The Role Of Acupoints in Rolfing®

by Stanley Rosenberg, Certified Rolfer

This article originally appeared in the October 1994 issue of Rolf Lines. *Mr. Rosenberg modified it in 1997 and again for re-publication here.*

A few years ago, I wrote an article about my discovery that the superficial fascia was organized in "acustripes," i.e., the area defined on the edges by the acupuncture meridians. In my own practice, I continue to explore ways to release tensions in the connective tissue in the acustripes. I search for even more effective techniques with my hands-on applications as well as a deeper understanding of connective tissue organization in the human body.

In 1993, Jim Oschman published a monograph about the biophysical basis for the acupuncture meridians. I am writing this article as the first of a new series about some of my applications and insights based on the acupuncture model of connective tissue.

That year, I had Dr. Jho from Nanking visit for three days of private instruction in acupuncture. Dr. Jho is not only an acupuncturist, but has training in Western medicine. She is the director of a large acupuncture hospital. For more than a decade, Dr. Jho has taught at and has been the administrative director of an acupuncture school in Nanking, which teaches acupuncture to foreign students.

Watching her give individual sessions, I was surprised by how deeply she inserted her needles. Dr. Jho has a clearly defined direction for inserting the needles – the needles are not inserted straight down, perpendicular to the skin surface. Each point has a specific direction for the insertion of the needle. As I thought about where the needles were going, it became clear to me that the acupuncture points had an interesting relationship to body structure, much deeper than the superficial fascia.

The acupuncture needles that she used were not only long, but they were also quite flexible. They were capable of "snaking" through the deeper connective tissue, following the path of least resistance. Before seeing her work, my image of an acupuncture needle had previously been colored by my experience with Western medical needles, which are stiff and sharp and cut their way through whatever tissue lies in their path. But the needles that she used were very thin and easily bent.

I discovered several years ago that the acupoints, on closer analysis, are palpable openings in the skin. You can feel an acupressure point, if the related connective tissue in the area is tense, but you cannot feel the acupoint if the related tissue is relaxed.

An acupuncture point in tense connective tissue feels like a small ice cream cone, wider at the surface and narrowing as it goes down. It is easy enough to find the proper angle from surface to deep through trial and error, using a light touch. In the wrong direction, you hit a resisting plate of tissue and cannot go deeper, but when you find the proper direction, the tissue opens and you can go deeper without resistance.

Just getting into the acupoint and holding still for 15 to 30 seconds, or twirling your finger back and forth, clockwise and counter-clockwise in the ice cream cone for 15 to 30 seconds, is enough to release the tension in the acupoint and the surrounding tissue. As in cranio-sacral therapy, a light touch is preferable to using a Peterbilt or Mack Truck (forceful) approach.

Following the directions of the ice cream cone from surface to deep in the proper angle of insertion of the needle, I found that in most cases the acupuncture points penetrate the muscular organization of the body where the margins of two or more muscles cross each other and / or at the skeletal level, into critical joints of the body. Also, some of them lead into ligament structures.

Ida Rolf left us an understanding of the possibility that muscles can become "glued" together. In my Rolfing class, Michael Salveson used the word "differentiation" to describe the goal of freeing up the muscles, which had become glued together (rather than tearing the muscles apart from each other).

My experience is that it is difficult for me to unglue two muscles by plowing through or pressing hard on the top surfaces of one or both of the muscles. However, it is elegant, easy and effective to differentiate muscles from each other by going slowly and deeply, with a light touch, into an acupoint. By playing with the margins of the muscles where they cross each other with fine movements and sensitive fingers, I can actually get to the proper depth and into the edge of the layer of loose connective tissue, which separates the two muscles. I can feel the physical resistance of the tissue, if there is a functional gluing. With clear intention, playfulness, and the patience to wait the 15 to 30 seconds, a light touch at the right place is usually enough to loosen the entire sheet of connective tissue between the two adjacent, glued muscles.

