The original chart is from STILLNESS by Charles Ridley ©2006 The lavender column displays the evolving articulation of BCT and PBOL in Chapter 9				
Types of cranial work:	***Biomechanical***	***Functional***	***Biodynamic***	***Advanced Biodynamic Practice***
Degree of efferent application by the practitioner **(How much doing is there?)**	Spans a range between the extremely skilled application of precise physical forces to the cranial bones to create changes in the relationship between the sutures without the use of the cranial wave motility (direct method) to following the cranial wave motility, exaggerating it in its direction of ease (indirect method) to its endpoint and holding it there until a stillpoint is induced, which effects a more balanced motility in the cranial wave motion and thus create a change in the tissues being treated, which begin to function more healthfully.	Practitioner follows the cranial wave in the direction of ease within its freedom of motion only. There is no exaggeration, no holding at endpoint, or inducing stillpoint. Stillpoint arises naturally by waiting until the motion is inherently suspended and the tissues become buoyant—this is called neutral. During neutral, the client's breath is employed to balance the tissues, along with autonomic nervous system balance that effects a stillpoint and a body-wide physiological change.	Practitioner mirrors the motion present, but does not use the client's respiration, instead he waits until the client naturally relaxes in neutral and until stillness in the local part deepens and spreads to the whole body (this is stillpoint as redefined in biodynamics) after which primary respiration appears as a delicate breath-like motion throughout the client's whole body that creates a potency in the fluids that transmutes inertial motion into coherent motion, inherently, throughout the whole body, and in all systems.	There is zero practitioner efference, Pure Breath of Love is in total charge; it addresses the entire spectral human being - from the history held in the tissues to the evolving Spirit.
Therapeutic forces the practitioner employs	In the direct method cranial techniques move the bones based on a detailed knowledge of suture architecture and its range of motion. In the indirect method one follows the cranial wave motion, which is exaggerated to stillpoint. Both methods are structure-function models: Changes in structure, and function changes (direct), or, function changes, and structure will rebalance (indirect method).	One supports the permitted motion of the cranial wave until a neutral arises inherently, and with the use of the client's breath and a balance of the autonomic nervous system a stillpoint inherently arises in which a dynamic exchange between the potency, fluids and tissues ensues which will create a new function that effects changes in the structure.	One cooperates with primary respiration (PR) a developmental motion that begins at conception, creates the fetus, and continues as an innate motion that maintains healthy function in the body. PR creates potency in the body's fluids as a therapeutic force that appears in the neutral, segues to stillpoint in which primary respiration breathes healthy motion throughout the body.	No involvement on behalf of the practitioner.

Breath	***Cranial Wave***	***Fluid Tide***	***Long Tide***	***Dynamic Stillness***	***Pure Breath of Love***
Rate or motility	Variable rate: 7-14 cycles per minute Expands for approximately 4-6 seconds, then recedes for approximately 4-6 seconds.	Steady rate: 2 ½ cycles per minute Expands for 12 seconds, then recedes for 12 seconds.	Invariable rate: 1 minute 40 second cycle Expands for 50 seconds, then recedes for 50 seconds.	No rate	Pure Breath of Love presents a paradoxical phenomenon that consists of a precise combination of no rate, any rate, or all rates, which are combined within the one rate as the whole body Sacred Pulse of the SA Node. This one rate is an alchemical mix that is specific to the client's needs. Depending on that need, at any given time one can perceive any rate that expresses in each enfoldment as well as no rate of Dynamic Stillness … this is not logical, nor understandable … it simply is the characteristic of the Pure Breath of Love as it suffuses the client.
Character of each level	The presence of cranial wave (CW) depicts normal function in modern life, (indigenous people have no cranial wave). The CW disappears when the client deeply relaxes, and after whole-body stillpoints. CW rate varies, based on the client's status—whether they are stressed, ill, injured, traumatized, etc. The CW is protective and it responds to the stressors of life. Like a vinyl record, the CW holographically reflects a client's inertia, which can be discerned by a practitioner who chooses to be skilled in such.	The presence of primary respiration (PR) of fluid tide appears when a client relaxes into neutral and after a whole-body stillpoint. PR is sensed as a delicate whole-body 'breathing' that reunites the client's bodymind, connects them to their midline, and proceeds to resynchronize the body's inertial motion patterns and transmutes them to healthy motion. The practitioner's work is as a supportive witness to an inherent healing process with its own sequence and order. by including PR, fluid drive and motion present in awareness.	The presence of primary respiration of long tide appears if client has sufficiently reconnected to their bodymind-Soul, and their midline has re-balanced such that it is available to the more global infusion of the potency of long tide. The inertial patterns are reorganized in long tide en-mass and system-wide on many levels at once. Clients report encounters with the Self—as archetype; exalted deities are met here and clients feel *seen* and *contained* by a radiant *presence* that beholds them in unconditional love.	The presence of stillness only. An infinitely deep stillness literally enters the room from outside and permeates every aspect of both the client and the practitioner. Healing occurs behind the curtain of awareness in a cloud of unknowing, yet there is a certainty that healing has occurred on a very deep level. A deep sense of reverence to stillness is permanently instilled into consciousness, which unites with stillness such that there is no perceptible difference between the two.	Pure Breath of Love is sealed in Dynamic Stillness, which contains components of all enfoldments. The feeling sense may have a quality of super substance, unifying matter, or matter in liquid motion (all elements, all levels, all at the same time). This paradoxical presence possesses intensity and intimacy in a specific combination of both/and/neither/all/none/infinite/infinitesimal … again, not rational.

