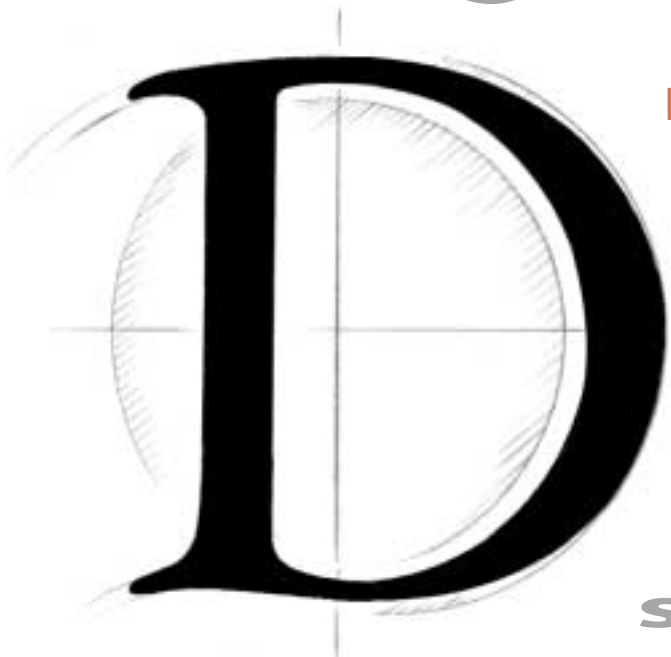



# Body Language

**BY THOMAS MYERS**

**An excursion  
through the  
alphabet in  
somatic terms**



ILLUSTRATIONS BY TOM BOWMAN



**B**ody Language is a column where we explore the alphabet in terms of the body and bodywork. Each issue, we look at a letter's origin, introduce a bodywork approach that begins with the letter, and look at one clinical issue suggested by the letter. This month we explore the letter D—its origin, Erik Dalton's Myoskeletal Alignment Technique, and depth.

## The letter D

D comes from the Hebrew *daleth*, meaning door. The original Egyptian hieroglyph showed a door swinging on its hinges. Later, forms of the letter changed from a square to a triangle with various orientations, including the upward-pointing triangle of *delta* from the Greek alphabet, until it settled into the familiar rounded triangle of the Roman alphabet.

If we remember our meanings up until now in the spiritual journey of the alphabet, we had A = ox = primal energy; B = house = corralling that energy; and C = camel = journeying away from that security toward something new. Now we have D = door = the opening from the known into the

unknown. Makes some kind of sense, doesn't it?

Opening the door into the unknown is something we do in our hands-on work, depending, of course, on how we view our work. If we perceive our work as a fix-it job—the client has a problem and we are going to identify it and fix it—then our task becomes returning people to their familiar normal state. This is similar to the medical model, and can be a good thing for the people who are hurting, and it is a great test of our skills—can we get the job done?—but it is not what I signed on for. For me, the great attraction of manual therapy was and is its ability to deliver people to the portal of *terra incognita*, to take them where they have never been before. Bodywork was, and is for

me, a way to open up new areas of perception, feeling, thought and movement, to bring in new ways of being and even to tread on and awaken untried parts of the client's corporeal soul.

Sometimes the client and I together achieve this lofty goal, and it is always rewarding for us both. Other times you lead the client to a door, but they balk at walking through it (and pushing them through is a very bad idea, says the sadder-but-wiser voice of experience). Sometimes you are just fixing a frozen shoulder or straightening a twisted, shortened leg, but oftentimes, if pursued with sensitivity and gentle determination, this presenting symptom leads to something deeper, something meaningful. It is this ability of bodywork to deepen experience and give meaning to human suffering that has kept me slaving over a table in various small rooms for more than 25 years, fascinated by one person after another, instead of outside in God's fresh air where we all belong.

The very word door contains a clue into the nature of new experience in general. In linguistics, the letters d and t are very close, and are often interchanged. You just

have to make the two sounds one after the other to see how easily that could happen, in either spelling or pronunciation. We noted in the last column how c and k and q were substituted for each other. Similarly, the intervening vowels between consonants are subject to even more substitution as words shift between languages, or even from time to time or place to place within a language. “Weiss” in German, for example, becomes “white” in English; the noun tendon becomes tendinous when changed to an adjective. Hebrew, the originating language for many of our words, did not even note the vowels between the consonants, leading to many heated discussions among Biblical translators.

