

extend it deep into the earth. Now, from your nose, allow your breath to connect heaven and earth.

Rolf is said to have expressed concern that intra-nasal work would be the first technique Rolfers would drop after her demise.¹⁵ This author is hopeful that practitioners will re-evaluate the potency and appropriateness of intra-nasal work for inclusion as part of their integrative practice.

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Endnotes

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Craniofascial Structure

In Osteopathy, Dentistry, and Rolfing® SI

By Olixn Adams, D.O., former Certified Advanced Rolfer™, Rebecca Griffiths D.M.D., and Anne Hoff, Certified Advanced Rolfer

Anne Hoff: This interview originated from a comment that Olixn made quite a while ago on the Rolf Forum about Alternative Light Force® (ALF) dental appliances. Olixn, how did you meet Rebecca?

Olixn Adams: I was noticing that a lot of people who had received traditional orthodontic treatment, particularly in their teens, were exhibiting a lot of side effects that I believed were related to the compressive forces of traditional orthodontic mechanics – symptoms like headaches, scoliosis, sinusitis, allergies. So, I began exploring if there was another option for orthodontia and I came across literature about the ALF wire. I found Rebecca in Phoenix, Arizona, where I was living and completing medical school at the time. I started the work on my own body to experience it and we started referring patients and working together.

AH: Rebecca, tell us a little about yourself.

Rebecca Griffiths: I've been a dentist since 1982 and I've practiced non-extraction orthodontia since 1985. I'd had constant headaches myself for many years and TMJ problems after my third molars were extracted when I was eighteen. I had gone to several different practitioners over the years with no good results. I started treating TMD [temporomandibular dysfunction] patients after I was treated by, and subsequently trained by, Brendan Stack, D.D.S., M.S., a renowned orthodontist in Virginia, who has treated TMD for about forty years. His treatment resolved my headaches and TMJ disc displacement in less than two days. He and I were trying to effect positive cranial changes for our patients, like leveling the occlusal plane with mouth splints, but we weren't having a lot of success with the cranial aspects. We knew Darick Nordstrom, D.D.S., who invented the ALF appliances, and we received ALF training in the early '90s. By '93 I was using this appliance pretty much exclusively for my TMD and orthodontic patients and achieving excellent and stable results. It really rocked my world.

AH: Were you familiar with cranial osteopathy before you and Olixn met?

RG: After the ALF training, I signed up for the Basic Cranial Osteopathy course at the Cranial Academy because I perceived the power that the ALF had and I was afraid that I might actually hurt someone inadvertently with the appliance. I took the course, but it was taught using a disease-based paradigm, and I wasn't happy with that. It involved looking for a problem and then setting the intention to correct it. One day, I simply asked myself, "Who am I to decide what gets fixed in this body, in what order, and when?" I decided that it was not my right to treat this way, by trying to overcome the priorities and methods of the patient's body with my own. I continued to use the ALF, but I found myself during palpation just watching and waiting to be shown whatever the patient's body wanted me to see or feel. I always felt that my intentions were good; I was working from my heart in a pure belief that I could help these people, or I wouldn't take the case. After I met Olixn, he pushed me to take classes in biodynamics with Jim Jealous, D.O. I owe Olixn a debt of gratitude for that because it supported what I had felt about my role previously and expanded what I knew, or thought that I knew, intuitively. You do need to be able to palpate and to know what changes you're going to effect before you put the ALF in the patient's mouth and let him walk out the door. Even then there can be surprises sometimes. I really feel there is a prerequisite need for a strong background in osteopathy, neurology, and physiology in order to use this appliance properly, successfully, and without hazard for patients. There is a steep learning curve involved, you have to spend an appropriate amount of time with each patient at each appointment, and you cannot delegate the adjustments to assistants. So, you're going to have few practitioners that are willing to spend that kind of time doing this.

AH: ALF stands for Alternative Light Force appliance?

RG: Darick called it Alternative Lightwire Functional® therapy initially. To my knowledge, he never trademarked it formally, so I'm sure there are people that might be calling it other things.

AH: Was Darick aware of cranial movement?

