

Acupuncture Points, Meridians, and Stripes

by Stanley Rosenberg

I continue in my process of doing the ten sessions with an awareness of the location of acupuncture points, meridians and stripes. This approach continues to yield new insights into human structure and opens new ways of effectively reaching the goals of the individual sessions.

Before examining the inner arch of the foot in the second or fourth sessions, I would like to mention an article by Jim and Nora Oschman, called "Physiological and Emotional Effects of Acupuncture Needle Insertion".* They present a wealth of information about the effects on different structures - the skin, the perivascular tissue, vasculature, perineurium, nervous system, myofascia and the periosteum. One of the great values of the article was to extend my knowledge of the microanatomy of connective tissue and cell structure. Their paper gave me many new pictures of the processes set in motion with my hands in the ten sessions and specifically how touching can effectively change the bodies of my clients.

Two hypotheses guided the Oschmans' exploration:

The first is that acupuncture simulates an injury without actually injuring tissues, and thereby elicits local and systematic wound-healing responses that have a variety of therapeutic effects.

The second hypothesis is that the skin surface is not uniformly sensitive to stimulation - certain areas are more responsive than others in terms of their ability to activate particular injury responses and to spread those responses away from the point of stimulation.

As a practitioner of Structural Integration, I draw inspiration from the Oschmans' paper.

First, over the years there has been an ongoing discussion within the Rolfing community about "painless versus painful" and/or "hard and soft" styles of Rolfing.

I have been working effectively for several years using the lightest possible touch at specific places to attain the objectives of the ten sessions. A soft and pleasurable touch is not enough in itself. The touch must be applied at specific points (generally the acupuncture points) if I expect to get real changes.

On the other hand, I suspect that some Rolfers, out of enthusiastic dedication to do the best that they can for their clients, are doing tissue damage.

I read two recently published articles about Rolfing in magazines. Both journalists reported black and blue marks as a side effect of their sessions. Over the years in newspaper articles, a dominant impression which the journalists communicate about Rolfing is that it is "painful". Rolfing has traditionally had this kind of media image.

I often hear Rolfers talk about their own shoulder problems. From the soft Chinese martial arts, there is a guiding principle: "do not meet force with force". A defensive reaction from the connective tissue in the body of a client creates a resistance to the pressure applied by someone doing massage or myofascial release techniques. The harder the therapist pushes, the harder the tissue of the client pushes back. If I push against a wall with my hand, the wall pushes back into me with an equal and opposite pressure. If I push hard into bodies, they push just as hard back into my body. The shoulder joint is the mechanical weak point for many Rolfers, because of the way we stand or lean over the table as we work on our clients.

I think that as a community, we would have a better reputation and would do better work with less "cost" to our own bodies, if we could practice initiating a process of healing that only simulates tissue damage - rather than a process of change that damaged tissue. In this regard, the Oschmans' paper can confirm the theoretical possibilities of effectiveness from a minimum touch applied properly at specific locations.

As I mentioned in my last article about acupuncture points and stripes, I have experienced acupuncture therapists who needled in the superficial connective tissue and others who let their needles bend and follow the loose connective tissue between muscles deep into the body.

Because of the connectiveness of connective tissue, changes in the deeper layers can be set in motion by a soft touch in the layer of the superficial connective tissue between the skin and the muscular-skeletal structure beneath. Some people imaginatively refer to superficial fascia as the "body stocking".

But a soft touch can also continue in depth through the pathways in the loose fascial tissue between individual muscles, muscle groups, or even skeletal structures.

If there is a tension at an acupuncture point, I can feel a slight depression, somewhat like putting my finger tip into a shallow thimble. If I follow the pathway carefully, I notice that the bottom opens out like the base of a tunnel. From the shallow thimble on the surface, I can go deeper into the body without force. I have to be willing to follow that tunnel as it opens, as it twists and turns through the muscular-skeletal structure. If I lose the pathway through the tunnel, I start banging my finger onto a wall.

If I do not control my impatience, I can easily start to try to mash my way through the wall of the tunnel. I think that there is a little reactive voice in most of us, that says, "Nobody pushes me around! If I find something hard, I push on it until it gives up. I will meet force with force, if I think I can win."