These two bits of linguistic knowledge allow us to make connections among many words in our language. Just to take the example of door and apply it to something somatic, let’s look at the obturator muscle. The obturator foramen (opening) is closed by the obturator membrane, and covered by the obturator muscles. The word obturator breaks down into *ob*, meaning closed (Latin), and *tur*, meaning door (Old German). It comes into our language with the word obdurate, meaning stubborn, bull-headed, or, literally, a mind with the door firmly closed. But notice the ease with which d changed to t, and the intervening vowels shifted.

So what we are left with in considering “door” is “d-r-” or “t-r-.” Now let’s play a game: tell me all the words you can think of that



**Top row, left: The original Egyptian glyph, daleth, depicted a square door hung on its frame. Top middle: In the transition to the early Semitic alphabets, the door part changed to triangular. While the Egyptians had stone houses and wooden doors, the Semitic tribes were nomads, for whom a door was a triangular flap of hide across the front of a tent. Top right: By the time of Phoenician cuneiform writing, D was a simple triangle, oriented in various ways. This points to another association with D, which is with the primal feminine, the triangle as a representation of the pubic delta. Bottom row, left: The Greek D, now called delta, was always depicted with the triangle facing up. Bottom middle: The Etruscan D was softened on one side, which some scholars read as again representing the feminine, this time via the softened curve of the breast. Bottom right: The Roman D simply switched the Etruscan D left for right, and this form survives today in our alphabet.**

are built around these sounds—and never mind the vowels between or after these sounds. Here are some that came to me immediately: trip, travel, trick, drive, drain, truck, track, train, drag, tear, torque, drum, drip, traipse, trauma, turn, dura, tramp, torn, Torah, tarot, turret, direct, dare, dire—hey, we could go on and on, but tell me, do you feel a kinship among all these words? There is a subtle commonality of sense among this subset within

the larger family of “druh” words—a sense of movement.

Sure, there are many words that convey movement without being druh words, and there are some druh words that don’t have a sense of movement (like drab and darn). All the same, there is a large family of druh words that convey active movement, and this genetic resonance is one clue: one has to actively travel through the door; it is not a passive process. You have to swim onto the land, and leap

into the air, knowing that you will either have to learn how to fly or learn how to fall. This is the lesson, in my opinion, of *D, delta*, the door.

## D is for depth

Finding keys to meaning that allow clients to unlock and move through the door into something new is a function of another D: depth. Work superficially and real change eludes us. But depth itself is an elusive concept—it cannot be taken literally. So before you say, “Hey, just because I’m not pressing hard doesn’t mean I don’t get deep change...”; please understand that we need to explore exactly what we mean by depth.

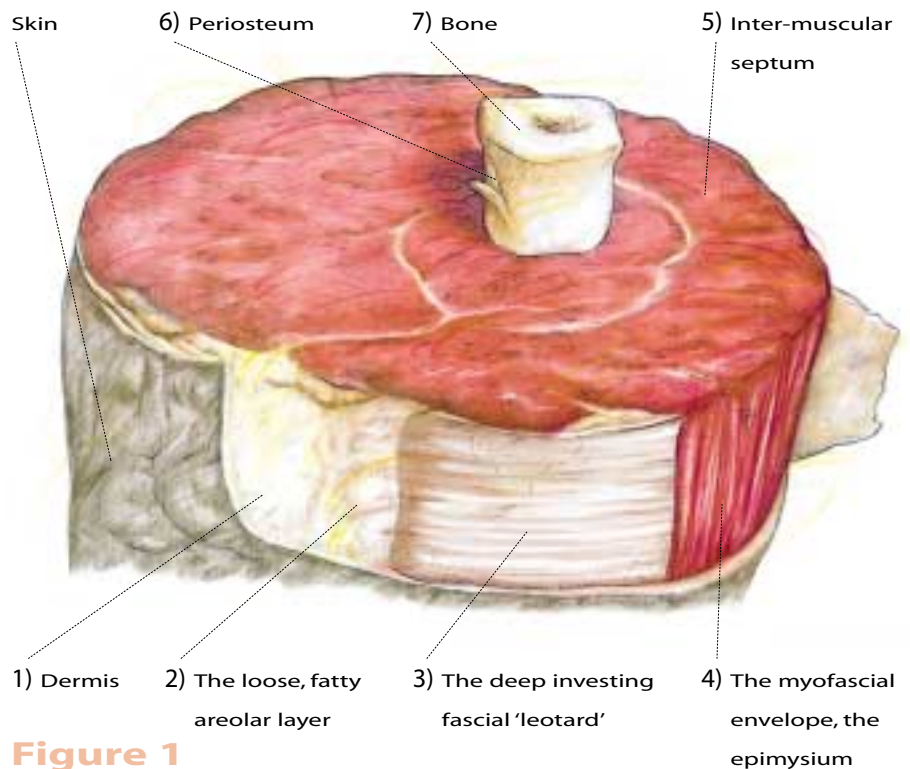
If we look at depth quite practically at first, we can tick off the layers of tissue in the body (see Figure 1). The first layer we encounter (leaving aside the etheric layers with which some of us work) is the skin with its backing layer of connective tissue, the dermis. The next layer in is the subcutaneous, or areolar, layer, with its many infection-fighting cells, fat cells and loose connective tissue mesh. The looseness of this layer allows the skin to be pulled up away from the underlying body proper. The third layer is the body’s leotard, the deep investing, or Scarper’s, fascia, which forms a restraining layer for the entire musculature, and which cannot generally be pulled away from the rest of the body. This fascia takes many names in different parts of the body—like fascia lata in the thigh and crural fascia in the leg. Beneath this fascial “skin” lies the superficial myofascial layer, the

