# Chinese Energetics and Osteopathy

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Introduction
This outline represents a state of development. It reflects my attempts to integrate osteopathic models of function and treatment with traditional Chinese models of acupuncture and qigong. The tables best represent my current level of understanding. From the Chinese side, I have found my treatments work best when the diagnosis is focused on the organ. However the treatment is based on the somatic meridians and their axial correlates. Herein I illustrate relationships between organs, muscles found along the meridians of Chinese Medicine and articulations not found elsewhere. Although I share personal treatment methods, I would consider it a complement if the reader agrees that there is really not much there. I believe it is more important how, when, why and where one applies OMT rather than the specific method. This monograph is primarily devoted to new diagnostic and analytic insights. I hope the reader finds something of interest and if so, please share it.

The organ is always involved- Ancient Chinese Proverb
The soma is always involved- Osteopathic Philosophy

There are no conflicts here; both statements are equally true. If the reader is familiar with the visceral manipulation methods promulgated by the French, he/she would recognize that findings in the visceral field always exist coincident with somatic findings. Acupuncturists would concur that physical findings in the extremities correlate with acupuncture points needing treatment. I would add that the cranial field also correlates with the body’s somatic and visceral findings. The Chinese correlate the organs to ‘orifices’ in the head, usually the primary senses. This forms the basis for my integrated approach.

Diagnostic triangulation of multiple layers:

- Of body regions; the “Five Outposts” of Still
- Of multiple osteopathic fields; OCF, visceral, somatic spinal and appendicular
- Of Chinese energetic and osteopathic concepts
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Dr. Herb Miller once said to me “The restrictions are in your mind”. I believe working with Chinese concepts of exercise and meditation (qigong) brought me closer to understanding what he meant. He also said to me that the most refractory somatic dysfunction is the toughest ‘see’. One must hunt for it with the hands as well as the mind.

I contend that without the presence of the energy the Chinese call ‘qi’, it is both more difficult to find somatic dysfunction, and treat it in a lasting manner. I also concur with him that the body responds as one functional unit to changes in its environment. Everything is in perpetual, shifting balance. We should include the effects of OMT and acupuncture in that context. The operator is merely a part of the patient’s environment. In efforts to introduce intelligent corrections into the patient’s mechanism, as clinicians we must resist the idea of primacy of the neuromusculoskeletal system, the cranial concept or the viscera.

In a fifteen to forty minute treatment, I limit my intervention to a singular primary organ-meridian pairing, based on diagnostic analysis of the viscera, soma, cranium and energetic anatomy, utilizing osteopathic methods. Meridian analysis is then correlated to arrive at a primary diagnosis of the dominant organ. This dominant organ function best represents the leading edge of the patients attempt to compensate for the problem, and also where the they are most poised for change.

I was surprised to find ironclad correlation between my osteopathic and meridian-based findings. The key feature of my diagnostic method is cross-verification of several fields or micro-systems such as visceral, cranial and spinal to enhance sensitivity and specificity. All point to a specific organ if looked at through the appropriate lens.

Since limiting my efforts to this singular organ, associated meridians and axial elements, my results are characterized by progressive and logical improvements based on a classical model of Chinese Medicine. My understanding has become so completely intertwined relative to the energetic and osteopathic approaches that I can no longer separate them in patient care. I believe a unique synthesis is demonstrated below.
Traditional Chinese Medicine (TCM)

Five-Element Model
TCM (Traditional Chinese Medicine) can be a confusing term. I am using it in this monograph to refer to an older model than that often associated with the term in the Chinese medicine community. TCM is often associated there with the system developed during Mao’s tenure. My usage will refer to an older model known as Five-Element popular internationally. For ease of usage I will use TCM to refer to all of Chinese Medicine but I specifically mean the 5-Element Model (5-EM). The Five Elements are also prominently applied to other aspects of Chinese Arts such as qigong, fung shui and the Internal Martial Arts like Tai Ji Quan (Tai Chi Chuan).

The Three Treasures: Qi, Shen and Jing
The energy known as qi is what manipulated in acupuncture, meditation-exercise and herbology to facilitate physiologic change. The other two parts of the energetic frequencies referred to as parts of the “Three Treasures” are shen and jing. Shen is one step higher in frequency and termed spiritual energy. Jing is one step lower, closest to the physical matter of the material body.

The 12 Zhang Fu Organs and the Five Elements
TCM models the human condition by dividing the body-mind into twelve traditional organs. Each organ has bilateral meridians with different forms of energy and information coursing through the soma. The organs are divided into solid (Zhang, Yin) and hollow (Fu, Yang). The organs are grouped by elements in an anthropologically classical proto-scientific manner. The special or anomalous organs are grouped with Fire, leaving five elements. The organ-meridian pairs relate to each other in two ways.

Table 1
Two sets of relationships between the organ-meridian pairings:

1) Yin-Yang or Functional Relationships between organs and their meridians:
These are pairings of meridians on the *same limb*. The relationship between organs is *yin-yang* or opposite in the sense that one organ of the pair is *rising* while the other is *sinking*. Through osteopathic training in the Visceral Field, I realize that this can be viewed as a literal interpretation. It is largely considered metaphor within the TCM Community. I find it plausible that this was the original meaning, obscured by time. Table 2 illustrates some common characteristics of *yin-yang* spectra. *Yin-yang* theory is one of the earliest pillars of Chinese philosophy. This relationship is important in muscle function along the meridians described later.
<table>
<thead>
<tr>
<th>dampness</th>
<th>dryness</th>
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</thead>
<tbody>
<tr>
<td>cold/cool</td>
<td>hot/warm</td>
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<tr>
<td>lethargic</td>
<td>restless</td>
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<tr>
<td>under active</td>
<td>overactive</td>
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<tr>
<td>weak musculature</td>
<td>tight musculature</td>
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<tr>
<td>lack of thirst</td>
<td>thirst</td>
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<tr>
<td>pale</td>
<td>red</td>
</tr>
<tr>
<td>soft</td>
<td>hard</td>
</tr>
<tr>
<td>curled up</td>
<td>stretch out</td>
</tr>
<tr>
<td>pale tongue</td>
<td>red tongue</td>
</tr>
<tr>
<td>empty pulse</td>
<td>full pulse</td>
</tr>
</tbody>
</table>

2) Divisional or Linking Relationships between organs and their meridians
The energy is represented as flowing through circuits beginning or terminating in the fingers, toes and head. This relationship occurs between meridians on ipsilateral upper and lower extremities. So the right large intestine meridian begins on the index finger and terminates on the right side of the face. It links there with the stomach meridian and terminates on the right second toe. The Horary Clock describes the timing of energy movement through these circuits. It is comprehensive depiction of chronobiology dating back thousands of years. Pictorial representation of the meridian topology is necessary and more easily visualized on the web than here. Consider yinyanghouse.com

*The linkages between organs in classical Chinese physiology belie complex neurological relationships that undergird relationships between visceral motility, neural tension, and resulting changes in muscle tone along the meridians.*