RG: Oh yes, most certainly. He was way ahead of his time. He's brilliant.

OA: Tell us the difference between the ALF and the other palate expanders.

RG: I used most of the existing palatal expanders for almost ten years before I found the ALF. I used cemented-in ones and removable ones. The cemented-in Rapid Palatal Expanders (RPE) have a screw in the middle near the roof of the mouth which is adjusted with a key by patients about half a millimeter in the morning and a half a millimeter at night. Generally you'll hear a crack when the mid-palatine suture opens, and there'll be bruising from bleeding under the skin in the roof of the mouth. It's pretty dramatic. You could leave it in for retention as long as a year after you had finished adjusting it, but I found when you took it out you got collapse. In essence, this appliance forces the joint open, but it will not stay there supported by scar tissue. The other problem with the RPE and the removable functional appliances is that you get a 50% shift in either direction, but most patients are narrower on one side than the other. You might want 60:40 or 70:30, or maybe somebody is externally rotated on one side and you don't want to push that side out any further. That's where the ALF is superior because you can get asymmetrical changes and it's achieved with very light forces and works 24/7. I think of a high, arched, narrow palate as a folding table where the legs (alveolar bone with the teeth) are folded medially and the tabletop (hard palate) is arched superiorly. Other appliances don't correct that arch; they just push the two halves apart from each other. The ALF will upright those bones very slowly so that you get a lowering of the hard palate, an opening of the nasal floor, and widening of the dental arches.

OA: You're talking about a de-rotation of an internal rotation of the maxillae, right?

RG: Yes. You're achieving a level maxillary plane, which is very stable. The forces of occlusion, or chewing, bang up into a level plane instead of a canted plane. The ALF assists the body to upright and level the bones. I think our bodies have innate knowledge of how close bones (joints) should be to each other. Studying the sutures and their different types of designs shows you that the body has inherent intelligence, and it's not going to preserve something that isn't functional. The body will make compensations and adaptations to dysfunction, but it's not going to preserve dysfunction as a stable situation. One of the

first things Darick said to me was that he never gave patients orthodontic retainers following their orthodontia. He taught that if you help put things in stable positions that are highly functional, the body will maintain that. It won't have to work to maintain that, it will just be maintained. It is much more work for the autonomic nervous system (ANS) to create and maintain compensations and adaptations to dysfunction.

Maintaining a functional airway is the most important body function. The ALF opens the nasal airway. When it de-rotates the problems in the maxillae and premaxillae, the hard palate will level out and move inferiorly. The floor of the nose lowers and that opens up space for the ethmoid and vomer (nasal septum) to make some correction on their own. This also decompresses the venous and lymphatic drainage in the mid-face so that sinuses can drain properly – another airway consideration. A number of corrections in the mid-face are precipitated by the ALF; it unleashes the unused genetic potential for development. One of the most difficult cases to treat is the Class III patient whose mid-face is underdeveloped and the mandible looks prognathic. Few patients truly have a mandible that's too long or too big. It's the mid-face insufficiency that makes it look out of balance.

OA: The mid-face fluid fields didn't develop.

RG: The ALF works with that quite well.

AH: What does an ALF appliance look like?

OA: It's a thin wire that goes on the inside of the teeth. She makes some buildups on the inside for the wire to secure into, and the wire's like a gentle spring. She adjusts tension into the appropriate locations so she can create a diagonal tension, an ipsilateral tension, like she was describing earlier, and then she inserts that into the inner-upper palate and you have a mild tension in that area expanding outwards.

AH: Do you adjust it periodically, and how long does the process go on?

RG: I adjust the younger patients a couple times per week, but just really subtle changes. The children can move very quickly, although I treated a lady who was seventy-five and she moved quickly too. My out-of-state patients don't come every two weeks. I have some who come about every two months, and Darick had a patient from Germany who came once a year.

In my practice the active ALF phase generally is three months for someone who's very young, say under ten. An adult can take anywhere from six months to a year. Some patients may need multiple appliances because after I've adjusted them so many times I can tell by the feel of it that it's lost its resilience. Once the wire has lost its resilience, I don't want to use it anymore.