I remember the first time I heard a Chinese martial artist say that he would never hit anyone with his own force. After years and years of training, he was reluctant to hit anyone. His reason was that to the extent that he hurt the other person using his own force, he would also hurt his own body. The trick in Chinese martial arts is to neutralize the other persons force and to return their aggression back to themselves without adding on to it. The person who started the attack or defense gets back what they put out - on the

physical and emotional levels, they get a mirror to their projection. The person attacking is confronted by their own aggression.

I work to avoid banging away on hard connective tissue. My role as a therapist is in two parts. First, I actively find the tension in my client's connective tissue. At the first sign of resistance on their part, I change to a passive role. When I am passive another force becomes active. I like to call that force the "stretch reflex".

Having initiated a process of healing with the first, minimal stimulation of the tissue-to-be-released, I have set the stretch reflex in motion and thus I have initiated a natural healing process in their body. If I keep my finger lightly on the tissue without adding any more force, I sense what is happening under my finger and I am aware that the traumatized tissue is releasing by itself. All I have to do is to be aware and to give it time, space, and acceptance.

I personally believe that my client's mind-body has the resources within it to heal itself.

My client's body does not need me to beat down their resistance. It is natural for traumatized or tense tissue to forgive. To "forgive" is to give by returning to the state before the event happened - to give back the state it was in before.

Tense or traumatized tissue knows what to do if I give the lightest touch possible and then rejoice as I passively feel the wisdom of the body's natural healing unfold under my finger tip.

From the tensegrity release techniques of the French osteopath and cranio-sacral teacher, Alain Gehin, the more specific the point of contact and the more precise the angle of pressure into the connective tissue, the better the result you will elicit.

I think that we as a community have a lot to learn about the possibility of initiating the process of structural change by simulating rather than creating tissue damage. As I recall images of my teachers in Rolfing classes, Michael Salvesson, Peter Melchior, Peter Schwind, and Vandam, I remember that they worked generally with a soft but effective touch. Peter Schwind gave us a beautiful model of what he felt as his fingers floated down through the connective tissue until they met grains of sandy resistance - and how these melted in time. But I shudder when I think about what some of my classmates and I did to our models. We all used too much force, pushing elbows and knuckles as hard as we could. I observe the same behavior in some Rolfers who studied with other teachers.

I hope that present and future students will be "corrected" away from tissue damage towards soft, effective, trauma release processes. In my opinion, the work of Peter Levine, Jim and Nora Oschman, Sutherland, Upledger and Alain Gehin are not "Rolfing add-ons", but should be mainstream in terms of guiding us to find the "how to do it" to effectively achieve the objectives of the ten sessions.

There is a second major idea that I get from the Oschmans paper: it points to the importance of acupuncture points. In order to be effective, I need to be specific in terms of where I use my hands. If as a community, we are going to be softer, I believe that we must know more about the possibilities of creating specific structural change from using the acupuncture points, meridians, and acu-stripes.

Dr. Rolf indicated a division of the foot into an inner and an outer arch. She stressed the importance of the inner arch riding appropriately on the outer arch. I have gone further with this basic idea and consider the inner arch itself to be in two parts: the big toe is in

one unit, while the second and third toes are in another.

The bones of the toes of the outer arch go from the phalanges to the metatarsals to the cuboid to the calcaneus. The bones of the inner arch go from the phalanges to the metatarsals to the medial, intermediate or lateral cuneiforms. The three cuneiforms meet the navicular, which is in touch with the talus. The outer arch relates to the calcaneus and the inner arch to the talus.

When I look at a foot or an ankle, I notice the relationship of the calcaneus to the talus. At first sight, the talus is often obviously medial or lateral in its relationship to the calcaneus. Getting the talus to rest where it should on the calcaneus is critical to achieving the aims of the second, third, fourth, sixth, eighth and tenth sessions.

To realign these two bones, I prefer to use any one of three techniques. One technique is described as "cross-strain" (there is a section on "cross-strain" in the appendix to Upledger's first book on Cranio-Sacral Therapy.). I hold the calcaneus in one hand and the talus in the other. I move the two bones in relationship to each other and find the axis of movement in the joint. I feel for maximum resistance (maximum restriction to the freedom of movement). Then I gently push the bones in the opposite direction into the position that gives the maximum ease of movement. I hold the cross-strain position for 90 seconds. This indirect technique releases the tension that I noticed before I started. A second technique starts the same way. I hold the talus in one hand, the calcaneus in the other and find the direction of maximum resistance. I keep on the point until a release comes from the joint. I usually repeat this process at least one more time. The joint between the calcaneus and the talus has two interfaces.