fascia that surrounds and invests the superficial muscles. The next layer is the intermuscular septum, which separates groups of muscles or, also seen in Figure 1, the superficial from the deeper layers of muscle. Close to the bone lies the next layer, the periosteum, which surrounds each bone like plastic cling-wrap. And finally, the bone itself. Bone, of course, is also a connective tissue, invested with a collagen webbing within the mineral appetite matrix, but bone is usually considered outside the purview of the bodyworker.

If we chose another part of the body to burrow into, we

might find ourselves layering down into the visceral or spinal cavity, where we might presume that the organic level was deeper than any of these fascial layers. Or if we took the cue to depth from our organic history, we might point to the digestive system, since this ancient tube forms our most original core (“Man is something built around a gut,” said the famous physiologist Walter Cannon).

For the sake of this column, however, let us confine our exploration of depth to the muscle and fiber tissues most usually addressed by bodyworkers.



**Figure 1**

**Figure 1: Typical layers of tissue, fascia and myofascia in the body (here, the thigh). From the skin down, we encounter: 1) the skin’s backing, the dermis; 2) the loose, fatty areolar layer; 3) the deep investing fascial ‘leotard’; 4) the myofascial envelope, the epimysium; 5) an intermuscular septum; 6) the periosteum, a fabric coating around the bone; and finally, 7) the deepest layer of connective tissue, the bone itself.**

## D is for Dalton

And what better way to do that than by stories! For our bodywork pioneer this issue, we present Erik Dalton, Ph.D. Although he may not be as well-known as some of the others in our bodywork alphabet, he will stand for a diverse group of somatic explorers of depth in the way that Columbus stands for a whole host of seafaring explorers reaching across the Atlantic.

Why choose Dalton? In searching around the bodywork field, there are a number of teachers and practitioners who stake a claim on depth, in the literal sense of “deeper into the body.” Dalton’s method is termed Myoskeletal Alignment Technique (MAT), which surely by its very name claims to be deeper than, say, Myofascial Whatever or

Whoosis Neuro-Muscular. I suppose if you follow this argument, you would be left with the chiropractors as the masters of depth, since they deal consistently with the deepest level of tissues we spoke of above, the bones and the ligaments right around the bones. However, I am not going there. For one thing, my intuitive sense balks at characterizing the chiropractors as a group—however sensitive and nuanced some individual practitioners of the art may be—as masters of depth healing. For another, I want to stay in the domain of soft-tissue manipulation.

In the realm of the recent soft-tissue renaissance in hands-on healing, structural integration (Rolfing and its derivatives, the heirs of Ida Rolf, Ph.D.) have been widely perceived—correctly or

not—as going the deepest into the body, among the many methods available. Sometimes this assessment is made in admiration, sometimes in condemnation—“Oh, yeah, Rolfing—isn’t that the one where they tear the muscles off the bones and make you scream about your mother?” Dalton is one of those heirs of Ida Rolf, who is making a particular claim to tissue depth in his teaching, so let us hear his story briefly told, and see what it can tell us about depth healing in general.

From the outset, let me be clear that I am not saying that Dalton’s MAT work is a knock-off of Rolfing. Each of the heirs of Ida Rolf—even those who claim her mantle—have built upon her work and made innovations (and maybe even lost some of her broad perspective, though who will admit it?). In Dalton’s case, though some of the technique and outlook may have come from his Rolfing training in 1983, his additions and developments have come from his subsequent self-exploration after an injury, from osteopathy, and from the pioneering Czech soft-tissue researcher, Vladimir Janda, M.D.