AH: Olixn, you went through this yourself? What's your experience been?

OA: Yeah, we haven't quite finished yet. We started when it was my last year in Phoenix, and we did about a year with the ALF wire upper and lower, and then I had to move. We're trying to figure out how to get together to finish the last phase of the work. I experienced very rapid and gentle change in the entire mouth, which had effects through the whole body. Opening of the palate and mid-face. Often after an adjustment I would feel a process we call "ignition," which we look for in osteopathic treatments sometimes. Sometimes we'd spontaneously get a process that we call "automatic shifting," which is a therapeutic fluid-fluctuation, that I could feel going on for several days to a week or more, whereby the fluid fields were correcting throughout the whole body. The most profound effects would be noticed in the mouth, face, and cervical region, but I could feel them down into the pelvis, knees, and feet sometimes. I experienced improved breathing through the nose – that's part of what I was looking for. I felt the traditional orthodontia that I had was not very good and not very good for my body, and I felt like I had had some side effects from it: I suddenly developed allergies, headaches, ADD-type symptoms from the time that I was fifteen, sixteen. Once I actually put it all together, it was right at the time that I was getting traditional orthodontia. As Rebecca corrected some of that with the ALF wire, some of those body memories were re-experienced – I could remember the oral trauma with the tightening of the wires, the angst my body would feel, and the headaches and symptoms that went along with that approach.

AH: People going through traditional orthodontia often have pain, headaches, discomfort from the appliances. Is that at all true with ALF?

RG: People will get slightly sore, but when they move into the final tooth-alignment phase with the braces, hands down they all ask "can't we just have the ALFs?" The

braces cause so much more soreness and discomfort because of each tooth being a joint unto itself with a system of ligaments and sensory nerves that don't respond well to inflammation and the movement that causes it. With the ALF, the forces are so gentle and you're working with bone. Of course the teeth are moving just because they're within the bones that are being moved, but you're not doing the same type of movement.

OA: We've found osteopathic treatments often minimize those effects quite a bit too, people are much more comfortable and they tend to change more quickly. It's sort of reciprocal. Sometimes we've had cases we were treating straight with hands-on osteopathy that for some reason we were at a sticking point or not making progress; we'll send them to Rebecca and all of a sudden huge changes start. And we've seen it the other way around where we're at a sticking point with the ALF, and a few osteopathic treatments and they're off to the races again.

AH: So you follow up the ALF with braces for straightening the teeth?

RG: In most cases I've had to do that because tooth positions are compensated to the relationship they had with previous bone positions, and changing the bone doesn't mean that the teeth are going to resolve spontaneously into their new and proper positions. I leave ALF wires in place as a stabilizing force and as a counteractive force to the traditional braces. It appears that no matter what type of braces you use, or how wide the arch wire for the tooth movement is, the orthodontia seems to collapse the arches. I'm trying to do more cases now without getting involved with the braces for a long period of time [e.g., two years]. Adults always want Invisalign®, which works to move things in the opposite direction from which the ALF works, and it does so very potently. So to use a conventional Invisalign after using an ALF is round-tripping the patient; basically you are taking them back from where they came. Invisalign as it stands does not work to finish those cases. A tooth positioner hand-made by a lab technician, and not made on a computer like Invisalign is, could work.

AH: So there's ways you can still do tooth straightening without putting the compressive forces back in?

RG: Yes, but it's very difficult and takes more time. You use extremely light wires, if you are using braces, with very wide arch

forms and those items are becoming more difficult to purchase. There are very few companies that make arch wires for braces that aren't shaped like dog (canine) arches – that's how narrow they are.

AH: How do you find a good practitioner?