The third technique is to follow the cranio-sacral rhythm between the calcaneus and the talus. Often, these two bones will spontaneously start a release in a therapeutic pulse.

As for the shape and range of movement of both the inner and outer arches, I am fascinated by the placement of some of the acupuncture meridians and points. For me, an acupuncture meridian is a divider in the connective tissue that differentiates the underlying structures to allow for a maximum of movement.

The bladder meridian divides the skin and connective tissue along the lateral edge of the foot into the dorsal surface and the plantar surface. The spleen meridian does the same at of the distal 2/3 of the medial edge of the foot into dorsal and plantar sections.

(Do not be bothered that the spleen meridian does not go all the way back posteriorly along the side of the foot. Remember that a distinguishing characteristic of the primates is that what we call the "heel of the foot" is on the ground. Many other mammals stand and walk on their toes - their heel is up, off the ground.)

Balance in the levels of inherent tension of the dorsal and plantar myofascia facilitates the maximum range of movement of the medial and lateral edges of the foot in both extension and flexion.

Imbalance between dorsal and plantar myofascial tension creates structural imbalances. If the plantar myofascial is tight, you get hammer toes - if the dorsal is tight, you get toes which curl upward at their tips. You can have tight dorsal fascia on the medial edge and tight plantar fascia on the lateral edge, or vice versa.

If the foundation in the feet is out of alignment, it is hard to balance the blocks on top of it.

Many four-legged mammals like cats, and canines rest their weight on two small pads made up from what in human beings would be the second to fifth toes. In these mammals, the bones which are the equivalent of the thumb and the big toe are there, but they are generally off the ground and at the back of the leg. The calcaneus is in the air. When man has come down to rest his weight onto the calcaneus and the soles of the foot, the big toe migrated forward to the front of the foot. Therefore, it has been interesting for me to reconsider the relationship between the first and second toes in the formation of the inner arch.

The liver meridian on the dorsal surface separates the big toe from the second toe. The first point on the kidney meridian, K1 does the same on the plantar surface of the foot. The liver meridian and K1 indicate the possible structural differentiation of the first toe from the other toes. This structural differentiation of the first toe from the other toes is typical in 4 legged mammals as well as in the primates. We often notice that the large toe is curled up at the distal tip while the other 4 toes are hammer shaped. This structural imbalance points to a different level of tension along the two sides of the liver meridian.

After I looked at enough feet, I began seeing that on most people, the first toe has moved away from the optimal neutral position in relationship to the adjoining metatarsal and tarsal bones: the phalanges, metatarsal, and cuneiform of the big toe have moved further than they should dorsally or not quite far enough and are rolled over or under. Most often there is a twist along the length of the liver meridian - part moving over and part moving under. The phalanges of the first toe can be held by chronic tension in one direction while the cuneiform is held in the opposite direction.

Two ways to improve the relationship between the bones of first toe and the bones of the second toe are to get hold of the adjacent bones and use the cranio-sacral rhythm, cross-strain or finding the direction of maximum resistance and pushing gently in that direction. The best place to get hold of the bones is to use your fingers on pairs of acupuncture points - one point on the liver meridian and another point on the kidney meridian.

We can use the acupuncture points to re-position bones in relationship to one other.

Moving from surface to deep at the acupuncture point, stomach 41, we have an important ligament from the anterior surface of the tibia. Deeper into the foot, the tunnel of S 41 passes along the lateral surface of the talus and the medial surface of the calcaneus. I believe that S 41 is the point in our feet through which our "line" should pass on its way from the point above the crown of our head to the center of gravity in the center of the earth.

This application of acupuncture points extends the range of applications of therapeutic possibilities of the acupuncture points.

Jim and Nora Oschman have indicated use of the points to simulate an injury without damaging tissue to induce the wound healing effects of therapeutic value. Earlier in this article, I described the use of the acupuncture meridians as a natural pathway, a tunnel, from surface to deep in the connective tissue. And now, there is a possibility of using these pathways to realign some critical relationships in the skeletal structure.

*Note: Copies of the article can be purchased directly from N.O.R.A., P.O. Box 5101, Dover, New Hampshire.