The Binary System of yin and yang multiplies the diagnostic possibilities of our model of somatic dysfunction (as based solely on restriction) by two. Now an imbalance in an organ-meridian pairing requires functional intervention of either tonification or sedation. Tonification is used for low-tone myofascial chains and
sinking organs; sedation for tight muscles with rising organs. A new paradigm of muscle function and organ dynamics is presented below. There are many other interesting concepts within Chinese Medicine.

http://www.yinyanghouse.com/

Tension in the central and peripheral nervous system
The neurosurgeon Alf Breig spent his career researching the significance of this idea. I find it closely related to the Rule of the Artery. I believe that subclinical ischemia affecting neural tissue at biomechanically vulnerable sites (intervertebral and cranial foramina, myofascial cleavage points, watershed weaknesses in the circulatory tree) can lead to neuromuscular dysfunction. Aberrant neural tension can lead to, or be the result of such vascular dysfunction.
Dr. Still also spoke of “tension in splanchnic nerves”. I believe this is the mechanism for what the Chinese consider characteristic excessive yin or yang regarding organ
function. Too little tension and excessive yin manifests. Too much tension characterizes yang excess. Neural tension has a norm, can become dysfunctional and can be modified through any number of treatment options. In fact, it is in balance with internal and environmental parameters, and fluctuates with the rhythm of Primary Respiration. The effect upon visceral motility and associated muscle tone within a meridian is a new way of defining the yin/yang relationship and muscle dysfunction.

**Rising Qi:** Excessive Yang: AKA hot/fire, full/excessive. The organ appears to be physically rising to palpation. Organ and meridian require sedation,. muscles along the meridian exhibit tender muscles along its path with give-way strength to testing and a polarized tension_Myofascial structures tether preferentially to its distal tendinous attachment vs. the proximal.

**Sinking Qi:** Excessive Yin: AKA cold, deficient, stagnant. The organ appears to be sinking; the meridian requires tonification. Muscles along the meridian exhibit a lack of tone, not characterized by polarized myofascial tension, tenderness or give-way strength.

**Direct Perception**
Sensing with awareness is a different skill from psychophysics and the sensory neurology of palpation. The teaching regarding the physical art of palpation we receive in school is the appropriate starting point. Yet at some point, we must get beyond our five physical senses. Dr. Sutherland taught us to transcend our physical senses. Dr. James Jealous reminded us of this teaching. We can learn to directly sense the energetics, just as some have with the anatomy within our Cranial Tradition. This is a function of the mind. The hands become “training wheels” to be minimized relative to the intention involved in treatment and awareness in diagnosis. This can be an extension of observation, the first step in osteopathic diagnosis.

Our use of intention in treatment can be likened to what the Chinese call ‘sinking the qi’. I’ve spent years learning to sink the qi. This is most prominently expressed in qigong and Internal Martial Arts like taijiquan. **It is the use of intention to produce an effect in yourself and those around through the qi field within and around us.** The effect can be to cause one, a patient or opponent to feel heavy or light, moved from side to side, or many other manipulations of their central equilibrium. By controlling another’s balance or central equilibrium, one can heal or hurt, enlighten or destroy. One can sink the energy to one point, or to the center or gravity and initiate the spiritual evolutionary cascade of Daoist Internal Alchemy.

**Daoist Internal Alchemy**
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Through meditation the Daoists were able to elucidate their longevity practices, qigong and Internal Martial Arts, and the foundations of TCM like the energetic anatomy and physiology. The most basic practice could be described as focusing on the lower dantien to transform jing into qi. The qi is transformed into shen in the middle dantien near the heart. Shen is transformed into dao in the upper dantien in the head. These energetic substances of differing frequencies move along the central channel from our lower pole to our top. In this way the adept may dredge his channels, build his energy and achieve enlightenment and ‘immortality’.

This process implies a general formula for health and enlightenment. When we practice together, it is possible to influence another so as to re-center and unblock their dantien, clear their channels and enhance their structure, function and performance. Touch amplifies this process for both giver and receiver. An exchange of energy is inherent in the process. The main ingredient may be either the energy itself or information contained using the qi as a sort of carrier wave. Most of the time unblocking is the primary aim, utilizing the patient or students own energy for the most part. These processes are demonstrable in the laboratories we call our clinics or taijiquan classes.

“All a physician can do is to remove the obstruction”

Andrew Taylor Still, MD

Mind/Intention → Energy → Blood → Strength/Mobility/Motility
(Yi → Qi → Xue → Li)
Interpretation: the mind leads the energy that leads the blood that in turn governs “strength”, or li. This is the Chinese formula deriving the mechanics of consciousness for the production of change in the biological world. It is their understanding of mental activity affecting physiology.

This should sound familiar to the osteopathic physician. Dr. Still’s formulation was “mind, matter and motion”. The concept of qi as a carrier wave, transposed between the mind and the matter/motion, is lacking. Our culture has lost connection with the concept. The Hindi word is prana, in Greek, pneuma (note the relationship to breath). In homeopathy Hahnemann called it the Vital Force. Fulford often called it the Life Force due to affinity for Harold Saxton Burr’s work on Life Fields.¹ It has been described as elan vital” or the animating force alluded to by Still and later osteopathic commentators. One cannot travel far in osteopathic studies without acknowledging that osteopathy has a vitalistic component. In fact osteopathy bridges the divide between the materialistic and vitalistic philosophies of medicine like nothing else.
Rule of the Artery
After the above formulation percolated in my brain for twenty years, I came to the realization that I had come upon a reasonable solution to the problem of the Rule of the Artery. This teaching is so lost within our profession that schools no longer mention it. What was the meaning of Still’s a most central themes in his philosophy?

Confusion arises due to belief circulation to the organ or muscle that is important. However, the microcirculation to neural tissue is lacking. Microcirculatory insult can subtly disable effector organs whether they are muscle, gland or viscus. The neural radicles are particularly vulnerable.

Biomechanically sensitive sites include the foramen magnum, transitional areas of the spine and cleavage points between fascial layers. Acupuncture, trigger and Chapman’s points are found here as well. Neurovascular embarrassment is a mechanism of neural entrapment. As a nerve loses its motility, it eventually stops moving and differentiates itself from everything around it. Thus, it can enter our perceptual field. The effector organ may be more easily identified, with gross changes in motility and later mobility. Biomechanical changes result in neural tension may arise producing the same effects and complicating diagnosis. A cascade of postural deformity ensues, contributing to the kyphotic posture of senescence.

A vascular watershed area vulnerable to this mechanism is the ventral thoracic spinal cord from T3-5. Rendering care to this region is often regarded as the most difficult to secure results by many traditions of manipulative care. The lone arterial supply for the ventral cord at these levels arises from the artery of Adamkiewicz at approximately T10 on the left. Deformations from scoliotic forces are prominent here; even slight changes can reduce efficiency of the circulatory tree. While the mechanics of the mid-thorax predispose to chronic somatic dysfunction and the viscera innervated therefrom are subject to emotional and dietary abuse, I believe microcirculatory insufficiency is the major factor in our difficulty treating T3-5.