RG: It isn't easy. This may become a dying art because of the amount of education that it requires and the time that it requires you to spend with each and every patient for the adjustments. I can't even find anybody to train. I would love to have someone to mentor and teach, because I think I could teach them in a relatively quick period of time – I could pretty much put in a nutshell what it took me years to uncover. The website www.alforthodontics.com has a directory listing of practitioners for anybody who wants to work with a doctor who works with the ALF. It lists dentists, osteopaths, SOT [Sacro Occipital Technique] chiropractors, and labs. The problem with just picking somebody is you need to know how long they've been doing it, because the learning curve is not quick with this appliance. There are some bastardizations out there, people that are calling these heavy-wire appliances ALFs, and they are not. So you have to be careful. There's a similar problem finding TMJ practitioners; there are weekend seminars that provide a certificate stating attendees can treat TMJ problems after only a few hours of training and dentists just put them up on their websites as one of many services that they offer.

AH: Rebecca, how do you know when to send a patient to someone like Olixn?

RG: I can feel it. I have had many patients that I send for other bodywork prior to beginning with me. When I examine them, when I speak to them, when I put my hands on them, I get the sense there's another primary at play. What I would be doing for them certainly would be beneficial, but not addressing the primary problem. Since our bodies prioritize issues, and I respect that, that's when I make that decision.

AH: When would you refer to a Rolfer?

RG: I have had patients come in to me that go to a Rolfer, but I have not worked directly with one on cases. I'm open to working with Rolfers; I want to do whatever is going to get that patient better. I try to triage my patients in terms of who I feel they should see. I don't know many Rolfers. [I contacted Darick after this interview, and he said: "I think Rolfers might be interested in ALF practitioners'

experience with spontaneous trauma releasing as the ALF is properly placed and adjusted (not necessarily activated, since the tongue will often activate by nature of its attraction to the pre-maxilla by the ALF). This release phenomenon, which complements Rolwing® Structural Integration, is thought to be initiated through proprioceptive and primitive reflex triggers in the head and neck that are accessed by the ALF. Another reason to work in a team with a practitioner trained in treating old trauma is that there seems to be a window of opportunity often created when the ALF is placed or during an adjustment visit, when it activates an internal connection to an old somato-emotional trauma. When this feels like a miraculous uplift, it is important that the patient not just 'bask' in the good feeling, but be supported in recognizing and fully releasing and working through the associated trauma(s) that the body would previously not allow out due to its self-preservation. It can also feel like an unexplained resistance or reactivity to what should be an acceptable ALF activation; in this case, the ALF could be bringing attention to or magnifying an old trauma, and it is important to try to understand that trauma, and treat/support the whole body in working through it. In this second case, the body has come to the point where it is almost ready to work through the trauma, but can't find enough 'health' to get through on its own (like the previous uplift-type healing opportunity). If it is given understanding (of where it is with the old trauma, and the health that it can move into) and support (physical/emotional), to lower the threshold, it will be able to move through the healing process successfully.]

AH: Olixn, when do you know that somebody needs the ALF work?

OA: If I was living in the same city as Rebecca we would probably meet at each others' office once a month and cross-work with the more difficult patients. There are some osteopaths in bigger cities that do work with a dentist directly.

RG: I wish Olixn was nearby. We could do some excellent work together again. I've been able to get an SOT chiropractor to come into my office and we double-team a few patients. It has shaved as much as nine months off the treatment time of a few patients in their fifties and sixties.

OA: Rebecca and I have seen the potency when she adjusts the wire, and we do an osteopathic treatment right there or soon

after. We balance out the fluid fluctuations that may be going on from the adjustment. The patient feels a lot better and the changes happen much more quickly.

OA: I think there's another aspect to the ALF that might be interesting for Rolfers. Forward-head posture (FHP) can be a really difficult structural imbalance to help correct. Rebecca, you see that primarily as an adaptation to airway. Is that correct?

RG: Yes. When we move the mandible down and forward as a result of what we are doing with the ALF and the cranium, the airway opens. Time and time again, when we take our progress photographs of patients in profile, which is done about every two months at my office, we see them straightening up and the FHP going away. FHP is a compensatory mechanism to airway problems.

OA: That's a really important consideration in Rolfing work. They're trying to get the head up over the shoulders, aligned on the gravitational line. If they are having trouble, the ALF might really change that case quickly once the airway starts to change.

AH: Does it relate to the maxillae issue you talked about?

