room to breathe – often just by acknowledging it, and occasionally by working it more explicitly – will support the goals of Rolfing SI. The fact that the psychobiological is one of our taxonomies of Rolfing SI (along with structural, geometric, energetic, and functional) speaks to its importance as a domain where change can happen – or be held back.

Although I will mostly be discussing the *childhood* histories of clients and friends with foot issues, and how that has shown up on the psychobiological level when doing Rolfing sessions, I will start with a personal story from adulthood to give some context. In Unit 2 of the Basic Training, each student is taken through the Ten Series by another student. One day about mid-Series, the student who was my practitioner took issue with my feet. My memory is that she called the instructor over to say something to the effect of, "I've fixed Anne's feet twice already and they are flat again!" – asking the instructor's assistance on how to proceed with these recalcitrant feet. Now there was no personal friction between us, and I understood that her frustration was with the learning process of how to become an effective Rolfer, yet my immediate *body* response to her statement was a felt sense of my feet responding with something like, "Well if that's how you feel, fuck you, I'm not cooperating any more." In my mind and intention I continued with the Series as if nothing had happened. But how did my feet feel? How did my *soma* feel? How well will Rolfing sessions proceed when the body, or part of it, has gone on strike or won't/can't engage because of some historical impasse or impression?

This article will be more client stories than any particular advice on how to work with feet – particularly in terms of hands-on work. But I hope that these shared stories of feet, of bodies, of *beings* in this intimate *psychobiological* territory gives you some inspiration for an added dimension that can (and will) show up in your sessions.

The Developmental Framework in Childhood

The events of our lives impact us emotionally, psychologically, even spiritually. Psychobiological material can relate to any time in one's life, but I believe that the feet/legs often contain early history, for two interrelated (because co-emergent) reasons. The first reason is that the child is not a coherent 'self' at birth but rather develops a sense of self over time. There are many views about this, from Freud onward, but here I'll use the terms delineated by groundbreaking ego psychologist Margaret Mahler (Mahler, Pine, and Bergman 1975). As we will see with a more detailed discussion of the phases, the child's identity, such as it is, is initially fused with mother and only gradually becomes differentiated as the months progress as part of the overall process that Mahler termed 'separation-individuation'.

Second, this does not happen in a vacuum, but rather is concurrent with, and no doubt dependent upon, the development of body capacity and motor skills and the increasing capacity to manipulate objects. Between around six to twelve months, the infant starts to creep (crawl), then to stand, then to move towards taking steps, culminating in independent walking (see Figure 1).

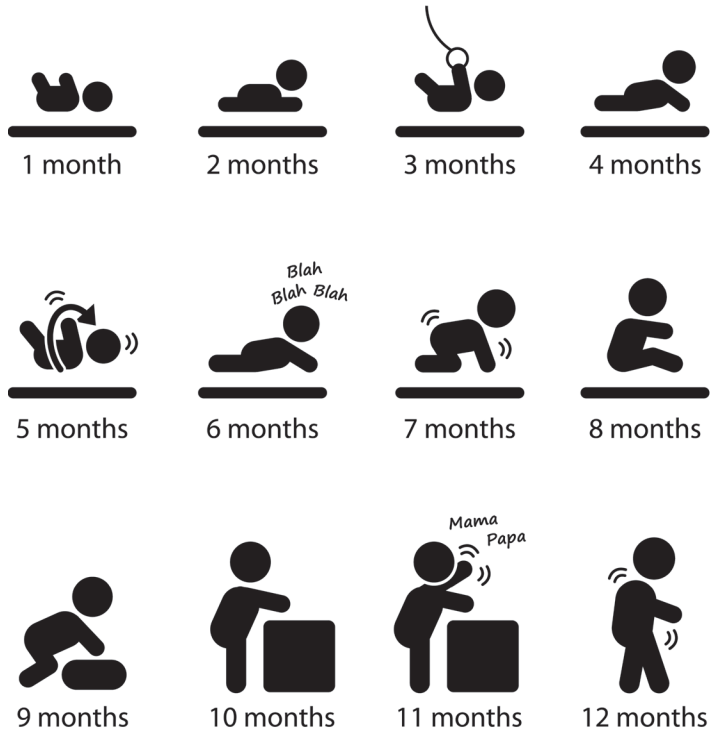

Figure 1: Schema of developmental movement milestones; ages are approximate and vary child to child.