The relationship to osteopathy pivots about the importance both TCM and osteopathy place upon blood flow. Returning to the Chinese formulation, qigong masters and Indian yogi’s are able to modulate the mind-body relationship in part via circulation through control of their sympathetic nervous system (SNS).

- To lead the qi via intention is to acquire skills through meditation
- To lead the circulation is to modulate the SNS
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- To lead the **strength** is to realize the effects of SNS modulation on blood flow to the neural tissue - the Rule of the Artery

In OMM we practice a kind of meditation, especially in the Cranial Field. Taiji and sometimes qigong can be moving meditations. We can certainly agree that we refine our intention, sensitivity and awareness. The importance we ascribe the SNS and circulation is well known. Strength in the capacity used by the Chinese herein is best described as a spectrum of movement from Primary Respiration to motion tests of mobility. Perhaps retracing Sutherland’s path, I recently concluded that CSF also responds to intention. In our local OCF Course, the direction of fluid technic yielded fresh insight. As untrained students induced the procedure, it became apparent that the mind of the patient preceded the movement of CSF from pole to pole across the neurocranium. So the mind leads the CSF, as well as the blood.

Although we lack the language, we are starting to find more threads to the elusive “something” that Dr Sutherland was referring to within the fluid. I am confident that the Chinese would describe this as simply another kind of qi. Dr. Fulford reported that the Chinese were discussing the sacral pump moving energy to the head in the sixth century CE. We must often transcend our physical senses seek the “cause behind the cause” of Still beyond the physical.

The concept of energy, meridians and a parallel physiology to the accustomed materialistic model may remain abstract. Recent scientific advances may ease the minds of those who haven’t personally experienced these phenomena.

**Bonghan Channels Verify the Meridians**

In the 1960’s a North Korean researcher Kim Bonghan found actual anatomic structures correlating to the meridians. His work was only recently duplicated by a number of approaches. Now there is evidence that a network of tubular structures 30-100 μm across are found within blood and lymphatic vessels and on the surface of viscera. Thin and translucent, they had escaped discovery. Bonghan channels are also easily confused with fibrin, obscuring easy visual detection in recently dissected tissues. Bonghan channels are rich in hyaluronic acid, a prominent component of synovial fluid and connective tissue ground substance. They are also rich in DNA sequences in ‘microcells’ rich in chromosomal material staining for adult stem cell antibody stains. When induced these cells differentiate into all three germ layers. These cells are speculated to be the source of pluripotent adult stem cells.

Another line of inquiry finds that the meridians conduct light. Like fiber-optic cables, these channels may carry very high volumes of information. Biophotons, emitted by
DNA molecules can produce coherent, laser-like light, supporting the idea of a super-information highway. The ability to conduct light only exists through the acupuncture meridians. Bonghan felt that the acupuncture meridians formed the grid that allowed for bilaterally symmetric differentiation. Something still poorly understood by embryologists. He discovered that the channels are present within 15 hours of conception in chick embryos and are involved with the development of all organs.

Stimulation of Bonghan channels powerfully affects local perfusion and nervous system imbalances. In contrast, acupuncture addresses both hypo and hyper functional states. Stomach 36 can modify diarrhea or constipation. Pericardium 6 can modulate tachycardia or bradycardia. Accessing the meridian system exerts unique and powerful effects upon homeostasis.

For many years clinicians and researchers have known that decreased electrical resistance/increased conductivity can be demonstrated around the acupuncture points. Neurovascular structures are closer to the surface at the points. Since the 1990’s the levels of endogenous opioids have been known to fluctuate with acupuncture treatments and is the purported mechanism of acupuncture anesthesia. But the recent research on meridians is far more significant.

**Palpable and Perceptual Characteristics of Qi**

In addition to the physical qualities of somatic dysfunction, I rely on certain qi qualities for direct perception in real time treatment.

1) *Seeing/feeling/sensing the direction, quality and quantity of qi flowing through meridians.* Working with lasers, micro-current, pulsed magnetic fields and vibration (e.g., the percussion hammer) can contribute to rapid perceptual progress. For example, I had a startling experience using LED phototherapy and felt as if the infant’s meridians were filling with colored light.

2) A ‘blowing’ quality at the major acupuncture gates (points). Whenever open the points emanate a palpable but inexplicable air pressure which some use in healing or martial arts. I was treating my taijiquan (tai chi chuan) teacher Grandmaster Sam Tam one evening. I felt as though being pushed backward, off of his leg. His comment was, “Oh, I exhale everywhere”.

3) A ‘filling’ quality very important to posture and managing somatic dysfunction. Manipulating areas of depleted qi, we feel as though we are forcing the articulations. Trying to find the key to restoring Primary Respiration, we might feel drained. Often
a sense of collapse that quickly returns after our treatment. If we treat areas bereft of qi, corrections are ‘unsupported’.

On my first visit to Master Tam, he lightly placing his finger upon my wrist. Remarkably, I was filling up like a balloon. My postural muscles engaged in a way I hadn’t experienced since adolescence, but it was more than that. This sensation was the yang qi filling the microcosmic orbit.

That the qi can be perceived as a positive quality of ‘filling, blowing, pressure’ is in This contrasts with a somatic model dysfunction characterized by negative terms like fascial ‘tension’ and articular ‘compression’, and restriction. By emphasizing the presence, absence or quality of a positive parameter, they can be closer to ‘the health’. We find parallels in osteopathic theory such as Sutherland’s potency and Breath of Life.

These relationships are palpable. Dr. Still spoke of “five types of nerves”. “Nerves of motion” describes how sympathetic outflow mediates visceral motility. Dr. Still spoke of “splanchnic tension”, referring to traction on splanchnic outflow proximal to the celiac plexus. This results from kyphotic forces in the thoracic spine extending nerves against diaphragmatic pressure.

Excessive tension in prevertebral splanchnic nerves is the mechanism of excessive yang (or insufficient yin) organ dysfunction. Insufficient tension in splanchnic nerves is the mechanism of sinking, low-motility organ dysfunction termed excessive yin, or insufficient yang.

Overview of Daoist Energetic Anatomy
Dantiens and ‘Extraordinary Channels’: This completes a basic description of Chinese Energetic Anatomy. The dantiens are the core. Vessels, sometimes referred to as the Eight Extraordinary Channels, connect the dantiens to the organ-meridian pairs. The meridians are superficial (with deep connections) and are therefore used in acupuncture and acupressure. This is the one-third of my integration of Chinese Energetics and Osteopathy relating to the meridians and organs.
This scant outline cannot hope to provide a useful foundation in Chinese Medicine. See the above link.