Level of human consciousness	Rational to Vision-logic. (Body mind split unites as bodymind)	Psychic (bodymind-Soul)	Subtle (Self)	Causal (Pure Spirit)	Beyond what is known as 'non-dual' … all levels of spectral consciousness are present, ranging from the infinite to an utterly embodied suffusion of Pure Breath of Love all the way into the inner space of each cell – all of which may seem as just ordinary. The depth of wholeness realized has no time, no space, no distance, no story, no unfolding… what we *call* 'evolution' is motion as it is.

Abide in love and it becomes your body

Biodynamic Cranial Practice

The three fundamental types of cranial work

Even though everyone's process is different, three fundamental types of cranial work are part of Dr. Sutherland's transmission stream. Understanding the differences between each model is important, because in the cranial field there is confusion. With the exception of osteopathic biodynamics, all popularized biodynamic cranial trainings that I know of unconsciously mix the three types of cranial work together.[i] These schools teach biodynamics overlaid with biomechanical principles of evaluation and treatment. For example, standard cranial techniques are changed into energetic ones by converting a physical technique to an intention, suggestion, or conversation skill in their biodynamic application. So instead of applying a physical technique, you are taught to apply a perceptual one by using your will to visualize the bone and then, imagining the bone moving to where you want it to go, based on the function of the technique (e.g., with sphenoid decompression you imagine the sphenoid separating from the occiput at the sphenobasilar joint). However, these efferent activities are not in cooperation with primary respiration, and are incompatible with what Dr. Sutherland taught in his last years, which will become evident as we proceed.

Let us start with a very brief review of biomechanical cranial work. References are provided to permit you to dig deeper if you so desire.[ii] I prefer the osteopathic definitions that are in the literature, which differ from those in the published biodynamic books. I am presenting the principles developed by Dr. Sutherland in his writings and from an oral tradition that have been handed down to us and published by his students.

Biomechanical Model

Biomechanical cranial work is most widely practiced and rightfully so, it was the first cranial work taught by Dr. Sutherland.[iii] This is classical cranial, a structure-function approach based on accepted biomechanical principles. Primary respiration is said to operate as a mechanical system powered by the inherent motility of the brain and its affects on the reciprocal tension membrane system (RTM). As the brain moves it carries the RTM with it, creating a mechanical movement model that was derived conceptually, not sensually.

Cranial wave theory has it that the brain coils and uncoils along the developmental axis of the lateral ventricles, which moves the RTM. It is believed that the RTM is firmly fixed at specific poles of the skull bones, so when the RTM moves, it pulls most strongly at the poles that act as levers to move the sphenobasilar joint (sbj). The sbj movement causes all the other bones to move in the vault, the face, and the sacrum via the core link, and this action moves all the rest of the bones from one position to another along their axial fulcra; this is known as *inter*osseous motion, which means the motion between the bones. The motion in the RTM in turn moves the arachnoid layer of the meninges, which fluxes the cerebrospinal fluid (CSF) and creates the longitudinal and lateral fluctuations of the CSF throughout the body. On inspiration, the spinal cord shortens while the brain coils along the axis of the lateral ventricles toward the lamina terminalis, widening in its transverse axis, shortening anterior to posterior, and decreasing in vertical height. Since this excursion produces flexion at the sphenobasilar joint, the movement of the facial and vault bones, as well as the sacrum via the core link, is also flexion (or external rotation for paired bones). On expiration, the spinal cord lengthens, as the brain uncoils and all the rest of the components reverse in motion; this is extension (or internal rotation for paired bones). Flexion and extension