Let's look at the stages of this progression. Note that when I refer to 'mother', I mean the 'mothering person' or 'primary caretaker' regardless of age or gender – it could be the father, a grandmother, one of the male parents in a gay couple, etc. I use 'mother' because that is the convention in the literature as well as the *archetype* for that role in art and imagery through the millenia.

Initially after birth, there's the **normal autistic phase** where "the infant spends most of his day in a half-sleeping half-waking state" responding to physiological stimuli such as hunger or other tensions (Mahler et al. 1975, 41). This moves toward the symbiotic stage with the arising "of dim awareness that need satisfaction cannot be provided by oneself, but comes from somewhere outside the self" (Mahler et al. 1975, 42-43), which initiates movements like turning toward the breast, visual following, rooting, sucking, and grasping.

Around two months of age is the start of the **symbiotic phase**, where the baby's consciousness seems to be very fused with mother in a sort of 'me-mommy' unit; according to Mahler et al. (1975, 44), "the infant behaves and functions as though he and his mother were an omnipotent system – a dual unity with one common boundary." In this state, "the 'I' is not yet differentiated from the 'not-I' . . . and inside and outside are only gradually coming to be sensed as different." A vague "feeling of self" is beginning to coalesce based on inner sensation, and it is hypothesized that sensations of pleasure are vital constituents for the developing body image (Mahler et al. 1975, 49).

At about four to five months, the **differentiation phase** begins, touch begins to form a sense of boundary, which begins to coalesce the development of body image, and the infant's attention becomes more outwardly oriented. There is new "alertness, persistence, and goal directedness" (Mahler et al. 1975, 53-54), as well as the recognition of strangers (with curiosity and/or anxiety). Not surprisingly, this coincides with the child gaining more control over his orientation in space (see Figure 1), which is going to give a whole new perspective on the world.

Next comes the **practicing phase**, "ushered in by the infant's earliest ability to move away physically from mother by crawling, paddling, climbing, and righting himself" and gradually moving into "free, upright locomotion" (Mahler et al. 1975, 65). The timing will vary, but perhaps will begin around seven months. Looking at the motor capacities that are developing (Figure 1), we can see why this ushers in a period of great exploration – the 'world' now extends past mother and the infant has the capacity to fully explore through all the senses as well as locomotion. This is exhilarating, giving the child a sense of omnipotence: the world is his oyster! Why wouldn't it be when you can begin to manipulate your body through space? Mahler et al. (1975, 72) write that, "the importance of walking for the emotional development of the child cannot be overestimated. Walking gives the toddler an enormous increase in reality discovery and testing of the world at his own control and magic mastery." In her observational studies of mother-child pairs, Mahler observed that, "mothers usually became very interested in, but sometimes also critical of, their children's functioning at this point" (Mahler et al. 1975, 73).

Although I am focusing on the development of the psychological self and motor skills, particularly locomotion, there are other developmental trajectories going on. In the practicing phase, at about ten months, the child will often speak his first word, and this developing capacity for language will continue through the next phase to about 250 words by twenty-four months (Columbia University, undated presentation). Then there's a whole other level of bodily control that represents a sort of mastery and independence from mother, particularly concerning bladder and bowel function. There is no control before twelve months, very little control between twelve and eighteen months, and actual control sometime between twenty-four and thirty months (Johns Hopkins Medicine, undated). These both overlap some of Mahler's phases, so I will leave it to the reader to interpolate.

Around fifteen months, the child enters the **rapprochment phase**. He can move freely and that combined with further cognitive development signifies "psychological birth . . . the first level of identity – that of being a separate individual entity" (Mahler et al. 1975, 76). However, he also begins to realize that he is not omnipotent and impervious to harm, as he felt in the practicing phase. "The world is *not* his oyster . . . he must cope with it more or less 'on his own', very often as a relatively helpless, small, and separate individual, unable to command relief or assistance merely by feeling the need for it, or even by giving voice to that need" (an earlier paper by Mahler, quoted in Mahler et al. 1975, 78). Thus, while he is more and more capable of independent motion and action, he also is more aware of needing mother's love and support. The child's great developmental achievement of being a separate (locomoting) self brings with it a dilemma – "I need you / I don't need you" – and this gives rise to behavior characteristic of this period: 'shadowing (of mother) and darting-away (from mother)' (Mahler et al. 1975, 77). To the degree that mother is tolerant of both behaviors – responsive when the child needs to cling to her, and willing to let go when the child needs to be autonomous – the infant psyche will successfully navigate this phase, which ends around twenty-four months, and integrate capacities for both autonomy and connection with a personally preferred 'optimal distance' for relating.