What Dalton shares with other structural integrators is the concept, as his ads proclaim, of “Don’t chase the pain!” MAT’s emphasis is on prevention—recognize the strain patterns, says Dalton, before they become pain patterns. Of course there are many other similarities in the emphasis on good body use, listening to the tissue and working with the Golgi tendon organ response, and obviously in the goal of total body alignment and ease. Where Dalton



Photo courtesy of Erik Dalton

**Erik Dalton, originator of the Myoskeletal Alignment Technique.**



Photos courtesy of Eric Dalton

**Photo A**

**Erik Dalton demonstrating a Myo-Skeletal Alignment Technique for the deepest layers of spinal soft tissues, Photo A: on the skeleton; and Photo B: on a model.**



**Photo B**

starts to carve his own trail is in bringing the soft-tissue worker closer to the individual joint facets in the spine.

In the late 1980s, Dalton sustained two martial-arts injuries: one to his lower-back ligaments; another, far more serious, was a non-displaced fracture at C4-5 that occurred when he tried to resist a judo throw and landed on his head. Although following the injury he wore a halo to stabilize his neck, he had continuing radiating pain down his right arm. As a Rolfing practitioner, he kept stripping and working the tissue around his own upper back and neck, which would bring temporary relief, but soon the drive-you-crazy pain was back, and Dalton was out looking for the miracle that would take it away more permanently.

Dalton's miracle came, in the end, from his own hands. One morning, working his way through the paraspinal muscles, he encountered bone-like knots in the soft tissue down near the level of the joint capsule, in the deepest layers of the multifidi and rotatores muscles, knots he had not encountered before. "As an experiment," writes Dalton in his manual, *Myoskeletal Alignment Techniques*,<sup>2</sup> "I slowly began to steadily apply pressure directly to one of the bony knots in the laminar groove about the C5-6 level. Suddenly, it felt as though the vertebral segment was pushing back at me. My fingers resisted the bony recoil in the same way I had resisted during deep tendon work many times before. To my surprise, the bone reacted in much the same manner as the

tendons—it retreated. As the vertebra retreated, I gently took up the slack and waited for the recoil against my fingers."

Dalton continued to experiment with this deep probing process of resistance and then taking up the slack, adding a respiratory component, working with the breath until the knot had disappeared and the bone had settled. Dalton worked on a few more of these knots over the following quarter of an hour, and then, sensing that his body had had enough, left it alone to settle. From that day forward, his pain lessened and his function improved, though his journey to understand what had happened had just begun.

Eventually, with more work and more experimentation, Dalton realized that the fibrotic lumps in

the fourth layer of spinal musculature—the deepest layers of the transversospinalis—were a key to assessing and treating underlying vertebral dysfunction. This makes the link between osseous manipulation—chiropractic and osteopathy—and the soft-tissue work of massage therapists and bodyworkers. Dalton's work focuses on the usual myofascial balance that structural integrators aim for, plus this near-bone musculo-ligamentous layer—a "bony intent" that sees bone as a soft tissue—the deepest layer, and a slow-changing layer, to be sure, but still a layer of connective tissue. This is, of course, the actual fact, but the artificial division between hard and soft tissues is one that has informed most of our education, and led to some separation between those who work with one (chiropractors and osteopaths) and those who work with the other (massage therapists and bodyworkers). Dalton's work, by progressing more deeply to the junction between the two, is beginning to bridge the gap.

Bridging the gap, but not crossing it, as Dalton is quick to point out. "One of the things that sets the MAT method apart from other modalities," he writes, "is the emphasis placed on restoration of function to joint capsules; particularly, restoration of joint play to the capsular articulations. Obviously, all our joints have a capsule of some kind, often consisting of fibrous, fatty, membranous or cartilaginous tissue." Although massage therapy schools commonly teach treatments for joints such as the glenohumeral, temporo-

mandibular, clavicular or the knees, MAT techniques “are directed primarily at the articulations of the vertebral, rib and sacroiliac capsules,” Dalton says. “Even though capsular routines are a major part of our program, I want to stay away from comparing the MAT program to chiropractic.”

Dalton devotes ample space in his manual to separating the two. “We work to restore mobility to the soft tissues of the joint capsules. When applying pressure to the articular pillars of the cervical spine, our intent is to not only mobilize the joint capsule, but to help release 4th-layer muscles like the intertransversarii that commonly cause joint fixations.