(external and internal rotation) are the fundamental motions of cranial wave. They combine with the secondary motions of side bending, torsion, strain, lateroflexion, decompression, and compression to become the named permitted cranial wave motion patterns. The sbj is the key joint—the fulcrum -- that dictates how all other bone lesions are named and defined. Even though when you apply a specific technique you orient to the axis or fulcrum of a particular bone (e.g., the frontal bone) the key is to name its motility pattern based on the defined permitted motion of the sphenobasilar joint. Therefore, when sensing cranial wave motion patterns in any bone, you name its pattern according to the sbj motion pattern, regardless of how you would otherwise name that particular bone motility.

The practitioner evaluates for the presence of cranial lesion patterns by applying a series of motion tests to determine the range of motion of a bone and to discern its direction of ease, that is, where the movement most easily goes in its range of permitted motion. A treatment is mechanical, which corrects the distortions from the normal pattern of the permitted sphenobasilar joint motility. To treat, the practitioner takes the permitted motion of a cranial bone in the direction of ease to its endpoint, or barrier, and he holds it there. This exaggerates the lesion pattern and creates a tension in the osseous-membrane tissues that matches, or is greater than, the unstrained osseous-membrane dynamic, which creates a point of balance. This is called balanced membrane tension (BMT) and can be compared to taking out the slack in a rubber band until it becomes taut. You hold the tissues in BMT, until you induce stillpoint, in which potency exchanges throughout the tissues and fluids that reorganize the inertial forces and change the tensile tone in the tissues. This new balance in the tone of the tissues creates a more synchronous motion pattern. When the practitioner senses synchronous motion arising out of the induced stillpoint, he moves to the next lesion and repeats this process until a sufficient number of lesion patterns have been corrected for that treatment session.

There are two basic approaches to a biomechanical treatment. First, to treat in the direction of ease is the indirect method in which you exaggerate the movement of the bone to where it most easily goes. An alternative to the indirect method is the direct method, where the practitioner who has a detailed knowledge of suture architecture and its specific range of motion will apply precise physical forces to the cranial bones to create changes in the relationship in the sutures between the bones without the use of cranial wave motility. As such he carries the bone directly back to where it belongs until there is a release.[iv] A familiar example of a direct method is a spinal adjustment, but the same principle can be applied to cranial bones: If it is out, put it back in. Stillpoints occur in two ways, as defined in biomechanical work. The first stillpoint naturally occurs, or it arises at the endpoint of each excursion—flexion, stillpoint, and, extension, stillpoint. You can also induce a stillpoint by exaggerating the motion to barrier and holding it until a synchronous motion expresses in the cranial bone.

Most cranial practitioners employ the biomechanical model. Some examples are classical “Cranial Osteopathy” (Magoun 3rd. ed.); “SOT Craniopathy” (DeJarnette, Pick); “Applied Kinesiology” (Goodheart); bodywork practitioners who have taken “Craniosacral Therapy” (Upledger); and countless other, less well-known approaches.[v] In general, most osteopaths and craniosacral therapists practice the indirect method; and chiropractors, applied kinesiologists, and some osteopaths practice the direct method. So now let us move on to the functional methods of cranial practice. There are differences that require our appreciation, because biodynamic cranial work is an extension of functional methods.

Functional Cranial Model

The functional approach differs from the biomechanical in the way that lesions are evaluated and treated.[vi] Like the biomechanical model, cranial wave motion, involuntary brain and membrane motility, and the axial motility of the sphenobasilar joint is the therapeutic focus. The functional practitioner follows the cranial wave, but also he engages the client to focus their breath on the lesion area as he waits for a balanced autonomic nervous system (ANS) to become a therapeutic aid in decreasing the stress reflexes in the body. He also evaluates differently; the functional practitioner motion tests by supporting the permitted motion of cranial wave in the direction of ease, as in the biomechanical, but he supports the motion within its freedom of movement. There is no exaggeration of the lesion pattern, no holding at the barrier, and no induction of stillpoint. Therefore, as you support the permitted motion in the direction of ease, a progressive increase in the freedom of the joint motion inherently arises until it becomes balanced membrane tension; and as you continue to wait, you begin to sense no tension in the tissues. In essence, balanced membranous tension inherently suspends the bone and it becomes buoyant, or free-floating, which in functional work is the dynamic neutral. The neutral is sensed as a feeling of buoyancy in the bone-membrane. There is a free-floating suspension of any tension in the joint space and it is free to move in any direction. In neutral, the practitioner actively engages the client's thoracic respiration, so the client's focused breath is directed to the lesion and, as it enters, its motion acts as a therapeutic agent to shift, and rebalance the lesion area, which also helps to further relax the client, which shifts the autonomic nervous system from a sympathetic dominance toward parasympathetic function and a more balanced disposition. As the ANS balances, the client relaxes more deeply, potency enters the area, and a dynamic interchange of potency, fluids, and tissues occurs. After a period of reorganization there will emerge a more balanced and synchronous cranial wave motion pattern, and then you move on to the next lesion in the chain. Stillpoint has the same definition here as in the biomechanical model except that stillpoints are inherent, or occur naturally, so you do not exaggerate the lesion, or hold at the barrier, nor use any outside force, and you do not induce or even a suggest stillpoint. In his transcribed cranial training classes, Sutherland spoke passionately about not applying any outside force to cranial lesions.[vii]