Many of the acupoints are extremely helpful for improving the integration of structure in the gravitational field.

Bladder 11 (B11) is an important acupoint for Chinese medicine. Following it in depth, you come down along the edge of the spinal erector muscles towards the joint between C7 and T1.

In terms of the thoracic outlet, B11 is closely related to SI15 (Small Intestine 15). SI15 is on the medial margin of the levator scapulae and moves in depth to the space between C7 and the first rib.

The anterior and medial scalenes descend from the transverse processes of the cervical vertebrae to the first rib. The posterior scalene connects the transverse processes of the 6th and 7th cervical vertebrae to the first and second ribs. The different levels of chronic tension in each of the six scalene muscles (three on each side) are partly responsible for the positioning of the cervical vertebrae C2-C7 in relationship to the

first two ribs and indirectly affect the position of the first two thoracic vertebrae. Thus, getting in both between C7 and T1 and between the first and second ribs can do a lot to balance tension and integrate the structure of the thoracic inlet.

My ex-wife had broken two vertebrae, one in her neck and one in her upper thorax, fifteen years ago in an accident at work. She has been asking me for years to give her deep massage at these points. I felt her myofasciae release again and again. I released the tension on the periosteum of the vertebrae. I could not understand why she continued to complain of discomfort.

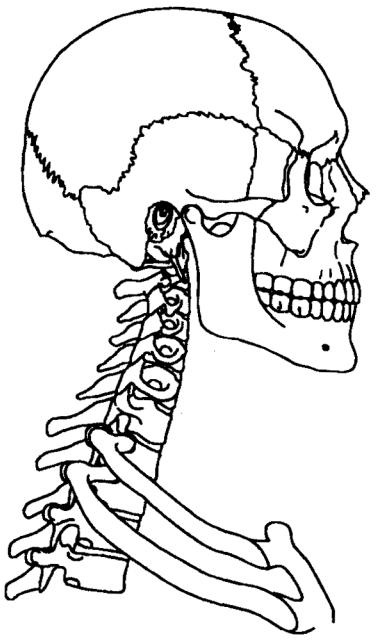
As I explored my failure over the years to definitively release the tension at this acupoint, I finally remembered Ida Rolf's admonition: "If you ain't getting it, go somewhere else." B11 lies somewhere else, away from the periosteum of the vertebrae in the neck and the thorax.

Could B11 provide a possibility of freeing the cervical-thoracic joint and thus release her dis-ease? There is a transverse connective tissue structure separating the vertebrae of the neck from the thoracic vertebrae. There is a technique to release this "diaphragm," the thoracic inlet, in Cranio-Sacral Therapy, by applying a light touch on the clavicle and the sternum with one hand and with the other hand under C7 posterior. In my wife's case, this CST technique was not enough. But working the tissue at B11 did the job, improving her range of movement and eliminating myofascial discomfort.

After exploring the possibilities of working at B11, I now believe that I can be much more effective freeing this diaphragm by including release from B11. (Work on the clavicles does other things and I do not advocate changing the CST procedure for freeing the thoracic inlet in a Cranio-Sacral therapy session.)

I vividly remember Stacey Mills showing us some backwork techniques, which she likened to opening an umbrella. She held the skin, and whatever tissue she could get her hands on, at several points just a bit lateral to the spinous processes and called for movements of spinal flexion and extension. One of the places she grabbed was around C7/T1.

I have had lots of Rolfers plow through the area of C7/T1 in backwork on a bench with their elbows or knuckles passing on the way down to the important lower back. In retrospect, they never had the necessary focus or spent enough time to do a good job there.



The skeletal elements of the thoracic inlet are the 7th cervical vertebrae and the first and second ribs. The scalene muscles connect the transverse processes of the cervical vertebrae with the first or the second ribs.