“Therapists should not be digging on the intertransversarii because of the neural structures surrounding the transverse processes, but these extremely important and frequently hypertonic muscles need to be worked, to help restore cervical function,” he continues. “Therefore, we use the bones as levers to release these hard-to-mobilize soft tissues. This is a different concept from chiropractic, where their focus is on localizing down to the dysfunctional lesion and thrusting the joint into a non-physiologic range of motion to unlock facets often stuck from adhesions caused by repeated friction to the articular cartilages. The [American Massage Therapy Association’s] rules make it clear that massage therapists are not allowed to take the joint into a non-physiologic range of motion. I intentionally do not disobey this rule, and this is what keeps the Myoskeletal

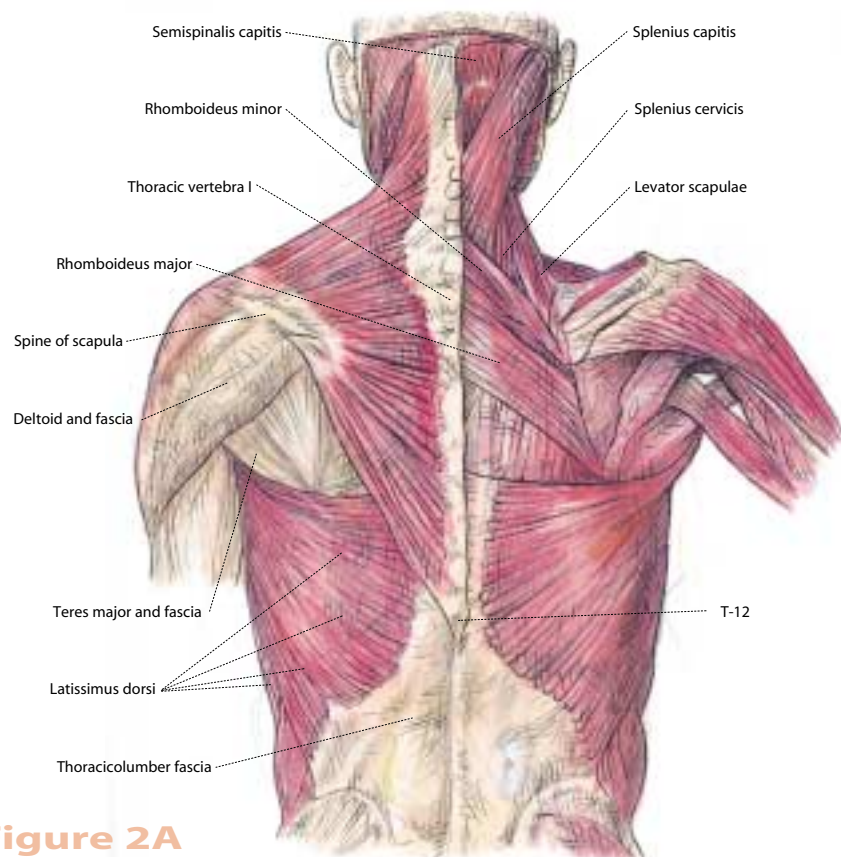
Techniques within the massage therapy scope of practice.”

While zeroing in on these specific and deep soft tissues, Dalton keeps a broad focus: “My intention is to help today’s therapist recognize that most of these chronic pain problems are much more involved than trigger points [or] muscle toxicity. Concentrating on neck and back dysfunctions, I try to teach that it is a waste of time to view chronic pain as emanating from a single structure. So we use (Janda’s) muscle imbalance theories, ligament work and capsular release techniques to achieve that goal.”

Dalton further differentiates himself from both Rolfing and chiropractic in two ways. One is through his concentration on assessment of the muscle firing

**Figures 2A, 2B, 2C: Working our way down into the 4th layer of back musculature, we start with the trapezius/latisimus layer (Figure 2A, left side). If we remove that, we see the levator scapulae rhomboid layer beneath, the core musculature creating shoulder stabilization (Figure 2A, right side).**