To summarize the functional approach, you follow the permitted motion within the freedom of movement to the neutral as the fulcrum for engaging the client's breath. The breath is the fulcrum for shifting the lesion pattern to a more balanced pattern and to balance autonomic nervous system toward deepening the neutral until it becomes stillpoint, which is the fulcrum for the dynamic interchange of potency throughout the tissues and fluids of the body. You then move on to next point in the lesion chain and repeat until you have corrected a sufficient number of lesion patterns for that office visit. Treatments are still oriented to the sphenobasilar joint, but are not based on biomechanics alone. You are aware of many other influences and you depend upon cranial wave intelligence to intuitively guide you in a sequence of techniques. There are many functional methods in osteopathy, but Hugh Milne's teachings are the most popular among non-osteopaths, not only because he combines biomechanical with functional osteopathic cranial work, but also perhaps due to his brilliant contribution of shamanic and intuitive skills that he brings to bear in his Visionary Craniosacral Work.[viii] Functional work is the portal into the biodynamic approach, so let us explore this to see for ourselves.

Biodynamic Model

There is a major threshold to cross between the functional and the biodynamic model.[ix] The most important difference is that the cranial wave is no longer looked to as the guiding therapeutic agent. In biodynamics, the practitioner acquiesces to the felt-sense guidance of primary

respiration (PR), an intelligence, which as an outside presence, is found in all living organisms. You sense PR, which creates all other motions inside the entire craniosacral system as one unit. This motion courses throughout the client's bodymind without regard to the layers. In other words, primary respiration fluidly moves and passes through every layer, be it osseous, membrane, fluid, or the psychic as if they did not exist, like a ghost passing through walls. Another way biodynamics differs from functional and biomechanical, is that your perception of specific bone and membrane motilities are replaced by a felt-sense of whole-body fluid, protoplasmic motion that dominates your perception, as the tissue layers recede into the background. All functional, healthy motions in the system are seen as effects of PR, which operates due to the biodynamic polarity between the forces of levity and gravity in the fluids. Biodynamic refers to the fluctuating forces in the fluids of the living matrix of the organism that produce mechanical equilibrium in the metabolic processes during the developmental motion process.

Biodynamics differs in many other ways. The PR rate of excursion is steady, as compared to the variable rate of cranial wave, and its motility is four times slower. PR is a stable two and one half cycles per minute, while the cranial wave rate varies between eight and fourteen cycles per minute. You no longer focus on lesion patterns based on the status of the sphenobasilar joint as the fulcrum for craniosacral motion, or on *inter*osseous motion -- the axial motion patterns between the bones. Instead, you sense a delicate, breath-like metabolic flow throughout the whole body as a unit, including the breathing within the bones as *intra*osseous motion, as well as in the membranes, tissues, fluids, and potency. You sense this motion as it wells and recedes without naming lesion patterns. In fact, the layers of osseous-tissue motility recede into the background and the fluid dynamics of living, breathing protoplasm become more prevalent in your awareness.