As the years passed, the area around my spine from C5 to T3 has become the "Achilles Heel" in my own structure – glued and out of line. In spite of the many Rolfing sessions I received (which certainly helped other important parts of my structure), this area was still "full of gunk." As a result, the back of my neck was shortening and my head was slowly sinking forward of my shoulders, like the Leaning Tower of Pisa.

I tried everything I knew or could invent by way of stretching and isometric exercise. These exercises gave me flexibility and incredible range of movement of my head on my neck – the occiput and C1-3. I got Rolfing sessions and a fair amount of Cranio-Sacral therapy. Nothing got to the heart of the problem between C5 and T3. Nothing got in and gave me the length that my structure needed at the back of the neck and top of my chest.

I remember hearing of the sacro-lumbar joint, the lumbar-dorsal junction, the mid-thoracic hinge, and the atlanto-occipital joint in Rolfing classes and six-day workshops, but I do not remember hearing of ways to get in to free the cervico-thoracic junction. There are two possibilities: I might have been asleep, or it was not mentioned when I was around. At any rate, the structural blockages in my own body after all the Rolfing sessions I have received make me suspect that this cervical-thoracic junction is overlooked by many Rolfers.

Following B11 from the surface down to the joint between C7 and T1 and calling for movement has given me a powerful tool for integrating the structure of my clients. Having some bodyworking friends press on B11 on both sides while I move, or working on myself (holding and moving) has considerably loosened my spine between C5 and T3. The back of my neck is lengthening. My body is moving visibly back on line. My movement looks more graceful and my body is feeling years younger.

For tracking movements, I presently ask my clients to roll their heads slowly forward until I feel the pull at the cervical-thoracic joint under my fingers. The tension comes up just on one side. As soon as I feel that, I ask them to rotate their head towards the side opposite to where I felt the pressure build up. I ask them to stop their rotation when I feel the tension increase under my fingers indicating tension in the rotational movement of the cervico-thoracic joint. Then, as they hold the position for 15 to 30 seconds, I monitor the process of their myofascial tension release with my finger tips.

Another acupoint which is fascinating from the perspective of integrating structures is Gall Bladder 30. Working this point allows me to free the skin from the muscles, as well as to work the outer surface and underside of the gluteus maximus, the margins of the gluteus minimus, gluteus medius, piriformis and the external rotators. These five muscles (or muscle groups) connect the femur to the ilium or the sacrum. The proper relationship of these five to each other is crucial to reaching the primary goal of Rolfing, i.e., to horizontalize the pelvis.

At G30, it feels as if there is a tunnel that goes through the gluteus maximus leading the therapist's finger deeper into a space from which he/she can access the piriformis, as well as the margins of the external rotators, the gluteus medius, and the gluteus minimus. As you work from surface

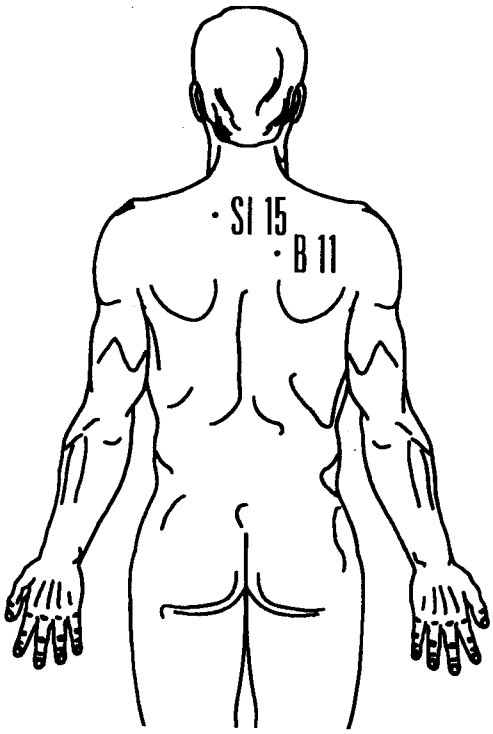
to deep at G30, you will have to snake your way down through the bending tunnel in order to work the individual muscles. When you get down to the depth of each of these muscles, you will do best to clearly change the direction of your intention and to slightly adjust the direction of the push from your finger tip.