The final phase of the separation-individuation process in Mahler's schema, **consolidation of individuality and the beginnings of emotional object constancy**, begins about two years of age. The developmental goals are "1) the achievement of a definite, in certain aspects lifelong, individuality, and 2) the attainment of a certain degree of object constancy" (Mahler et al. 1975, 109). What this means is that there is a sense of being an individual, separate from but in relation to others, and that the child knows that an 'object' (that is, a thing or a person – and this can be extended to the world) has permanency. Because a sense of mother is internalized, he can tolerate being apart from mother without a threat to his own identity.

Individual Considerations

We have so far looked at developmental trajectories common to all humans. Now let's get personal.

Ida Rolf has a chapter in *Rolfing: The Integration of Human Structures* called "Feet: The First Challenge" (Rolf 1977, 45). She is referring to the challenge of being upright, and the challenge the Rolfer faces in his work, but she may as well also be referring to the child's developmental challenge to stand up and move in the world, something we all went through, and which as the earlier psychological material shows is concurrent with the development of a sense of body image and, ultimately, individuality.

So, how was it for you? What can you remember of this time of your life, or what stories have been passed down? Were there issues with feet, legs, movement, and walking that affected your developing sense of self and capacity to individuate and operate in the world? Such history can be from many factors, some physical, some psychological. For example:

- In the practicing phase, when you felt omnipotent, did you get seriously hurt in a way that may have conditioned your view about your own capacities?
- When you tried to move away from mother in the rapprochement phase, was that allowed, or did she cling to you?
- And in the same phase, when you tried to return for love and support, did she welcome you, affirming that your autonomy was good, and that you didn't have to develop too fast? Or did she seem indifferent, forcing you to develop a sense of fending for yourself prematurely?
- Were there physical injuries or congenital issues that affected your developing mobility as an infant, like illnesses that kept you confined, leg braces that limited your free movement, castings for broken bones, or surgeries to correct problems?

I don't probe my clients for information they don't volunteer, but whenever they relate some issue around feet or legs, or some medical history from childhood that may have affected their development, my antennae go up and I pay attention for material from the psychobiological realm.

I got a taste of how significant this can be very early in my career as a Rolfer, when a young woman (who I will here call Louise, for privacy) came in for a Ten Series:

> *Louise was in her twenties and had a significant leg-length discrepancy, at least half an inch, which required her shoe on one side to have extra height added to the sole. She related that as a young child something was wrong from birth with one of her feet, and that necessitated it being broken and cast to heal in the right shape. (She had no more information than that, and who knows how correct that was.) That was the shorter leg, and as I worked on it I felt like I was trying to transform wood, not fascia. Working on this 'wooden' calf, I was sure I was hurting her, but each time I checked in on whether the sensations were okay, she said, "It feels great!" As the work continued, it changed her physical form, letting that leg lengthen, and it also evoked emotion – particularly nonspecific anger at her father. She also derived intense joy and satisfaction when after each session she could whittle down more of the support on her shoe. We don't know, but I would speculate that this early medical intervention in some sense deprived her of a sense of agency and control vis-à-vis her parents. The work, which brought her into a new relationship to her shorter leg, and began to change it, returned some of that agency, both in free-flowing emotion toward the parent and in her sense of control over how own body.*

Braces

I've also had a number of clients who wore some kind of foot or leg braces in childhood. Most of them couldn't give me a detailed history, but I imagine they were generally to treat conditions like clubfoot. Like Louise, what the clients 'knew' came from what they had later heard from family members, rather than from medical records or direct conversation with medical providers. In my experience, it seems that parents often do not give children (or the adults those children became) complete medical information about early events. This may be because the parents themselves did not understand the diagnosis or procedures. It may be because the situation was explained at a young age in unsophisticated, nonmedical terms (or even metaphors). It may be that the parent had forgotten the details by the time the older child or adult asked. Or it may be that the parent glossed over what happened – either in the way our society tends to undervalue childhood injury (e.g., "He'll get over it" or "She won't remember"), or because the parent in some way sensed how difficult the child's early experience may have been and was unable to hold that.