RG: If the mandible is positioned posteriorly and superiorly, it's because of what's going on in the cranial base with the maxillae. There are always maxillary reasons that will explain mandibular position. When the teeth are together and if the mandible is back and up, the tongue will obstruct the oral-pharyngeal airway. There are other things that happen cervically and the biomechanics are explained in Casey Guzay's "Quadrant Theorem." There's a direct and mathematical relationship between mandibular position and the upper cervical spine. When the mandible is posterior and superior, the cervical spine will compress, the atlas will be out of position and as it moves anteriorly, it decreases the A-P airway in the pharyngeal portion, and FHP results. Also, the person is constantly dropping the mandible down and forward to get the tongue out of the airway and will use the insides of the cheeks and the sides of the tongue to brace the mandible in that more open-airway position. This produces ridging on the lateral borders of the tongue and mucosa of the cheeks. The ANS drives those muscles into performing 24/7 function in order to maintain a better airway. Neurological disarray results because there are no rest periods for these muscles now and you get muscle splinting. You can see

what's happening to the airway if you take a lateral skull film with the patient's teeth together and look at the A-P pharyngeal airway. Then you compare it to a film taken with the patient open or biting on a block that brings the jaw down and forward. There's an immediate change in the airway. The ALF acts also on the pterygoid plates and that's where the posterior nasal airway can be improved as well. You can really see that you are getting the airway open with 3D CT scans of patients.

OA: The mandible is generally going to go where it can get the best occlusion with the upper molars, is that correct?

RG: True, but the anterior teeth also guide it on its closing trajectory, so if the pre-maxilla is detorqued or internally rotated, then the teeth are tipped inward towards the tongue, which forces the mandible to retrude upon closure. Typically, those patients have the gummy smile; when they smile widely you see a lot of gum tissue along with the teeth. The pre-maxilla is rotated inwardly, so it distorts the trajectory of the mandible on closure. The pre-maxilla is where your incisors are and there's a suture there called the premaxillary suture that runs transversely. This suture allows internal or external rotation of the premaxillae.

AH: What about TMJ and do patterns you see there relate to FHP?

RG: There may or may not be a relationship. I think that in the vast majority of patients you probably will see some sort of internal derangement. But if you have a Class III patient, with the prognathic lower jaw, there may not be a TMJ problem but you could still have an airway restriction that encourages the FHP.

OA: Where does forward tongue thrust play into that?

RG: Well the tongue thrust is a compensation for airway obstruction. The myofunctional therapists I've heard say that somewhere around age four the patient should have converted to an adult swallow, during which the tongue goes up into the roof of the mouth, and not towards the front of the teeth or between the teeth. The conversion doesn't happen in tongue-thrust patients. Supposedly, we swallow 2,000 times a day while awake and 1,000 times while asleep. That's a lot of repetitions and the tongue has been measured at being able to produce 500 grams of force. It takes about 2 grams of force to move a tooth, so you have this balancing act between the tongue and the

orofacial musculature, which I believe can exert 250 grams of force inward while the tongue is exerting it outward or forward. If you have a tongue that is shooting out between the front teeth instead of up into the roof of the mouth every time a swallow occurs, it's not going to take very long for the maxilla to manifest the results of that, which is narrowness bilaterally and then that bucktooth appearance. Or, a complete open bite can result from the tongue shooting between the upper and lower front teeth for so long that it depresses the development of the bone and the teeth in that area. When this patient bites on the back teeth there's an opening in the front where the teeth can't touch. He is unable to bite off food. Traditional orthodontists have attempted to correct tongue thrusts by using appliances with "tongue rakes." They're banded in the mouth and cemented to the molars. There's a wire that comes up behind the upper front teeth and sharp vertical spikes extend off that wire. The goal is that the tongue will learn by getting raked, every time it goes through that opening, not to go there. Well, that doesn't work because the patient is thrusting the tongue to keep it out of the airway during the swallow; yet if the airway has not been treated appropriately, the patient will simply convert from the anterior tongue thrust to a lateral tongue thrust.

OA: What's your approach to this forward tongue thrust?