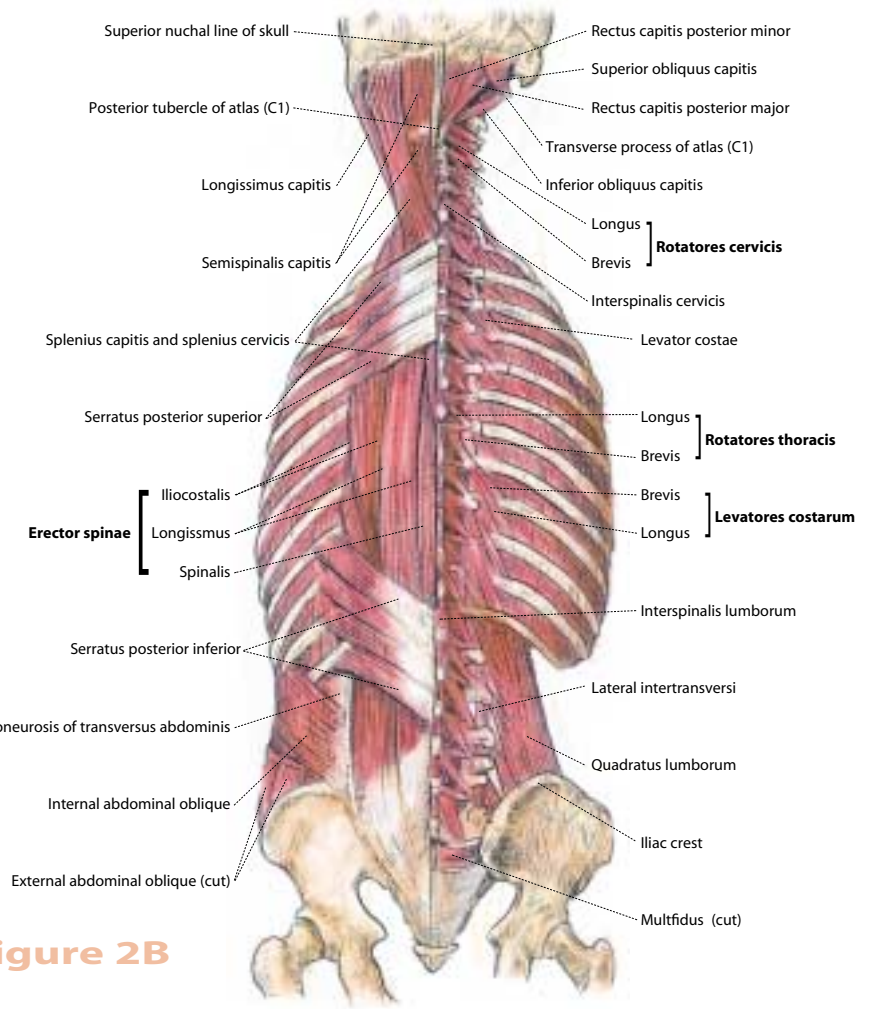
**Beneath these lie the erector spinae with their retinacular coverings, the serratus posterior muscles (Figure 2B, left side). Deep to these lie the tiny but crucial muscles of the transversospinalis—the fourth layer. The longer**