So let's consider the treatment of clubfoot. I'm not a doctor, and I don't know if there are variant treatments, but in preparing this article I came across a children's hospital website with an article on the treatment of clubfoot (Ponseti 2017). The author, a physician, indicates that treatment should ideally begin at two weeks of age, with a series of five to nine plaster casts worn each for a week, and the last one(s) for three weeks. As the casts are changed, the baby's affected limb(s) are "stretched with weekly, gentle manipulations." After casting, the feet are braced in position using shoes that are connected by a bar (see Figure 2), full time for two to three months, then overnight until up to five years of age. By my rough math, these periods of full-time casting and bracing would finish by the time the child was beginning to stand and crawl, but they would have some impact on earlier motor capacity, as both casts and bracing would add weight so that the child would need greater muscular effort to move his/her legs, and any bracing would limit differentiated movement between the limbs.

Figure 2: The Denis Browne Bar used in treatment of clubfoot and used as part of the Ponseti method. By Dolmanrg (Own work),via Wikimedia Commons.

In corresponding with Liz Gaggini as I prepared this article, she related this story:

> *I [had] a client who had had casts from legs through hips from about three months old to about one year old for what was thought to be excessive turnout. What was remarkable was that she had very little refined kinesthetic perception in her legs. If she was not looking, she could not tell which foot or leg I was touching and was also unsure of where on the foot or leg I was touching.*

Consider the developmental psychology of the time – the symbiotic phase, differentiation phase, into the early practicing phase. Consider that the casts are on just at the time a young baby spends a lot of time on its back waving those little arms and legs. Casting would either limit or prevent leg mobility, or add significant weight for the infant to overcome to be able to move, surely having some impact on the developing sense of self or body image. Likewise, there may well have been pain or discomfort. As Mahler and other psychologists theorize that touch and pleasurable sensation help form body image, and we can imagine how the casts were a hindering factor to pleasurable touch and pleasurable sensation, so it is little wonder the client had difficulty

with kinesthetic perception and a sense of embodiment through her legs.

On this note, let's go back to Ponseti, the doctor describing the casting and bracing protocol, who says: "The baby may feel uncomfortable at first when trying to alternatively kick the legs. However, the baby soon learns to kick both legs simultaneously and feels comfortable." He further notes, the "shoes attached to the bar may cause pressure blisters and sores," and that "difficulties with compliance of bracing" may occur. While the doctor is optimistic about (or glosses over?) the baby's felt sense, the tissue damage he notes, and the difficulties with compliance suggests that either some children fight it, or that some parents recognize distress in their children and are reluctant to follow the methodology.

Let's try a thought experiment to what the infant may feel. Imagine what that experience is when those little feet and legs are, at least one of them, encased in plaster that limits mobility except at the hip. Imagine the extra effort to move that additional weight, the limits on free and graceful exploratory movement. Now imagine the brief weekly respite as the plaster casts are removed for the "gentle manipulations." It must be exquisite relief and at the same time perhaps painful, the brief liberation and movement of those muscles and joints that have been under unrelenting stress. Now imagine the next stage, the feet in shoes fixed to a bar. Perhaps now the knees and ankles can move some, but the legs cannot move independently, and the baby may not be able to turn over without assistance. Feel those little feet encased in shoes, those shoes under pressure, fixating the legs into a position that carries tension – enough to cause pressure sores – either all day or all night . . . And all of this as the child is developing, not yet a formed sense of self, not yet in mastery of his or her world. Imagine the inner experience, and compare it to what somatic experience would be for a child innocent of these medical interventions.