RG: You treat the airway to get it open enough so it's highly functional. Then you need to retrain the tongue because it's a learned pattern and I've not found that it will retrain on its own. So, myofunctional therapy comes into play; there's an excellent seven-week program by Janet Bennett that you can buy from www.ijustwanttocorrectmytonguethrust.com. One of my patients found it. She was completely open in the anterior. I had corrected her airway and orthodontically I could not get her anterior teeth to touch because she still had a tongue thrust that completely counteracted everything I did. The myofunctional therapist told her it would be a two-and-a-half year program and a couple of thousand dollars, but the patient's mother researched on the internet and found Janet Bennett's program. I could tell after only her second week of using it that her diction had changed, her enunciation had changed, and her lisp was going away. It took about six more months to close the open bite and during that period she had to

redo the program because she had relapsed. We're talking about a twenty-one-year-old girl here and the muscle patterns were pretty well-established, so she had to repeat the program a couple of times. However, I don't believe I would have been able to get the open bite closed in her case without the retraining.

OA: Interesting. With TMJ dysfunction, some dentists have a "recipe" [of what they do]. You are working more with each individual patient and how they are expressing, but there's probably going to be some principles that you work with?

RG: I have a specific diagnostic protocol that I do on every single patient, and that's the only place that I come close to "cookbooking" them. Most "TMJ doctors" don't bother with imaging protocol that includes MRIs of the joints. They'll do the 3D CT scans because they own the machine. The only way to see the discs and to diagnose properly what's going on in the joints is to obtain the MRIs. MRIs give you more information about the joints than the CT scan – with no radiation.

Patients are treated differently and according to the derangement that's present – is it a closed lock? Is it reducing? What's going on? And then you have to look at the causes – why is this functioning like this? You just keep asking why, why, why until you can't ask it any more, until you've got what you think are all the answers. And then of course you have to triage the patient too, because the lateral pterygoid muscle is totally capable of pulling the disk out of place in the joint even with someone who doesn't have a bad occlusion. Internal derangements can be caused by the mouth being open too long without rest periods during a dental procedure. Or maybe the patient had general anesthesia for third molar extractions and there was skeletal muscle relaxant in the mix, allowing hyperextension of the TMJs, and subluxation occurred that way. Because it's attached to the disc, spasms in the pterygoid muscle can certainly pull it out of place. You need to know what it is you're treating, and to just put a generic splint in everybody's mouth isn't the answer. Most times the splint isn't designed appropriately for the condition that exists. I've even seen splints that actually helped to push the mandible posteriorly and superiorly in a joint case, which is the worst thing you could do. You want to create joint space and you do that by moving the mandible downward

and forward, not shoving it up and back. I don't agree with upper splints. From an osteopathic standpoint, they're detrimental for the skull and for cranial motion.

OA: Yeah, I'm treating a lady right now who has had chronic migraines and she was wearing an upper splint for several years. We finally got it out of her mouth and she's doing a lot better.

RG: A lower splint, not designed properly (so that when the patient closes into it the acrylic wraps up and over the cheek-side cusps of the upper teeth), will have the same effect of locking up the cranium. There are other things that can cause TMJ problems. Maybe a patient's TMJ function is not ideal, but the body's working with it, and they're doing okay. Then they go and have some veneers or cosmetic dentistry done and the dental restorations are made a little too thick or a little too long. Now we have the same effect that the patient with the de-torqued premaxilla has; when the mouth closes the mandible is forced posteriorly and superiorly up into the temporal bones. Fixed bridgework that crosses the midpalatine suture can be a problem. I don't believe that a clicking joint or limited oral opening are ever "okay." Although, if a patient is asymptomatic other than the clicking and the choice is made not to treat, that's the patient's business. However, I think I have still the professional obligation to inform these patients that they may, or do, have an internal derangement and things are not what they should be.

OA: What other kinds of physiologic derangements have you seen as a result of either poor occlusion or poor alignment within the oral region?