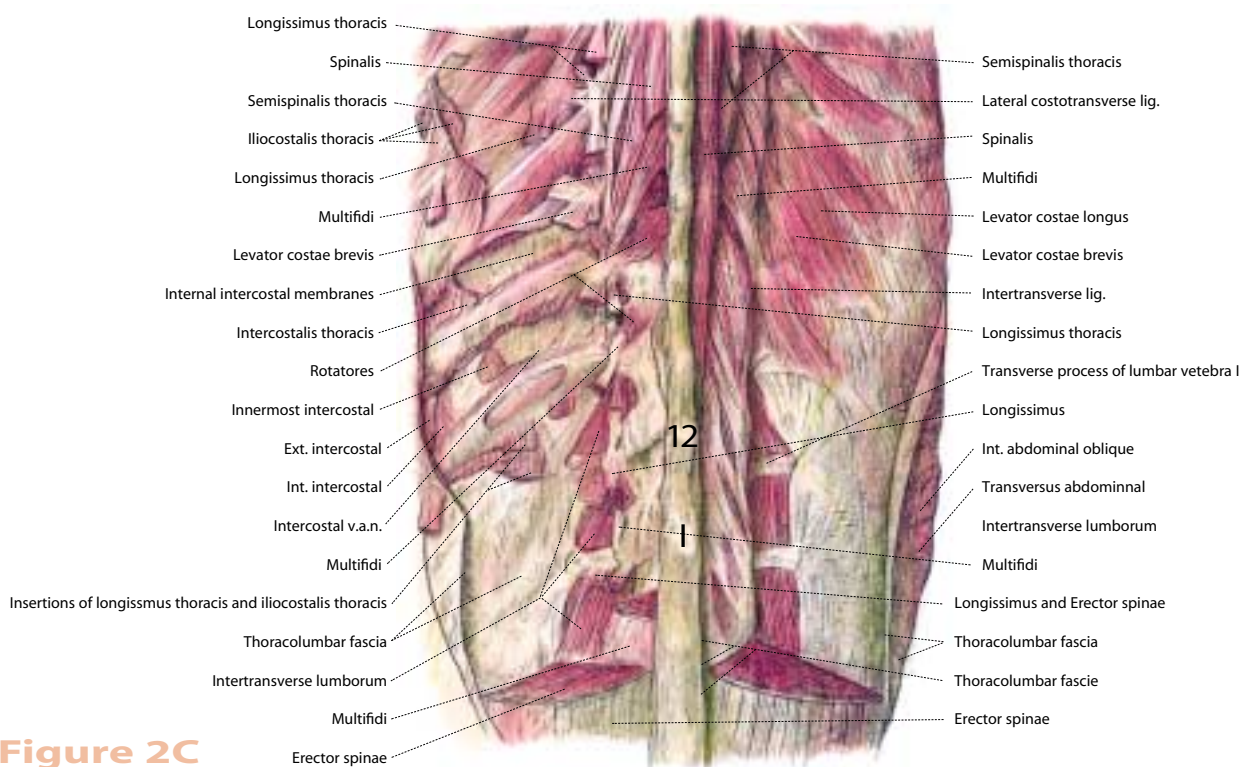
**Figure 2A**

**multifidus muscles are shown cut at the bottom, so that you can see the deepest layer close to the joint capsules, consisting of the rotatores, levatores costorum, interspinalis, and intertransverse muscles.**

**In Figure 2C we see a detail of the lower thoracics and upper lumbar, with the amazingly complex layering of both small and large muscles which either create and permit movement of the individual vertebrae on each other, or, as in Erik Dalton's pain patterns, restrict and limit it.**



**Figure 2B**



**Figure 2C**

order in walking (as developed by Janda, though the treatment is specific to Dalton). He also distinguishes his work through techniques for *generating* muscle tone via spindle-stimulating techniques (see Body Language, "C," November/December 2000), and frictioning techniques specifically designed to stimulate fiber proliferation in lax ligaments and capsules.

Although the proximal and distal crossed syndromes of Janda—looking for the muscle patterns that predictably contain the strain patterns that lead to the pain patterns—are a very important element in soft-tissue work, they will be considered in a later column. Right now, we wanted to explore Erik Dalton's unique contribution to depth.

## Depth

Depth has been a problem for Rolfing bodywork since its inception. Part of the reason that Rolfing got such a reputation for pain is that Ida Rolf kept exhorting her students to "Go deeper!" Those of us who were just starting out in this business, in the first rush of pioneering enthusiasm, took "go deeper" to mean "go harder." It was a limitation in her teaching, and definitely a limitation in our understanding. More than two decades later, the teaching of depth in Rolfing and structural integration schools has changed considerably, though the reputation lingers on.

My own journey into depth was changed by Ida Rolf herself in a singular moment. In 1978 I was in the midst of my advanced training with her. As it turned out, this was

Rolf's last training—she was to die of congestive heart failure and complications from rectal cancer less than six months later at the age of 83. During this training, she spent most of her time in a wheelchair, although she could still walk for short distances. Mostly, she directed the work of others, though she occasionally would do some hands-on work herself.

On this particular afternoon, I was working with Tweed, my model. Tweed was a nurse, a bright and gentle soul who unfortunately was compelled to live with a severe ideopathic scoliosis, which had strongly distorted her rib cage and spine. At that time, I was living and working in Little Rock, Arkansas, and Tweed, who had benefited greatly from our first 10-session series (I had learned a lot too), had traveled all the way to Philadelphia to be my model for advanced sessions under Ida Rolf's direction. This afternoon, Rolf's eyes were going from watchful to baleful to increasingly frustrated. Tweed was seated on a bench, slowly bending forward over her knees, while I stood behind her, using the flat of my knuckles to open the locked myofascia in her knotted erectors.

Ida Rolf was fidgeting in her wheelchair, saying "Get in there, man!"—at which I would redouble my efforts, and Tweed would grin and bear it as her back got redder—but not longer. Finally, Rolf could take it no more: she wheeled her chair over closer to the back of the bench, barking my shins with the footrests. She jammed on the wheelchair brakes so the chair wouldn't move, and then leaned

way forward. At full reach from the chair she was just able to put two gnarled fingertips on either side of Tweed's spinous processes. Slowly her fingertips traveled down Tweed's twisted spine.

Tweed, who was bent forward and so did not know Rolf and I had changed places, cried, "That's it, now you've got it!" as her back started to let go of another layer of long-held tension. At this moment I realized that depth was going to be an elusive and hard-won property. If this failing little old lady could achieve more depth with two fingertips at full reach out of a wheelchair than I could in my young prime, standing right over the client with my fists firmly placed in her back, then certainly going deeper and going harder were not remotely equated.