**Five-Element Relationships**
The Five-Element Theory (5-EM) concludes the introduction to selected aspects of TCM. The Elements are the organ pairings from table 1 usually arranged in a circle. The outer circumference is called the *Sheng* cycle and represents a constructive or supportive relationship with the energy of the preceding organ pair feeding into the next. The pentagonal relationships are the *Ko* cycle and represent destructive or regulatory influences. My use of these relationships is illustrated below.
Osteopathic Models

The basic elements from the osteopathic side of the equation are enumerated below:

1. Visceral: French diagnostic methods informed by my interpretation of the 5-EM
2. Cranial: Sutherland’s Model informed by the 5-EM

Diagnostics

The French identify the most restricted organ to manipulate. I employ the 5-EM and term the most restricted organ the Organ Poised for Change (OPC). The OPC may account for many patient symptoms. This is step one of my diagnostic method. I began by palpating the abdomen and thorax for visceral immobility but progressed to
reading the energy field around the body for deficit. Now it is part of my observational exam.

In **step two** I identify the soma meridian generating **Whole-Body-Response (WBR)**. WBR refers to spontaneous movement of the patient when the operator contacts the correct meridian. The patient’s body moves toward a posture typical in *qigong* standing meditation. This is a subtle movement occurring below the level of patient perception I identified through 24 years of *qigong* practice. There is no gross motion, rather something that can be appreciated by medical students when shown what to look for.

WBR is the prelude to treatment along the meridians’s somatic structures, organ and associated spinal and cranial structures described below. When one sticks to the meridian generating WBR, it balances each of the five elements. But one may limit the analysis to the OPC and WBR. This is the 5-EM Model in action. An important principle described in both *taiji* and osteopathy is found in the WBR concept.

*When one part moves, all parts move.*

In treatment I stick to the organ and the structures associated with its meridian generating WBR. Deviation may lead to attenuation or fragmentation of treatment response or adverse reaction. The tables below elucidate associations between axial structures and the meridian-organ pairings. Taken together they mutually reinforce each other, enhancing diagnostic sensitivity and specificity.

**Diagnostic: Checking The Five Outposts**

Dr. Still had a number of references as to what is now called a screening exam. One of my favorite references is “the five outposts”.

**THE HEAD**

Select areas must change to balance the cranium during a given treatment in my model. While there are many efficacious OCF approaches, one set of related structures must change for successful treatment of any body region. Even in cases of direct cranial trauma, the cranium responds as completely by balancing the key structures as by conventional methods. Applying OMT through the 5-EM lens was a new and useful way of thinking about our work. The response signifies a better understanding of inherent healing mechanisms. The 5-EM concept is best exemplified
in the head where normalizing one (or a bilateral pair of) articulation(s) correlated with pairing of solid and hollow organs suffices for normalizing the entire cranium.

The Chinese believe that every element has its ‘orifice’ in the head. Usually associated with a primary sense organ. I have refined these to constant relationships between the element of organ pairs and specific articulations, dural folds and cranial nerves (foramina). I owe a debt to Earnest “Bud” Bernhardi, DO, FCA for expanding my understanding of clinical dural mechanics. One of his contributions was to describe the benefits of “separating the leaves of the tent”.

To relieve dural tension upon the *anterior clinoids*:

1. Endocranial sources of anterior-superior dural tension include the ipsilateral superior leaf of the tentorium cerebelli (free border of the tent) and the anterior dural girdle
2. Extracranial sources of anterior-superior dural tension include ipsilateral and midline mid-face structures

For normalization of dural tension affecting the *posterior clinoids*:

1. Endocranial sources of posterior-inferior dural tension include the ipsilateral inferior leaf of the tentorium
2. Extracranial sources of posterior-inferior dural tension include the sacrum and third cervical
<table>
<thead>
<tr>
<th>Element</th>
<th>Orifice</th>
<th>Cranial Articulation</th>
<th>Dural Fold</th>
<th>Cranial Nerve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>Tongue</td>
<td><strong>Presphenoid-Sphenoid Body</strong> <em>(pseudo SVS +/- ipsil. torsion)</em></td>
<td>Sup. Leaf Tentorium Cerebelli</td>
<td>CN III &amp; XII Sup. Orb. Fissure &amp; Hypoglossal canal</td>
</tr>
<tr>
<td>Earth</td>
<td>Mouth</td>
<td><strong>Maxillo-Frontal</strong> <em>(h/l IR maxillae; sidebending-rotation also TMJ and orbital plate-lesser wing)</em></td>
<td>Sup. Leaf Tentorium Cerebelli</td>
<td>CN V: distal foramina &amp; terminations in the face</td>
</tr>
<tr>
<td>Metal</td>
<td>Nose</td>
<td><strong>Ethmoid-Sphenoid</strong></td>
<td>Falx Cerebri</td>
<td>CN I: Cribriform plate</td>
</tr>
<tr>
<td>Water</td>
<td>Ears</td>
<td><strong>Petro-jugular</strong> <em>(also SBJ, OA with bladder and Condylar Compression)</em></td>
<td>Inf. Leaf of Tentorium Cerebelli</td>
<td>CN IX, X &amp; X: Jugular Foramen</td>
</tr>
<tr>
<td>Wood</td>
<td>Eyes</td>
<td><strong>Temporal-Spina Angularis of sphenoid</strong> <em>(ipsil. to Sidebending-Rotation)</em></td>
<td>Sup. Leaf Tentorium Cerebelli</td>
<td>CN V: Trigiminal Ganglia in Meckel’s cave</td>
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<tr>
<td>Triple Energizer</td>
<td>--</td>
<td><strong>Petrobasilar</strong> <em>(singular- IR ipsil. to Lateral Strain)</em></td>
<td>Inf. Leaf of Tentorium Cerebelli</td>
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<tr>
<td>Pericardium</td>
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<td><strong>Occipitomastoid</strong></td>
<td>Inf. Leaf of Tentorium Cerebelli</td>
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**THE NECK**

The cervical vertebrae correlate beautifully with the organs. As elsewhere, the head and neck adds layers of diagnostic verification. Note relationships with the spinal dura and longitudinal ligaments. The tension is usually perceived first in the anterior or posterior spinal dura. Progressive levels of compensation ensue to limit effects on the neural tissue. This occurs first in ligaments and then in pre- or paraspinal musculature.
After correcting the thoracolumbar spine, a degree of tension on the anterior cervical fascia arising from the mediastinum is unmasked. This may relate to unresolved emotional stress, affecting what the Chinese call the Heart-Mind (xin).

We lack concept and language for this so we hyphenate. The main difference is we would think of this as a process occurring in the head and they, in the thorax. “His heart sank” or, “she felt her heart come up into her throat”, suggest the transcultural meaning. The shen (spiritual substance/energy), is converted from qi in the middle dantien near the heart and affects the Heart-Mind.