RG: There are a lot of things that can happen. When you impact the trigeminal nerve, you're also impacting other cranial nerves. Drs. Stack and Sims wrote about ephaptic transmission in the brain in an article in the *Academy of Craniofacial Pain Journal*. They state that noxious input into the trigeminal nerve (CN V) can activate noxious input into the vagus (CN X), the facial (CN VII), and the glossopharyngeal (CN IX) nerves. That's pretty substantial nerve stimulation. We see people with sympathetic overload quite a bit, and those patients I refer out first for osteopathic or SOT work to try to get them quieted down before I start doing what I do. What I do can have such an impact on them, and if they're too far gone already, I don't want to push them over the edge.

OA: You've seen profound changes just by making a few buildups on the lower teeth and changing the occlusion with the mandible. Could you talk about that?

RG: A couple of pediatric cases come to mind. I had a four-year-old girl with constant headaches. Children generally won't complain of headaches; they're just miserable all the time and cranky because they hurt and they don't understand that they are supposed to feel any different. If they've had headaches since birth, they accept that as a normal day-to-day thing. The pain threshold elevates so they can take more and they don't complain. This child had had a history of a lot of ear infections too, and drainage tubes placed in her ears. She had a very deep bite and no spacing between the primary incisors, which is common but abnormal. We put some resin build-ups on her primary molars and opened her bite up to where she was almost in an open bite, where the mandible is positioned down and forward so there might be a slight gap between the lower front teeth and the upper front teeth; the lower front teeth would be down and forward to where they are pretty much even with the upper front teeth, instead of behind them. So, we opened her bite up this way and a couple of days later her mother called and told me that green stuff was coming out of her ears, eyes, and nose and the child was happy; all this drainage that was backed up was coming out. Another case was the son of one of my assistants. He failed his hearing test in third grade, and he had a very deep overbite. We put a removable splint in his mouth. This was before I was doing resin build-ups. We didn't even think he'd wear this thing. The mother called me up to say "I can't get him to take it out of his mouth to brush his teeth! He does not want to be without this appliance." When she took him back to have his hearing rechecked after a month, he was 50% better, and at three months they said to her, "Why did you bring him here?" His conductive hearing had been affected by the mandibular condyle seating too far up into the temporal bone. Pinto's ligament runs between the middle ear and the disc of the TMJ. If the disc is displaced, then it pulls on Pinto's ligament and you can experience conductive hearing loss. It can be reversed by getting the disc back in place.

OA: Did studying the biodynamic approach to osteopathy have an impact on how you worked with the ALF?

RG: It really did. My palpatory skills just went skyward. It really helped me in the sequencing of things. Now I had palpatory skills to back up what I was feeling intuitively. That made a huge difference.

OA: So you have a better sense of what the body is trying to prioritize in the treatment plan?

RG: Yes. I re-diagnose at every visit. At the end of the visit I'll make some notes on what I think I want to do the next time around, but often when you re-diagnose at the subsequent visit, you find that "Well, what I was going to do today isn't what I should do today." So I'm not going to do what I had planned earlier; I'm going to do what I should do, not what I thought I was going to be doing.

OA: Letting the mechanism guide the treatment.

AH: Olixn, how do you view the Roling Seventh Hour now after all of your osteopathic studies? Having gone to such a subtle approach with the biodynamics, how do you feel about something like direct fascial work with the pterygoids or in the nose? Do you think there's a time and a place for it?

OA: That's a big question, which we could dedicate an entire article to. First, I don't consider osteopathy or biodynamics to be subtle; when the long tide comes in sometimes it feels like a tsunami, the potency . . . all I can do is bow to it. But generally speaking, in an osteopathic treatment many of us are taught to listen to the mechanism and the tide, and we become more of a servant to the tide. Like Rebecca was saying, in osteopathy we can't come in with an agenda like "I'm going to do a Seventh Hour, I'm gonna do this, I'm gonna do that." We have to listen each moment along the way and see what the tide is trying to do, how the tide is trying to treat the patient, heal the patient, bring the patient to wholeness, and how can we support that process. That's a little different than coming in with a plan that I'm going to do a Seventh Hour today; it's fine to have a plan, but as a cranial osteopath, I couldn't really start that way and follow the tide as a principle of treatment.