Here is another story from one of my clients, a man in his thirties who I will call Bill:

> *Bill related that he experienced some type of foot braces as a child. He remembers being a child in the crib, unable to turn over because the brace connecting his feet prevented that movement (or he had not developed that motor control yet). So he would be terribly uncomfortable, which would lead to crying and emotional distress. He remembers his father's anger at the crying, and that his dad would come in, pick him up by the brace, and roughly flip him over to make him stop crying. An articulate man with a developed sensing capacity and trained in somatic practices, Bill is aware of how the bracing is likely the cause of ongoing hip and sacral issues. His somatic sense is that there is limited 'flow' in his left hip and that his legs hang from his diaphragm.*
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> *Work with Bill initially is to unwind these old physical patterns, as well as to deal with later injuries. We focus on the pelvis and viscera, and that leads to work into the neck and midback and a sense of how stuck his neck feels. As the work progresses over some sessions, he feels he's getting into the deeper emotional side of the childhood trauma.*

Another Rolfer – I can't remember who – once theorized that foot or leg braces to correct strong internal or external leg rotation are effectively trying to force change on the soft tissue, and may corkscrew tension up into the sacrum and lumbars. Bill describes a pelvic issue that could be from that or from his injury history, but I also remember another client who had experienced braces as a kid, and who as an adult presented with ongoing sacral difficulties. I'll call him George. Although George didn't offer any psychobiological material, I found it interesting that he presented in a childlike way (his house – where I saw him for outcall – was decorated with a lot of Mickey Mouse items, even though he was in his twenties or thirties). Work with George focused on both legs and pelvis to relieve his sacral issues.

Another client, who I will call Kathy, reported in her initial intake that she wore leg braces at night as a child for femur anterversion. Besides this there's injury history affecting her pelvis. She came in for a second Ten Series. Her earlier Series was a positive experience, but she was curious to repeat it with a female practitioner, thinking it would go further. Kathy was familiar with both therapy and meditation, making her quite open to the psychobiological level. We did not need to process it at all explicitly; it was a straight-up Ten Series, but her familiarity with her interiority and personal process allowed her to take the work into a place that began to undo that early history. In her own words:

> *I was born with a femoral anteversion which was treated by metal leg braces that I wore at night in an effort to correct the way my legs caused my toes to point inward. This summer I completed a Ten Series of Rolfing [SI] that completely changed my relationship with my legs and feet. Once the structural change occurred it took about a month for my brain to catch up, but now I'm able to stand in a new way. The healing I received through Rolfing [SI] has not only changed my body but helped me to feel more grounded in general. It's quite remarkable and noticeable to my partner too.*

Later Childhood Considerations

Now let's look at foot issues in a nonmedical context, and related to periods after early childhood, but still during impressionable times. I'll start with what my Rolfing colleague Michael Boblett shared with me about his childhood experience with his feet. If you read the Editor's Letter that prefaces this issue, you'll know that I asked Michael to be the Guest Editor for this theme because I knew of what I can affectionately call his 'foot fetish'. Over the years, Michael has written for this Journal three times, and each time his topic has been the feet. Now, knowing his story, I see why he has this fascination. I am very grateful for his evocative writing, which shows us how even past the early developmental stages of infancy, there are still many ways that psychobiological material and the feet can become intertwined.

> *When I was seven years old, my parents took me to my mother's podiatrist. I never asked them why they did this. I was already an active boy, fond of long walks in our small town of Riverside, California. I also enjoyed our family hikes in the nearby deserts and mountains. My mother already saw a podiatrist as part of her ongoing treatment for childhood-onset rheumatoid arthritis, which had left one leg three inches shorter than the other. My mother worked very hard not to let this slow her down. Perhaps she just wanted to spare me a similar struggle. Her concern might have been my own bout with osteomyelitis when I was two, which left porosities in both acetabula and femoral heads.*

In any case, my impression is that the podiatrist took one look at my anxious parents and saw dollar signs! In 1959, the standard fix for foot problems was not today's expensive customized insole. Instead, it was an even pricier custom shoe. He was already making good money with my mother's shoes, so this was gravy.

He declared that I had "fallen arches." He drew up a design for heavy black wing tips with stiff leather soles. The soles were reinforced with a high steel rod that dug up into my longitudinal arch, coming to a sharp peak at my transverse arch. The soles were also designed for dress wear, not for sports, so they were smooth and had no traction. I was expected to wear this shoe for all activities, including hiking and running.