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<thead>
<tr>
<th>Element</th>
<th>Segmental Level</th>
<th>Spinal Dura and Long. Lig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>Cervical 4 (Ht + Si)</td>
<td>Periosteal to vert. bodies, SBJ to T12 to mes. root</td>
</tr>
<tr>
<td>Earth</td>
<td>C5 (St), C7 (Sp)</td>
<td>ALL (PLL for eso, T3)</td>
</tr>
<tr>
<td>Metal</td>
<td>C2 (Lu), C6 (Li)</td>
<td>ALL</td>
</tr>
<tr>
<td>Water</td>
<td>C3 (Ki, Bl; also Occ w/Bl)</td>
<td>PLL</td>
</tr>
<tr>
<td>Wood</td>
<td>C5 (Lr + Gb)</td>
<td>ALL</td>
</tr>
<tr>
<td>Triple Energizer</td>
<td>C3</td>
<td>PLL</td>
</tr>
<tr>
<td>Pericardium</td>
<td>C3</td>
<td>PLL</td>
</tr>
</tbody>
</table>

**THE THORAX**

Tension in splanchnic sympathetic outflow is observed coincident with ALL tension. So most visceral disturbances, whether subclinical or symptomatic, are characterized by kyphotic stress to minimize this neural tension. Pre-vertebral muscle tone is elevated. Posteriorly the para-spinal tension reflects segmental specificity of the organ in question. The new feature recognizes that muscles along the meridians and distal articulations of the hands and feet also show consistent changes with the corresponding viscera.
Still and Sutherland note the importance of the costovertebral articulations. Sutherland spoke of the preganglionic sympathetic fibers being mechanically disturbed (neural tension?) over the rib heads in articular dysfunction.

The ribs usually require treatment at the indicated spinal levels. Constant and precise relationships are identified below. These restrictions have predictable coupling patterns. While the fulcra between the coupled patterns vary, the remarkable consistency of patterns enhances treatment. Thoracic articulations are biomechanically sequestered between sternum and spine and the ventral cord suffers from aforementioned vascular vulnerabilities. They are surprisingly accessible using principles of suspension and coupled articulation.

**Strain Patterns**

All somatic dysfunction exists not as isolated motion segment abnormality between osseous segments but as *strain patterns*. I will suggest a concept for strain pattern because no clear definition exists in our literature.\(^\text{xii}\) Strain patterns consist of a minimum of three elements. These arrange themselves as triads with the tightest, second tightest and third tightest.

- **Tightest motion segment pair** or most restricted gets all the attention and Stiles calls it the “key lesion”.\(^\text{xiii}\) However treatment directed here results in a kind of wrestling match, or at least significant degree of manipulative skill.
- **Second tightest motion segment pair** represents the coupling mechanics in the table below.
- **Third tightest motion segments** represent the fulcrum interposed somewhere between the most and second most restricted motion pairs. It requires the least amount of force and skill and has the greatest effect upon the other two.

One must usually treat two of the three motion pairs to resolve the strain pattern and avoid recurrence. The first and second tightest are reliably found in association with organ restriction patterns. The fulcrum is the easiest to treat, but varies in location and is the most difficult to find. The choices are then to treat the constant physical coupling between the organ and systemic strain pattern, or search for the fulcra between the somatic couplings.

Resetting the fulcrum moves the “fluctuant mass of the matter” back to norm of involuntary (or voluntary) motion.\(^\text{xiv}\) However it is easier and faster to treat the first and second tightest elements of the strain pattern because they are *constant physical findings associated with the organs*. Using the suspension principle with four-point
Chinese Energetics and Osteopathy

contact and ¼ squat as an activating force in ambulatory adolescents and adults is a remarkably safe and simple approach to spinal manipulation.

The fulcrum is a concept that must be differentiated from the biologic milieu in which it occurs. It is not a physical entity but something that can be calculated.

Characteristics of fulcra include:

1. Singular: It is in the center
2. Non-Physical: By definition
3. Stillness: Motion occurs only in the levers
4. Inaction: Force manifests only in levers

Fulcra may occur inside or outside of the physical body, as it is a description of force factors affecting the body. The phenomena of somatic dysfunction describes the way the body processes unresolved forces. Nervous system action manifesting in the musculoskeletal system is “neurobiologic access to the fulcrum”. The nervous system creates the geometry of the strain pattern. In this way cranial, axial and appendicular segments are organized into a motion segment response to forces that overwhelm the organism’s ability to dissipate them in real time. The signs of fulcrum somatic dysfunction in the spine would be the same as more obvious dysfunctions i.e., increased muscle tone, apparent vertebral malposition, tenderness and edema or
fibrous change as the case may be. They differ only in degree. The concept is equally applicable in the extremities, viscera or cranium. It even can be used with the meridians that seem to transmit force as well. The meridians definitely transmit the sense of heaviness or of lightness between taiji players or qigong healer and patient. This is readily demonstrable. It may be the meridian network that transmits the palpable sense of embedded force we perceive in our osteopathic work.

Treat the spine as per these three simple patterns. One for three quartets of organs that relate the divisional pairings between upper and lower extremities, to those on the same limbs (the functional or yin-yang) relationships.

<table>
<thead>
<tr>
<th>Axial Component of Organ-Meridian</th>
<th>TCM Organ</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach</td>
<td>T5, L2</td>
<td>T3, L3</td>
<td>T7, T10</td>
<td>T2, L5</td>
<td>EARTH</td>
<td></td>
</tr>
<tr>
<td>Spleen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>METAL</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WOOD</td>
<td></td>
</tr>
<tr>
<td>Large Intestine</td>
<td>T5, L2</td>
<td>T3, L3</td>
<td>L4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WOOD</td>
<td></td>
</tr>
<tr>
<td>Gallbladder</td>
<td>T4, L2</td>
<td>T3, L3</td>
<td>T12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WATER</td>
<td></td>
</tr>
<tr>
<td>Bladder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FIRE</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small Intestine</td>
<td>T5, L2</td>
<td>T3, L3</td>
<td>L4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pericardium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Like Triple Energizer)</td>
<td></td>
</tr>
<tr>
<td>Triple Energizer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WOOD</td>
<td></td>
</tr>
</tbody>
</table>

*Follow with treatment of ribs at same levels as indicated.

Note that when the PLL is involved there is extension strain throughout the spine and posterior lower extremities. The organs most consistently implicated include the Ki, Te and Pc, and the St if there is esophageal involvement. T3 and C3 are the constant vertebral levels coupled with predictable findings in the posterior cranial fossa.
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<table>
<thead>
<tr>
<th>Element</th>
<th>Segmental Level</th>
<th>Sympathetic Plexus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>T4 (Ht + Si)</td>
<td>Cardiac (also cervical)</td>
</tr>
<tr>
<td>Earth</td>
<td>T5 (St, also T3 w/esophagus), T7 (Sp)</td>
<td>Celiac</td>
</tr>
<tr>
<td>Metal</td>
<td>T2 (Lu), T10 (Li)</td>
<td>Pulmonary</td>
</tr>
<tr>
<td>Water</td>
<td>T12 (Ki), L2 (Bl), T3 (Ki + Bl)</td>
<td>Inf. Mesenteric(?), Aortico-renal, Celiac for adrenal</td>
</tr>
<tr>
<td>Wood</td>
<td>T5 (Lr + Gb)</td>
<td>Celiac</td>
</tr>
<tr>
<td>Triple Energizer</td>
<td>T3</td>
<td>Represents PSNS to some</td>
</tr>
<tr>
<td>Pericardium</td>
<td>T3</td>
<td>Represents SNS to some</td>
</tr>
</tbody>
</table>

### Substituting the Meridians on the Hand:

The hand provides excellent diagnostic information for fully half of the twelve Zhang Fu organs. By recognizing the distribution of the meridians through the five fingers, with their relation to the musculature of the shoulder girdle, forearm and hand, one can verify visceral diagnosis by a combination of muscle testing and palpation plus tender point analysis. This is my method.