To understand the body-wide effects of primary respiration let us look only at the bones and membranes for a moment. The membrane system -- the falx, tentorium, and anterior dural girdle—do not attach to any place more strongly in the skull at the poles. Instead, the membranes are uniformly contiguous with the brain on the inside, and the outer layer of dura that lines the inside of the skull, the endosteum, and it continues through the sutures and becomes the outer bone covering, the periosteum. Therefore, in the biodynamic model, you sense the motion of primary respiration *in* the bones as a uniform, skull-wide subtle breathing. It is this intraosseous motion that moves the brain, membranes, and cranium as a whole unit of function by virtue of it all being enveloped by membrane. During inspiration, if only observing osseous motility, you would sense the motion well up the midline and simultaneously radiate peripherally as a transverse widening *within* the bone as if it were a breathing lung. This inspires potency into the fluids inside the bone, which infuses levity that suspends the effects of gravity, creates more space, and disengages the compressed inertial patterns of motion within the tissues. The fulcra that are now buoyant have the space and freedom to shift under the influence of the motion of primary respiration into a more aligned relationship with the midline, which transmutes the inertial patterns of motion into the always and already healthy motion of primary respiration. With expiration, the potency recedes in a tide-like manner leaving in its wake the rebalanced fulcra and the resynchronized the fluid patterns, which subsequently reorganize the shape and spatial dynamics (position) of the tissues, based on the matrix of healthy motion patterns laid down by primary respiration. This is Wolff's law in action, and its principles can be extended from the bones to throughout the body. Treatment, therefore, is under the guidance of the coherent matrix of healthy motion that is created by primary respiration as it moves throughout the fluids in the body as a whole unit. So in biodynamic work, your perception expands from focusing only on the motion in the parts—an individual bone, membrane, or an aspect of fluid fluctuation for example—to bringing your awareness to the motion inherent in the fluids in the client's entire body. You sense how primary respiration influences the *fluid body* as a whole, and,

you observe how the potency of primary respiration concentrates itself and shifts around the body as the *fluid drive*, which works through specific localized fulcra of the body as the *motion present*. So primary respiration operates as the whole field of activity throughout the bodymind; the fluid drive is the concentrated potency that moves from place to place in the body, and each place where the potency dwells to resolve the specific local inertial fulcra is the motion present. One way to characterize this is to imagine that primary respiration is like a lake, the fluid drive is like the river whose concentrated water currents move in the lake of primary respiration, and the localized eddies created by the river, like tide pools, are the motion present.

Sensing *both* the whole-body primary respiration and the specific motion present of the fluid drive remains most primary in your awareness. This is crucial in biodynamics, because the practitioner's job is to witness the whole and the parts at the same time. You let your perception expand to sense primary respiration and its affects on the entire fluid body as it wells out of the midline and distributes peripherally into the body, *and*, at the same time, your hands mirror the motion present within the concentrated potency that shifts from place to place in the body as the fluid drive, without influencing any of it. The particular localized motion patterns that are sensed in the fluid drive under the influence of primary respiration are the *motion present*, which essentially is the motion *as it is*. In my teaching, you apply no efferent activity to the motion present, no motion testing, no techniques, no intentions, no instigating, no suggestions, no fluid direction, no visualization, no tracking, no conversation skills, and no augmenting in the presence of primary respiration. At most your hand contact is a fulcrum of stillness in a fluid neutral that allows the flower petals of the metabolic fields to inherently unfold and find their natural shape under the influence by primary respiration. You are guided and moved by the inherent intelligence of the potency in the fluid body, which, in turn, is precisely guided by the tidal forces of primary respiration, as it wells and recedes from the client's midline. As potency infuses them with intelligence, the fluids make specific movement decisions. The fluids shift from place to place, like a river coursing within a lake, as the fluid drive, and the potency dwells as the motion present in particular fulcra in the body to bring the inertial motion in that area into a more healthy coherent relationship with the midline in synchrony with the healthy motion of primary respiration, and thus, with the body as a whole. The motion of primary respiration, the fluid drive sequence, and the various places that the potency moves to and in what order, as well the specific areas where the potency dwells to resolve discrete inertial motion as the motion present—all combined, is called the inherent treatment plan. Inherent means what is says: The specific sequence of flow, as the fluid drive, and the precise resolution of inertia in each locality, as the motion present, arise out of intelligence from *within* the fluids as directed by primary respiration, not by your human intelligence. So there is no need to efferently apply *any* outside force to the system based on your conceptual ideas of what you think needs to happen. Any efferent activity impregnates primary respiration with your will, which impedes the inherent treatment process, even if you mean well and think you are helping the Breath of Life along through 'conversation skills;'[x] or aiding primary respiration by having silent conversations in which you offer her a gentle suggestion to go into stillpoint, such as 'would you like to take a pause?' [xi]

This intelligence is perhaps billions of years old. She is the genesis of life that creates all living organisms, and is the source for all therapeutic processes, so she can certainly resolve inertia without your help. This inherent power of transmutation is the reason that any treatment modality works, whether it is surgery, drugs, nutrition, manipulation, bodywork, homeopathy, acupuncture, movement, psychotherapy, hypnotherapy, spiritual healing, prayer, or meditation. If you can be present, in neutral, you may be granted the privilege to witness a miraculous process that is already built into our systems.