For fourteen years, from age seven to twenty-one, these were my only shoes. As I grew, they were replaced every year. The design never varied. I remember falling down a lot. I remember developing a fear of heights, of being knocked over by accident, and of anything that involved climbing. I stopped climbing trees. I stopped dancing. I had foot cramps. The ones at night were the worst.

At twenty-one, I moved to Jerusalem as an exchange student, met my first Rolfer, and bought my first pair of tennis shoes. The feeling of freedom was astonishing. At twenty-two, back in the States, I began experimenting with sandals, kung fu shoes, and even bare feet. The old shoes gravitated to the back of my closet. Finally, I threw the shoes in the dumpster. I remember feeling afraid because they were so expensive. I also felt ungrateful to my parents. These were my only concerns. I wasn't worried about the effect on my feet. My feet were ready for freedom.

My recovery process has involved over four decades of excellent manual and movement work. In the process, I have developed a healthy respect for the ability of the human foot to recover from severe trauma. As well, I have become passionate about 'paying forward' the good work I have received, so that functional feet can once again be the rule rather than the exception.

Another client, who I'll call Renee, presents with strong medial rotation in both legs, that she corrects at the knees and feet. Initially she would come in once or twice a year, wanting some targeted work, then increased the frequency of her visits some. The predominant pattern was always stubborn.

> *One session, the ninth time we had worked together and about two and a half years after she initially came in, I was working on her in the Fourth-Hour position, and she relates for the first time an interesting childhood story. There was a time, around age seven or eight, when she persisted in wearing shoes that were too small – to the point that her feet turned purple. I ask her what was going on at the time, and she says it was a time of frustration, feeling stuck and confined, and that she remembers that she didn't want to tell her dad that her shoes were too small, even though he asked her if she needed new ones . . . Then there was a later period in her life, during junior high school, where she intentionally wore shoes that were too big, perhaps in reaction to the earlier confinement, she says. This material came up at a time when the client was actively envisioning her future, how she wanted to move forward. While I continued working with her body, I invited her to connect to her sense of herself as a child, and to her current self, and to the future self she is moving toward.*

In this case I just described, I stayed focused on the Rolfing task of organizing fascia, but gave the client a pretty minimalist suggestion of a way she could invite in an inner process around the psychobiological material, if that called to her.

I do have other clients where the interweaving of fascial work with a dialogue about the psychobiological has been both more explicit and an ongoing thread in our work. Recently, I've been doing a Ten Series with a woman I'll call Jane.

> *Jane is in her early fifties and for a few years has been in the midst of both relationship and career transitions, and other significant emotionally impactful events. In her intake she says that she is "heading back into the light and feels different, like everything is new," and that she "needs structural support." From birth she is missing three toes on her right foot, which is much smaller and that leg is shorter. She compensates heavily but well, although her left hip, the longer side, is starting to ache. In her Second Hour, I give her Valerie Berg's 'juicy paw' metaphor as a description of where we are headed, and do pretty standard work but suited to what each leg needs. When I work with the right foot, she reports that she feels like she has 'virtual' toes where the physical toes are missing, and that those toes want to spring out, like her car key from its fob, relating to the work I'm doing at the 'eye of the foot'. I encourage her to go with this sensation, to trust her virtual toes. She reports that as a child she would ask her parents when those toes would grow, as she was convinced that they would. Feeling virtual toes seems to connect her to this inner confidence that was stunted by conventional medical views. My sense as a practitioner is that just as amputees can have phantom limbs, and it can be beneficial to acknowledge them, it is useful to acknowledge the sense of virtual toes wanting to emerge.*
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> *She comes in for her Third Hour a week later and reports that the leg and foot work has been integrating well, that she notices her right foot more when walking, and takes more time with walking, loving her juicy paws. In this session, I add in some extra attention to the right foot in particular, and – related to what she had said in her intake about everything in her life feeling new – I give her the image of a butterfly emerging from the chrysalis. It had gone in a caterpillar, and transmuted into something completely new. She loves this, and tells me that in the chrysalis the caterpillar actually turns to goo before reconstituting as a butterfly. These images – the virtual toes, the butterfly – become important parts of her articulation of the new sensations she is feeling and the context of meaning for them in her life.*
>
> *Further work: In session four, she realizes that while her right leg loves the work, her left leg feels self-pity and tired. (Note: I feel such mismatches are important to recognize, and to treat each side as the individuality that it expresses.) In session five, besides the traditional work, I budget time for lots of further work to her right foot. Jane 'realizes' that she "has five toes on her right foot, two physical and three invisible."*