Of course, a truer language of depth has suffused our profession in the years since. Here is a summary list of my current thinking on the components of depth, with a brief explanation following:

- 1. The three ins: intention, invitation and information**
- 2. Practitioner body use**
- 3. Slower is better**
- 4. Knowing the anatomy**
- 5. Resonance**

1) A clear intention precedes your fingers into the tissues, so that mind and body are aligned. Do you know what your intention is each time you enter the field of the other person? Having a clear intent makes achieving depth so much easier for both of you. Each move is also an invitation—I love this word, it means bringing life

in—an invitation to greater awareness, greater movement, greater relaxation. If your hands are suffused with the attitude of invitation as you come into the body, the waves of tension and resistance part in front of you, and depth is more easily found. And finally, each move informs—brings in form. That is the uniqueness of bodywork, Deane Juhan tells us: Nothing is added but information, nothing is subtracted but what the body lets go of. Hands-on work is essentially an educative process. If—and I am talking to myself as well—we come into the body with the intention of informing the tissues, giving them information they might be missing, our work is very different from when we come in with the intention of fixing it—breaking up that fascial adhesion, stretching that spasmodic muscle, annihilating that trigger point, whatever.

2) Effective body use on the practitioner's part is a second essential element—use your muscles and your force to change tissue, and the disturbance to the client will be much greater than if you use your bones and your weight. Not only will you generate resistance in your client if you muscle your way in, but your hands and shoulders will likely not serve you well for a long career. The absolute minimum force to get the job done while maintaining maximum sensitivity to the many levels of the client's state, both local and global, is our goal here. Good practitioner body use, seen in this light, becomes more than a good idea, it's the law.

3) Speed is the enemy of depth—the faster you go, the more resistance you generate. Waiting and sinking and swimming slowly through the tissue takes a little longer—but like the tortoise, wins the race. How fast is determined by two simple questions. First, is the tissue melting in front of your fingers? If you have to pry it open, you are going too fast. If nothing is happening and you are bored, you are probably going too slowly. If it is melting just in front of your hand (or elbow or whatever), you are sitting in the Goldilocks seat—just right. The second question is in your perception of the client: Is she trying to get away from what you are doing? If your work includes the client having what Ida Rolf called "the motor intention to withdraw," then, in my opinion, you are going too fast.

4) Admitting my prejudice—I am an anatomy teacher—I find that depth is also a function of ever-more-precise knowledge of exactly what is under your hands. If I can reconstruct the picture of where I am in my memory and connect that image to what I am feeling in my hands, my intuition and my ability to go deep improve by leaps and bounds. If I am lost in a wash of tissues whose orientation and purpose I am not clear about, my intuitions become vague and fairly useless.

5) Last but by no means least is the concept and experience of resonance. There are so many

rhythms in the body—the rise and fall of breathing, the beat of the heart, the hum of metabolism, the buzz of the brain waves, the idling purr of muscle tonus, the ebb and flow of the cranial pulse, the irregular grumble of peristalsis, the reciprocal metronome of walking, and perhaps a hundred more drumbeats, known and unknown. Training your awareness to your favorite pulses and increasing your sensitivity to the biologic rhythms allows you to enter a state of resonance with your clients. When you are so linked, your ability to make deep change, to obtain access to the deeper layers of tissue, as well as the deeper layers of being, increases wonderfully.

What would you add? What is your experience of depth, and how do you attain it? Depth is an elusive concept, an artistic experience, a mysterious property. The list above is my current one drawn from my practice, and developed even more in my attempt to lead others to depth in my classes. These are the doors to depth that will lead to opening new doors of somatic experience for our clients. M

For more information about Erik Dalton's technique, call (800) 709-5054 or visit [www.erikdalton.com](http://www.erikdalton.com)

Footnote

1. *Mysteries of the Alphabet*, by Marc-Alain Ouaknin, 1999, Abbeville Press, London, England.

2. Vol. 1, published 1998 by the Freedom From Pain Institute, Oklahoma City, Oklahoma.

*Thomas Myers studied directly with Drs. Ida Rolf and Moshe Feldenkrais, and has practiced integrative bodywork for more than 25 years in a variety of cultural and clinical settings. He directs Kinesis Seminars, Inc., which develops and runs international training courses for manual and movement therapists. Myers served as a founding member of the National Certification Board for Therapeutic Massage and Bodywork, and as chair of the anatomy faculty at the Rolf Institute. His articles have appeared in numerous magazines and journals, and a book is now underway on his Anatomy Trains Myofascial Meridians approach.*