As far as your question about direct fascial [work], yes there's definitely a place for it. There's direct-action technique – things like direct myofascial release, high-velocity low-amplitude adjustment, muscle energy –

and then there's indirect action where you stay out of the barrier and allow a potency to build and make the correction. There's a place for both of those approaches. One thing is certain – if you effect a big structural change from foot to neck, you have to have a way of effecting the same level of change in the cranium or problems are going to arise. Dr. Ida Rolf envisioned the level of change she thought was required in the cranium in part through intra-oral and intra-nasal work. Osteopathy has a long history of intra-oral and intra-nasal work and quite a few conversations about balancing the side effects of this work. Some osteopaths find they get better treatments and results by avoiding intra-oral and intra-nasal work and working with the embryological fulcrums for growth and development of the head and neck. There is a particular fulcrum that organizes the growth and development for everything from bregma to xyphoid. We will sometimes work with that fulcrum for ulcers, GERD, hiatal hernias, tonsillitis, and sinusitis, but it is a lot of years of study to work that way. In the biodynamic curriculum, that is taught at about year six or seven – that's six years of post-graduate study and practice, so maybe ten or twelve years into our osteopathic study and practice. Rolfers certainly need some means to effect change or create the potential for change within the cranium that matches what is going on in the rest of the body. Intra-oral and intra-nasal work is the means that is traditionally taught. I think we need to proceed with caution, really know our anatomy, study the effects, and study with a mentor, because it's very easy to lock up the mechanism with that type of work, particularly the mid-face fluid fields that Rebecca was talking about earlier. What looks like an underbite and a protrusion of the mandible is sometimes actually a loss of potency in the mid-face fluid fields – it hasn't fully developed, it isn't fully expressing. Is our direct action with nasal work going to support an opening of that or is it going to create a further lesion? This, I think, is a question we need to be asking ourselves. What amount of pressure is right, how do we evaluate?

Part of what Ida Rolf was after, I imagine – she may not have had this type of language – was creating the space and freedom for life to express through the mid face and lower face, but what was the quality of her touch when she went into the nose, where was the fulcrum of her intention? I never met her, so I don't know; we rely on the elders of the

profession to pass that kind of knowledge along. Embryologically there's three distinct regions in the face – upper, mid, and lower. The mid and lower can often lose vitality or experience a compressive force, either in childbirth or trauma during life. You'll see lack of growth and development and loss of function and physiology, it can look like and underbite when in actuality it is lack of expression and compression in the mid face. There's fluid fields all over the body; these in the face are three very dynamic and important ones. The upper one would be basically in the frontal region of the head, the mid-face field would be along the zygomatic arch region, and the lower face fluid field would be in to the mandible and hyoid region. These are approximate, not exact.

RG: It's the distribution of the three trigeminal branches; V1, V2, V3.

OA: Embryologically they are, you can trace it back. And then they kind of come together as a single fluid field that goes down into the brain stem and the cervical spine. So we begin to see embryologically the effects that Rebecca was speaking about earlier, where a change in the mandible or in the maxillary region has a profound effect on the cervical spine, brain stem, and ANS. It's a big deal, very powerful, very beautiful.

AH: Rebecca, can people contact you if they are interested in ALF work?

RG: I encourage that. I have people emailing me from all over the world that go to my website and I try to give them answers, even if I don't see them as patients.

OA: Rebecca's a great resource, she's really passionate about this work, and extremely knowledgeable. I think we just scratched the surface.

RG: Thank you, Olixn.

AH: Thanks to both of you for your time.

Olixn Adams is a Certified Advanced Rolfer who went on to become an osteopath. He practices full-spectrum family medicine and traditional osteopathic medicine at Spanish Peaks Regional Health Centers in La Veta, Colorado, and Walsenberg, Colorado. (The hospital will soon be the first in the state to have a full homeopathic pharmacy.) Rebecca Griffiths has been a practicing dentist for thirty years, has treated TMD patients successfully for twenty-seven years, and has been an ALF specialist for twenty years. She is located currently in Phoenix, Arizona and her website is www.tmjarizona.com. Anne Hoff is a Certified Advanced Rolfer in Seattle.