We have not yet completed her Ten Series, but it's been wonderful to witness her unfolding. She found her assigned role at work a bit boring, but was inspired to create a whole new role for herself with the company, and that has really opened up her career and brought her a lot of validation. It seems that the work of becoming more whole and connecting her inner sense of transformation with both the physical work and powerful metaphors has allowed her a new kind of ground in her life that is both physical and psychobiological.

I'd like to close with some words from a client I'll call Kim. We all have favorite clients, and Kim is one of mine. I've worked with her over more than seven years, initially a fix-it session then both basic and advanced series and other post-ten work. Kim is deeply in touch with her intuition and interiority, and highly creative. Her legs have been a theme throughout our work, and the dialectic between us has allowed both traditional work as well as a lot of experimental play with things like unwinding. An educator and writer, Kim's evocative description of her process with relating to her legs through this unwinding seems like a fitting closing story of the transformation that is possible when we include the psychobiological realm.

My legs have always been a feature of my own physical meta-awareness. Some of my earliest memories are of becoming aware of the strength of my legs as I learned to ride a bike, or climb one of the many trees in my backyard growing up. I also remember noticing how brown they turned in the summer sun after only an afternoon, and how they never let me down as I would run from neighborhood bullies. As I moved through my childhood, and my family life became more complex with younger siblings and a slowly unraveling relationship between my parents, my body lengthened and stretched to meet the energetic demands of being the oldest child, the one with the most capacity to help carry some of the domestic burdens. I have memories of my father, seated at his favorite perch in the house, a hand-rolled cigarette in one hand, and a cup of coffee in the other, his legs braided around each other. I have memories of my mother, walking in the door from a long day at work, her legs firm and rooted as she stood in the doorway, holding her purse and maybe some groceries, as she greeted us.

But these memories are new retrievals in my personal archives. They came to me slowly, then in a rush, as I worked with Anne on addressing some foot pain and leg tension in my bodywork. Anne had asked me to allow my legs to tell me what they needed, and as she held my feet, gently, I felt something unwind, and kick free, and present itself. I shared these images with Anne, and as she held my feet steady, I shared the images of my childhood from the point of view of my legs. Since that session, I have been in a relationship of compassion with my feet and legs. They have carried me forward, steadfast and determined, to a place of safety and privilege, and their reward now is quiet gratitude and attention through continued bodywork and self-appreciation.

Conclusion

I believe the psychobiological dimension is critical to our lives and to a sense of interiority, meaning, and fruition. Equally, I believe that as Rolfers it is not up to us to force anyone to go there. Ida Rolf believed that our work had psychological benefit, but that the benefit was obtained by working with what we could touch. So when I work as a Rolfer (rather than as a Diamond Approach teacher), that is always my entry point: the fascia and the goals of Rolfing SI. However, I find that for some percentage of my clients, the psychobiological is explicit – in their histories, in their articulation of their experience, and in their experience of the work. With those clients, I step tentatively into that terrain, and see if there's uptake. Most process those offerings in their own time at home between sessions, and some dive right in during sessions to great effect. It is always in the client's hands, and always grounded in our primary work of organizing the fascial system in gravity.

Anne Hoff is a Certified Advanced Rolfer with more than twenty years in practice. She has a practice in Seattle, Washington and makes occasional forays over to Port Orchard, Washington. She was drawn to Rolfing SI as a client in a quest to sync up body, mind, emotions, and spirit, and the co-emergence of these realms has always been the guiding principle of her own process. Her understanding of the body is deeply informed by the Diamond Approach, a spiritual teaching she has been a student of since 1995. She became a teacher of that work in 2015, following eight years of seminary training. She currently works with private students in that path, which offers another way to address psychobiological material and egoic versus authentic identity. She offers workshops in material related to the Diamond Approach logos. See www.wholebodyintegration.com for Anne's Rolfing practice and www.innerworkforourtimes.com for her Diamond Approach activities.

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