Ungluing these muscles from one other, and balancing the level of myofascial tension in each of them in relationship to each other is crucial to integration of structure in the field of gravity. It is my belief that people fall out of balance and lose their line because they lose the proper muscle tone to maintain the integrity of the tensegrity relationship among psoas, quadratus lumborum, the erector muscles and the five lumbar vertebrae. For most people who are off their line, loss of the dynamic interplay among these elements makes it impossible for them to easily hold their body erect in the gravitational field. In their unconscious attempt to stabilize their body, people generally tense in one of the muscles at G30, i.e., the gluteus maximus, piriformis, external rotators, gluteus medius, and gluteus minimus. It is always helpful to reduce the level of tension of all of the muscles accessible at G30.

Tension in one of these muscles is unavoidable as long as the pelvis is not perfectly balanced in space. When one of these muscles is dominant in chronic tension, it brings about or fits in with a whole pattern of muscle tensions on that side of the body. Depending on which of the muscles is used primarily to compensate, they create a "body type" for that half of their body.

For example, if the external rotators are tight at G30, we get a typical ectomorph, by Sheldon's classification. In the external rotator type, you will generally find a corresponding tightness in the posterior tibialis, quadratus lumborum, latissimus dorsi, posterior scalene, clavicular part of the pectoralis major, rectus abdominis, occipitalis, serratus posterior inferior, pterygoid medialis, digastric, mentalis, opponens pollicis, etc. There will also be a tightness in the fascia in connection with the stomach, spleen, liver, bladder and small intestine meridians. There is also a tension in the deep mesentery of the small intestine, surrounding the major vein and artery supplying the small intestines.

(We could also describe a piriformis type, a gluteus maximus type, or a gluteus medius/minimus type.)



People who started as ectomorphs will often have discomfort, severe pain, limited range of movement in the hip joint, or acute structural problems, if, in addition to tense external rotators, they get a secondary tension in one of the other four muscles accessible at G30. Such an overlay of tension from one of the other muscles is not appropriate to their body type.

There are many possible causes for this overlay of tensions not appropriate to their body type. The tension might come from emotional stress, physical trauma, operations, scar tissue, past illnesses or visceral dysfunctions. It might be the result of a need to compensate for structural disintegration in other places. The tension might also come from over-development of some muscles of the body through weight training or repetitious movement patterns over long periods of time.

When two of the muscles are tight at G30, my primary objective is to loosen the tension in the muscle that has been overlaid onto the original body type. This can be done by working on the muscle individually or by focusing on the loose connective tissue between the two muscles. In both cases, enter the tunnel at G30, snake your way down, hook your finger and get in there. "Getting in there" through the acupuncture point tunnel has its benefits. In most massage techniques, therapists work on the external surface of the muscle. By entering through acupuncture points, you can access the margins or underside of the muscle. Working on the epimysium where it is rarely touched often gives surprisingly successful results compared with more traditional approaches which just push in on a muscle from the skin downwards.

I believe that each side of the body unavoidably has an original body type as manifest in tension in one of the muscles at G30. Tension in this muscle remains to some extent, regardless of our strivings to eliminate it. But it is always a good idea to reduce, as much as possible, the level of tension in the muscle, even though it fits the typical pattern. If the cup of tea is a little too strong, add some water to dilute it. It still tastes like tea, but it is a bit more palatable.

In summary, this model of connective tissue has given me many insights into structure and has generated many effective, specific strategies to help integrate the human structure in the field of gravity. In my work with acustripes and acupoints, I have made many useful discoveries over the years, but my work is far from complete. There are 360 points, so there is enough to explore over the coming years.