Alternatively one could use Chinese Pulse Diagnosis. Not being trained in pulse diagnosis I trained myself to read the meridians in this way. Analysis of the muscles along the meridians is indicated below. Tenderness or give-way weakness refers to the palpably polarized fascial tension of the yang pattern of dysfunction referred to in the table. The yin pattern mirrors these findings in the same extremities (upper or lower, see table I).
<table>
<thead>
<tr>
<th>Organ</th>
<th>Indicator Muscle</th>
<th>Finger/Interphalangeal</th>
<th>Diagnostic Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lu</td>
<td>Flexor Pollicis Longus 1\textsuperscript{st} MC</td>
<td>Thumb/PIP</td>
<td>Weakness</td>
</tr>
<tr>
<td>Li</td>
<td>Extensor Indices- 2\textsuperscript{nd} MC</td>
<td>Index/DIP</td>
<td>Weakness</td>
</tr>
<tr>
<td>Pc</td>
<td>Flexor Digitorum Profundus- 3\textsuperscript{rd} MC</td>
<td>Middle/DIP</td>
<td>Weakness</td>
</tr>
<tr>
<td>Te</td>
<td>Levator Scapulae- 4\textsuperscript{th} MC</td>
<td>Ring/DIP</td>
<td>Tender at scapular origin</td>
</tr>
<tr>
<td>Ht</td>
<td>Pronator Teres (ulnar head)- 5\textsuperscript{th} MC</td>
<td>Little/DIP</td>
<td>Tender at ulnar head</td>
</tr>
<tr>
<td>Si</td>
<td>Infraspinatus- 5\textsuperscript{th} MC</td>
<td>Little/PIP</td>
<td>Tender at center of scapular body</td>
</tr>
</tbody>
</table>

1) Fascia Extremis

Another diagnostic feature of the hand relates to the distal finger articulations. The tension in a fascial array always manifests at the distal attachments first. This is true within the PRM. Think of spinal dura. The decision regarding which end to treat usually involves attention to this factor. The finger and toe joints reflect distinct patterns of restriction depending upon the meridian involvement, which are at the ends of all fascial arrays. The head, hands and feet collectively reflect these connective tissue tension patterns I call, fascia terminus or fascia extremis.

“When we stretch the neck, the two ankles and the two wrists we have stretched all the ligaments of the body.” - Wang Xiang Zhai

Similarly the qi polarity is easily identified. When manifesting as the excessive yang pattern, it shows asymmetry of the fascial tension
with preferential tethering to one attachment. There is tenderness and/or give-way strength in the indicator muscle in one end of two linked channels, accompanied by finger and toe DIP findings. A degree of bilateral symmetry of findings is the norm. Perhaps electron flow and voltage gradient postulated injury current theory partially explains the phenomena.

<table>
<thead>
<tr>
<th>Element</th>
<th>Finger</th>
<th>Primary Meridian</th>
<th>Linking Meridian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>5th (Ht=DIP, Si=PIP)</td>
<td>Ht + Si</td>
<td>Ki + Bl</td>
</tr>
<tr>
<td>Earth</td>
<td>1st (Sp), 2nd (St)</td>
<td>--</td>
<td>Lu + Li</td>
</tr>
<tr>
<td>Metal</td>
<td>1st</td>
<td>Lu</td>
<td>Sp</td>
</tr>
<tr>
<td>Water</td>
<td>4th</td>
<td>--</td>
<td>Ht + Si</td>
</tr>
<tr>
<td>Wood</td>
<td>3rd</td>
<td>--</td>
<td>Lr</td>
</tr>
<tr>
<td>Triple Energizer</td>
<td>4th</td>
<td>Te</td>
<td>Gb</td>
</tr>
<tr>
<td>Pericardium</td>
<td>3rd</td>
<td>Pc</td>
<td>Lr</td>
</tr>
</tbody>
</table>

**THE ABDOMEN**

Direct Palpation via French Methods
Barrel’s method of abdominal and thoracic palpation (when prudent) is efficient and economical. I also recommend his thermal diagnostics.

Substituting the Foot Meridians
Using the feet, particularly the first ray from the interphalangeal to the navicular is useful for comparison with abdomen. The navicular in relation to the kidney is particularly interesting. When the kidneys drop, the tibialis posterior loses tone and the navicular drops, becoming tender inferiorly. It crowds the cuneiform distally and the renal reflex of Chapman appears. This is the pattern of kidney *yin*.
Conversely the *yang* pattern find the navicular mildly dropped and less often tender; it crowds the talus proximally and the adrenal Chapman’s reflex manifests. The kidney is perceived as rising. Functional syndromes of adrenal vs. chronic fatigue are partially differentiated by simple physical exam.

The feet are less helpful on the *yang* side, involving the other four toes. Utilize palpation of the other lower extremity structures because they are more definitive.

<table>
<thead>
<tr>
<th>Organ</th>
<th>Indicator Muscles</th>
<th>Toe</th>
<th>Diagnostic Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ki</td>
<td>Tibialis Posterior/Medial Hamstrings</td>
<td>Dropped Navicular</td>
<td>Tender Inferiorly, esp. when <em>yin</em>; crowds proximally/distally</td>
</tr>
<tr>
<td>Sp</td>
<td>Abductor Hallucis/Vastus Medialis</td>
<td>Great Toe DIP &amp; 1st MT</td>
<td>Palpate tone &amp; tension pattern/tight joint &amp; MT position</td>
</tr>
<tr>
<td>Lr</td>
<td>1st Dorsal Interosseous/Adductor Longus</td>
<td>Great Toe MTP &amp; 1st MT</td>
<td>Tender distal AD+weak+tight joint &amp; MT position</td>
</tr>
<tr>
<td>St</td>
<td>Tibialis Anterior/Vastus Lateralis</td>
<td>2nd MT</td>
<td>Palpate tone/tension pattern &amp; MT position</td>
</tr>
<tr>
<td>Gb</td>
<td>Extensor Digitorum Brevis/ITB</td>
<td>4th MT</td>
<td>Palpate tone/tension pattern &amp; MT position</td>
</tr>
<tr>
<td>Bl</td>
<td>Soleus/Biceps Femoris</td>
<td>5th MT</td>
<td>Palpate tone/tension pattern &amp; MT position</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element</th>
<th>Toe</th>
<th>Primary Meridian</th>
<th>Linking Meridian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>5th</td>
<td>Bl</td>
<td>Si</td>
</tr>
</tbody>
</table>
### Chinese Energetics and Osteopathy