Here is an example of how you begin with the biomechanical approach, segue into the functional, and proceed into biodynamics. The practitioner senses the cranial wave excursions of flexion and extension while he supports the permitted motion in the osseous-membrane tissues in the direction of ease to a balanced membranous tension, (in the biomechanical model, this is where you would exaggerate the lesion to the barrier, then you hold at the barrier to induce stillpoint, which marks the end of treatment for that bone). Wait, until the BMT becomes buoyant. Remain in this buoyancy, while the suspended motion begins to float in a neutral. As the client's thoracic respiration naturally deepens, the ANS will begin to inherently balance, which further resolves the inertial forces (this is the end of the treatment in the functional model). Wait, while the potency continues to inherently infuse levity into the inertial motion pattern and the buoyant space begins to expand. In this expansion there is a progressive disengagement of the inertial fulcra. Continue to wait, as you sense the disengaged fulcra begin to automatically shift toward a more balanced position relative to its midline. Wait, as stillness begins locally in the part that you are supporting. Wait, until stillness spreads to the whole body that now begins to feel like fluid protoplasm suspended in stillness (this is where balanced membrane tension transmutes into balanced fluid tension). Wait in this whole body stillpoint, and primary respiration will begin to well up the midline and radiate peripherally into the fluid body as a whole. You now sense a delicate whole fluid body breathing that wells up the midline and radiates out as a transverse widening on inspiration, and recedes on expiration in twelve-second excursions that are four times slower than the cranial wave.

Let us review: This delicate whole fluid body breathing is primary respiration. The way in which potency gathers in a concentrated manner in this delicate breathing field and begins to move from place to place through the fluid body, like a river moving within the lake, is the fluid drive. Where this concentrated potency dwells, attends to, and resolves very specific inertial motion patterns, is the motion present. The biodynamic treatment begins here, but the potency of primary respiration treats inherently. In my teaching, it is not the practitioner's job to decide on any treatment sequence, therefore you do not direct the fluid drive, or make suggestions, nor augment the motion present; the treatment is completely managed by the intelligence within the fluid drive *because you are not doing anything*. In the osteopathic biodynamic model, stillpoint is that moment when stillness passes from the local part to the whole body as a unit, and after which, a delicate whole body primary respiration is sensed. It is important to understand that after stillpoint, when primary respiration begins to arise in your perception as a body-felt-sense (and the client's) -- that moment determines the beginning of the biodynamic session, specifically, it is when primary respiration has taken over the healing of the client's whole bodymind.

The client neutral is fundamental, because it marks the point where her ego has begun to negotiate how to hand over control to primary respiration of the Breath of Life. As the neutral deepens it leads to stillpoint, which leads to primary respiration, and the biodynamic treatment process begins. To recap, the neutral begins as BMT, becomes buoyancy in the tissues, and becomes still locally (this is stillpoint in biomechanical and functional work). This local stillness, in biodynamics, is the beginning of the neutral, initially, as a potentization, which infuses levity into the tissues and expands the space. It then suspends the motion, which disengages the inertial motion and frees it, leading to automatic shifting of the fulcra to a more balanced disposition relative to the midline. When stillness spreads from the part, locally, to the whole fluid body it begins as balanced membrane tension and transmutes to balanced fluid tension—perceptually you sense tissue transmute to fluid. The neutral culminates as stillpoint, which, by definition, ends when you sense whole body primary respiration as a two and one-half cycle per minute, whole body delicate breathing, called fluid tide. Primary respiration feels like subtle delicate whole body breathing within the fluid body—a fluid within the fluids—that has a felt sense of a metabolic, protoplasmic flow in which you also sense a body-wide ebb and flow.

Throughout fluid tide there will be a series of balanced fluid tensions (BFT), and even though they feel like the same whole body stillpoint that brought on primary respiration, these are consolidations of an ever-deepening neutral that is in the process of sequentially rebalancing the midline. After a sufficient portion of the midline has rebalanced and reestablished, it becomes available for even greater levels of potency. Hence, when primary respiration stops breathing in fluid tide and you sense balanced fluid tension (BFT) transmute into an even more rarified balanced potency tension (BPT), it marks the last time we refer to a client neutral. As the fluids transmute into potency your perception will expand in tandem with your sense of a build-up of stillness that seems to come from outside the room, from as far as the edge of the horizon (the known). Then you encounter a very profound and prolonged stillpoint, out of which emerges a vaporous, oceanic, breathing Presence that also comes from outside, and you enter the trans-personal domain of potency, known as long tide in which your perception expands to the horizon. When the client's ego has completely surrendered control over to this Presence the neutral has reached its fruition. Long tide is an archetypal, global phenomenon that expresses a one minute forty second ebb and flow rate, that is, fifty seconds inspiration and fifty seconds expiration, which ultimately segues into Dynamic Stillness, a universal non-phenomenon that has no rates.