<table>
<thead>
<tr>
<th>Element</th>
<th>Toe</th>
<th>Primary Meridian</th>
<th>Linking Meridian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earth</td>
<td>Medial 1st (Sp=DIP); 2nd (St)</td>
<td>Sp + St</td>
<td>Lu + Li</td>
</tr>
<tr>
<td>Metal</td>
<td>--</td>
<td>--</td>
<td>Sp + St</td>
</tr>
<tr>
<td>Water</td>
<td>(Ki=navicular is Dx); 5th (Bl)</td>
<td>Ki + Bl</td>
<td>Ht + Si</td>
</tr>
<tr>
<td>Wood</td>
<td>1st (Lr=PIP); 4th (Gb)</td>
<td>Lr + Gb</td>
<td>Pc + Te</td>
</tr>
<tr>
<td>Triple Energizer</td>
<td>--</td>
<td>Te</td>
<td>Gb</td>
</tr>
<tr>
<td>Pericardium</td>
<td>--</td>
<td>Pc</td>
<td>Lr</td>
</tr>
</tbody>
</table>

Of course we are responsible for the pelvic floor and diaphragm. Along with the pedal arches, these are prerequisite to engaging the cranium. This takes care of much of the visceral manipulation. I use some methods learned from Herb Miller. I have my own set of visceral manipulations.
THE PELVIS

Diagnosis of these entities is critical but I seldom provide direct treatment. This illustrates the power of a functional approach. It is a remarkable feeling. Although our diagnosis remains so, as Rollin Becker said, “The treatment is not mechanical”.

i. Respiratory locking of sacrum
ii. Pelvic floor dysfunction
iii. Visceral restriction, tissue reaction or displacement
iv. Lumbar compression locks
v. Postural locking of pelvis

1. Iliac shear and pubic dysfunction
2. Torsions and unilateral flexion/extension

Method of Diagnostic Verification

a. Triangulate by comparing data from the 5 outposts
b. Select dominant and singular finding by element and organ
   1. Dominant because findings must be greatest in magnitude relative to the other organs
   2. Singular because the treatment under consideration will have this organ as the constant therapeutic focus

Logical positivism

Treatment: Getting away from the physical senses (WG Sutherland)

First balance energetics, which reside in the soft tissues

1. Do not worry about having to learn a lot of acupuncture points. Most acupuncturists learn to work through a small number of point combinations. Instead think of the points as
access gates from which to observe spontaneous fascial release spread throughout the body. This is due to energy transfer, unavoidable in manual medicine (Fulford). The issue is not whether to give your energy to the patient. It is where, how much, what kind of energy, etc.

2. When we do mechanical things to the patient and try to withhold our energy, the treatment doesn’t work and adverse reactions are invited. We are generally unaware of this side of the equation and pay for it with less than adequate results and understanding.

3. Good news: the energy knows where to go [(think, ‘...the uncanny, Intelligence of the CSF’(Sutherland))]}. We only have to observe the effects through the fascia, the mechanism, etc as we treat. Developing your energy with qigong is the traditional Chinese way to become more effective and protect oneself against the depleting aspects of patient care and life in general. It is possible to substitute an abundance of energy for skill to some degree but not the converse.

4. What is required is:

1. Knowledge of a few points in the distal extremities
2. Knowledge of the topography of the meridians
3. Knowledge of the relationship between the organ-meridian pairings
   1. Linking or circuit-like relationships
   2. Yin-Yang or the functional relationships

1. Remove blockage in etiologic organ, its primary and subsidiary channels from tip of toes to tip of linking and functional channel’s fingers. This usually involves emphasizing the distal extremities, balancing our inherent tendency to focus on the axial structures as
osteopathic practitioners. Removing blockage is the primary method, adding energy for the depleted pt is sometimes required. Manual practitioners often fail in the latter, because our corrections are unsupported by the energy which must come first. The analogy in our world is the soft tissue work preceding attempts to adjust the skeleton.

1. Include an element of bilaterality in treatment, as though visceral and systemic concerns are primary, even in traumatic cases of recent origin

2. When the energy is full in all digits of the extremities (equivalent to equalization of all fascial tension), it is axiomatic that the pt is in balance. It becomes stable when axial elements and any remaining appendicular fascial tension is ameliorated. That is why we need soft tissue and osseous/adjustive methods, and acupuncturists need osseous/adjustive methods. Qigong can be an inexpensive alternative.

3. Full and effective resolution of the dominant organ’s findings will leave the entire person in balance including:

- all of the meridians and visceral motility
- fascial tension and osteo-articular compression
- autonomic balance and vasomotion
- Primary Respiration

Energetic approaches cut across all these parameters of function, affecting them simultaneously. Mechanical approaches cannot do this. Energetically we can work from one point of contact. Manipulative procedures require at least two points of contact. When one part moves, all parts move in either case.

Then balance force, which resides in the bones
4. For the adjustment phase I use balanced tension methods (BTM) and low-velocity articulation adjustments (LVHA). The use of patient assistance where possible reduces operator force. Dr Bellew and I collaborated to refine a set of BTM’s that use no force, just operator contacts and pt cooperation. They derive from standing techniques of Sutherland.

5. Osteopathy deals with the forces and fluids in the body (Still). Chinese concepts of energy or qi bare similarities to osteopathic concepts of CSF, potency and the Breath of Life. Sutherland said, “We are mechanics of the fluids as well as the bones”.

6. The opportunities for the use of force is limited in human interaction; what can be done without force is far greater (to paraphrase Sutherland)

7. Don’t bother to adjust if it isn’t ready, meaning necessary to attain balance at the end of treatment. Be satisfied with the moving their energy.

**A sequence for treatment:**

1. *Begin by balancing meridian function* in left then right lower extremities, trunk, and indicated upper extremity. Consider the neck, head and opposite arm.

2. *Adjust spine using BTM’s* in adults and children, modifying as appropriate. Adults are efficiently handled by the method developed by Bellew and Laseter. I sometimes use the method of Laughlin as taught by Steele in infants and children. The method of Davidson (Neurofascial Release) works for all ages and levels of infirmity without introducing force.
3. *Cervical and cranial adjustments never require force* when this sequence is employed. Cranial treatment directed at one of the seven articulations (or their b/l pairings) balances the entire cranium.

4. *Finish by eliminating residual fascial tension by adjusting (LVHA) extremities as indicated.* I use the classical methods passed on to us by Fulford.

*When one understands the problem, the treatment is simple* (Sutherland). The power of this method resides in diagnostic analysis and sequencing. As judged by ease of application and reduction in manual force, it is very powerful. The formulaic approach to the spine is surprisingly effective. Osteopathy in the Cranial Field is especially simplified.

Limiting the treatment to the dominant findings associated with one organ within the 5-EM balances the entire body, mind and spirit. The patient then re-equilibrates with a minimum of reaction and is ready for the next treatment after experiencing definable progress.