You can directly sense transmutation as gleaned during the progression of the neutral. Recall that a neutral in the biomechanical work is balanced membrane tension (BMT), which segues into buoyancy in the functional model, which becomes balanced fluid tension (BFT) in fluid tide, which progresses in a sequence to resolve inertia in the motion present until BFT becomes balanced potency tension (BPT) to acquiesce to long tide. In summary, tissue transmutes to fluid, and then fluid transmutes to potency, and potency transmutes to Dynamic Stillness, which transmutes back to healthy tissue. We will go into this in detail in the next four chapters, so let us stick to our brief review of the differences between the three models.

See if you can appreciate this major difference between the biodynamic, when compared to the functional, not to mention the biomechanical model. The biodynamic treatment begins after the cranial wave disappears into the neutral, which deepens to a whole body stillpoint in which you can sense primary respiration as one unitary metabolic flow that feels like a delicate ebb and flow breathing throughout the whole fluid body. It is important to understand that until you sense stillness in the part spread to the whole body and out of whole body stillness you sense PR, you are still in the development of the neutral (which continues to deepen until long tide arrives, but we are getting ahead). When primary respiration enters your perception, do not treat—wait. If the rate of primary respiration is a stable two and one-half cycles per minute, this is fluid tide. Many published biodynamic cranial books state that fluid tide rate is variable, and the authors instruct how to apply techniques as intentions, and to suggest stillpoints, but that is inaccurate based on Dr. Sutherland's oral teachings that he transmitted to his closest students who practice the biodynamic model.[xii]

In Sutherland's biodynamics, after primary respiration emerges, the practitioner adds no efferent activity into the craniosacral system, because it will stress the delicate field of primary respiration that is already breathing potent healthy motion throughout the client's system into precise areas to resolve inertia as the inherent treatment plan. My list of prohibited efferent activities include any outside force a practitioner can apply, such as motion testing, applying techniques, intentions, suggestions, conversations, augmenting, fluid direction, tracking, searching for midlines or other anatomical structures in the client, even focused perception will disturb the field of primary respiration. Instead, the practitioner abides in his heart, he waits, remains relaxed, open, and in his own neutral. When a practitioner abides in this disposition, he lets the Breath of Life manage the healing in her pristine natural state in which she is free to engage the inertia in the client via her inherent treatment plan as the combined excursion of

primary respiration, the movement of the fluid drive, and its motion present. The practitioner's job is to wait, be still, and present in a neutral, and synchronized with primary respiration, as the concentrated potency moves from to place to place as the fluid drive to resolve the inertia by breathing healthy motion into the motion present. If a practitioner applies biomechanical techniques here, even if they are cloaked as subtle suggestions, conversation skills, or intentions, then he is not only interrupting the inherent treatment plan, but he is also introducing his own efferent energy vectors into the delicate field of primary respiration. *Any* applied efferent energy injects vectors of stress into this extremely sensitive field, which is very transparent, and will precisely reflect your input, therefore it adversely affects the already underway, healthy motion of primary respiration that expresses the inherent treatment plan. Subtle intention imprisons primary respiration and forces her to deal with the vectors of stress that are introduced, even if it is only a minute suggestion, and creates what Dr. Jealous coined false fulcrums. These points of power create more inertia that further imbalances the craniosacral system and must be immediately resolved. So the potency that is reserved for the client's inherent treatment plan is utilized to resolve these false fulcra. This not only uses up the available potency, but false fulcra can create enough stress to marshal the fight-flight response that floods the client's system with neural-hormone and immune reflexes, which create noisy interference patterns and cause primary respiration to disappear from your perception. Cranial wave then reappears, which leaves the client bereft of the resources of PR. If efferent activity continues to invade her system, it will be necessary to protect her self, so the client's system may automatically enter into a freeze response, also called a shutdown, or she may dissociate, go into unwinding, or even suffer treatment reactions. The best indicator that your good intentions have gotten in the way is when, after an intention or suggestion, the fluid body suddenly begins a rapid lateral fluctuation, fluid tide disappears and cranial wave appears. We will cover this in more detail later, so let us return to the effects of practitioner intention from another point of view, its effect on the Breath of Life.

My efferent intentions or suggestions, when introduced into this sensitive field of primary respiration, force it to respond to the stress I introduced before getting back to the inherent treatment plan that is very specific to the client and is already underway. Keeping in mind that the mother is the Breath of Life and the father is Dynamic Stillness, Trevor in his beautiful book the *Tao of Healing* says:[xiii]

"The Mother and Father of All Things

When labeled, judged, divided, structured

Become prisoners

Locked in little minds

They agree to imprisonment

They agree to enlightenment

They always say Yes."

Because of coherence, every cell in the whole body is extremely dynamic and interconnected; all cells can be remodeled within minutes when subject to subtle signals from the environment. Each cell and the entire system act as a coherent whole, so information or disturbance in one part propagates promptly to all other parts. The whole cell and its members form a tensegrity system that always deforms or changes as a whole when local stresses and strains are experienced.[xiv] Applying biomechanical methods while in contact with the sensitive biodynamic field of primary respiration (fluid tide or long tide), even if they are applied with only the slightest of intention

(intend decompression, flexion, extension, side-bending, or suggest stillpoint, etc), is a stressor that affects the whole organism; it is an inappropriate biomechanical overlay onto a biodynamic model. This is my biggest criticism for popularized "Craniosacral Biodynamics." I have no doubt that this misperception is innocent on behalf of the teachers of these methods, but none-the-less in my opinion it is 'not on.'[xv]

The idea that you can apply treatments or suggestions inside the sensitive field of primary respiration is at odds with Dr. Sutherland's transmission stream. We have the writings of Dr. Sutherland and Dr. Becker, and thankfully, Dr. Jealous has published his interactive CD text. These texts may help clear the confusion that is rampant in biodynamics. In the following paraphrase, Zen master Bankei articulates this whole point of not interfering with the Breath of Life, especially if you substitute Stillness where you see the word unborn:[xvi]

> The Unborn is the origin and beginning of all there is; no source is apart from it and no beginning that is before the Unborn. Thought has fallen one or more removes from the living reality of the Unborn. Because of the Unborn-ness and marvelous illuminative power inherent in the Unborn, it readily reflects all things that come along, and transforms itself into them, thus it turns the Unborn into thought. It is only our ignorance of the Unborn that makes us go and transform it into thoughts. In the external world we turn it into all manner of things and then we become those things. You must thoroughly understand about not transforming the Unborn into other things. Therefore, whatever happens, leave things as they are; do not worry yourself over them, and do not side with yourself. Just stay as you are, right in the Unborn and do not change it into something else. Resist the partiality for yourself, which makes you want to have things move in your own way.

Now, with that in mind, let us taste a mere sampling of the unlimited variety of sensory experiences that we may encounter in biodynamics as we explore the five cranial enfoldments.

This brief synopsis leads us to the need to define some important terms, which are representative of the patterns that repeatedly appear in a biodynamic session. Like a map, these terms put into language the sensual perceptions that are encountered when practicing biodynamic cranial work that is based on Dr. Sutherland's transmission. It is important to understand that what follows are the general patterns, the archetypes. The specific details of each session and the patterns in it are never the same twice; so do not be deluded into thinking that this is a specific order that must happen as I describe it. I am providing one example of an infinite array of possibilities. So let us take a freeze-frame look at one version of a biodynamic map through which we may navigate all of the enfoldments of cranial wave, fluid tide, long tide, Dynamic Stillness, and undifferentiated Breath of Life. We will start with the motion present, which I called *motion as it is* before discovering Dr. Jealous' terminology, but out of respect for his brilliant contribution I will use his definitions in this book. Any errors in these definitions are mine.[xvii]

[i] This includes any teacher or practitioner trained by Sills, Shea, or Kern.

[ii] Greenman, Magoun, Johnston, Becker, Jealous.

[iii] Sutherland 1967, Magoun 3rd edition.

[iv] Pick.

[v] Magoun, DeJarnette, Pick, Upledger.

[vi] Greenberg, Johnston.

[vii] Sutherland 1990

[viii] Chaitow p.289, Milne.

[ix] Sutherland, Becker, Jealous.

[x] Sills Volume One p. 313.

[xi] Shea p. 251.

[xii] Becker, Jealous.

[xiii] Trevor.

[xiv] Ho p. 122.

[xv] Sills, preface to revised Volume One.

[xvi] Wadell.

[xvii] Dr. Jealous developed these definitions.