Sequencing the treatment is the key to achieving results without force. I generally balance the energy from the linking channels in the feet and finish in the head and arms. Similarly I begin adjusting midline osseous structures from below-up. This is a familiar osteopathic approach: the postural-structural model. ‘When one part moves, all parts move’ is a famous axiom from Taijiquan (Tai Chi Quan). When the treated parts respond individually adverse reactions are invited.

Note that the head reveals but one finding per element, lending credence to that concept. One only has to differentiate between the two organs associated with the element. I can do this by correlation with the neck, abdomen and hand, adding information from the feet and spine as needed. With a few touches of the five outposts one can easily come up with the definitive, primary organ diagnosis (for that point in time).
The pelvis and lower lumbar spine require less direct treatment in this model, even in cases of stenosis, scoliosis and acute low back pain. Sometimes squatting after the treatment articulates any remaining (usually iliac) dysfunction. Some like the idea of ‘treating around’ a particular area. I place great importance on the center of gravity, in some ways equivalent lower dantien in the Chinese vernacular. There are other ways to work more directly with this.

**Conclusions**

My emphasis here is on diagnosis and analysis. I hope that this contributes to the idea that there is room for improvement in our global approach to organizing each treatment. Without more of a concept as to a singular goal with each treatment, we are more or less flying blind. In other words, I oppose ‘search and destroy’ approach to somatic dysfunction. Please do not conclude that I am leaving no room for the unknown. That is very important as well. I want to be surprised with each pt encounter, learning as well. However Dr Still advised us to be able to explain what we do, not so much for our patients as for ourselves.
<table>
<thead>
<tr>
<th>Element</th>
<th>Thoracolumbar</th>
<th>Cervical</th>
<th>Cranium</th>
<th>Emotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>T4 (Ht + Si)</td>
<td>C4 (Ht + Si)</td>
<td>Presphenoid-Post Sphenoid Body</td>
<td>Joy</td>
</tr>
<tr>
<td>Earth</td>
<td>T5 (Sp), T7 (Sp)</td>
<td>C5 (St), C7 (Sp)</td>
<td>Maxillo-Frontal</td>
<td>Worry</td>
</tr>
<tr>
<td>Metal</td>
<td>T2 (Lu), T10 (Li)</td>
<td>C2 (Lu), C6 (Li)</td>
<td>Ethmoid-Sphenoid</td>
<td>Grief</td>
</tr>
<tr>
<td>Water</td>
<td>T12 (Ki), L2 (Bl), T3 (Ki + Bl)</td>
<td>C3 (Ki + Bl)</td>
<td>Petrojugulars</td>
<td>Fear</td>
</tr>
<tr>
<td>Wood</td>
<td>T5 (Lr + Gb)</td>
<td>C5 (Lr + Gb)</td>
<td>Spina Angularis Sphenoid</td>
<td>Anger</td>
</tr>
<tr>
<td>Triple Energizer</td>
<td>T3</td>
<td>C3 (Ki + Bl)</td>
<td>Petrobasilar</td>
<td>--</td>
</tr>
<tr>
<td>Pericardium</td>
<td>T3</td>
<td>C3</td>
<td>Occipitomastoid</td>
<td>--</td>
</tr>
</tbody>
</table>

**Examples- limited to manual Dx and Tx**

FIRE: Cranial and somatic pattern of C4, T4 and the odd sense of restriction behind the ethmoidal-sphenoidal articulation but anterior to the SBS. DDx would be made by multiple methods-

1. Visceral tension in thorax vs abdomen. But realize that because of the binary *yin-yang* dynamic, the Si or Ht *qi* could be rising or sinking thereby multiplying our diagnostic possibilities by two. A cold, sinking or weak Ht won’t be tight in the chest, yet still could be the primary dx.

1. Paraspinal viscerosomatic changes above vs below T5. Yet the meridians will also clearly differentiate Ht from Si. The tension will be in the 5th fingers bilaterally.

1. If the Ht is rising the ulnar head of the pronator teres (Ht-3) will be tender and exhibit give-way strength. The DIP will be tight. The
2. If the Si is tight the infraspinatus will be tight centrally (Si-11), the PIP will be tight and the abdomen will be centrally tight, pulling toward the umbilicus superficially and the Si upon deeper palpation. Tx would begin by normalizing lower extremity function as it relates to Bl-Ki, and continue through the Ht-Si in the hand. Then adjustment of T4, C4 and Presphenoid, the order can vary. If the pattern is more severe adjustment of the linking channels spinal elements (Ki and/or Bl) is required, but never in the head.

EARTH: Cranial and somatic patterns of either St: T5, C5 and b/l maxillo-frontal locking, or Sp: T7, C7 and b/l maxillo-frontal restriction.

3. St: Begin with Sp-St in the legs progressing through Lu-Li in the arms. OMT isolated to T5-C5 and the maxillae, supplemented Sp associated midline elements and linking channel elements as needed will be highly efficacious.

4. Sp: Begin with Sp-St in the legs progressively balancing meridian/myofascial tension in the Lu-Li in the arms. Primary adjustment of T7-C7-Maxillae supplemented by adjustment of linking channel elements, see METAL.

METAL: Cranial and somatic patterns of either Lu: T2, C2 and Ethmoid-Sphenoid or, Li: T10, C6 and Ethmoid-Sphenoid.

1. Lu: Begin by balancing Sp-St in the legs; carry the balancing of meridian function thru the trunk and into the upper extremity (Lu-Li) as indicated. Attend to the midline corrections as above. Include EARTH and Li midline elements as indicated.

2. Li: Begin with St-Sp in lower extremities, end with Lu-Li in upper extremity(s). Adjust the midline structures. Adjust the EARTH and Lu midline as necessary.

Benefits attributable to adoption of the 5-EM include:

1. Precise, definitive treatments

2. Pt safety: Avoidance of extreme positioning or forceful techniques
3. Progressive, logical improvements based on the cycles in the 5-EM

4. Staying on time; my whole-body treatments take 15-25 minutes

5. Reduced effort and increased energy for the operator

1. My training in Chinese methodologies is unusual. I claim no expertise in TCM. Although I trained in a standard 300 hour North American course in acupuncture for physicians my primary experience is over twenty years of *qigong*. Any direct perceptual ability I’ve acquired for the energy work comes through my training with Grandmaster Sam Tam of Vancouver, BC. His healing abilities are surpassed only by his skills as a boxer in the Internal Martial Arts. My osteopathic influences were Robert Fulford and especially Herb Miller, who mentored and cared for my wife and I for ten years. Also Isaam Nemeh, MD of Cleveland, Ohio, a Syrian born physician and electrical engineer who understanding of energy, spirit and medicine has only begun to bring him the attention he deserves.

Still’s advice was to “keep perfect images of articulations in the osteopath’s mind at all times”. The Chinese use their understanding of energetic anatomy in the same way.

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1 HS Burr, PhD was a Yale anatomist who spent decades developing a body of research on EM fields of plants and animals. He was able to predict longevity and detect disease with simple equipment measuring subtle voltage gradients around living things. R Mathews *Subtle Energies & Energy Medicine* • Volume 18 • Number 2 • Page 55
Chinese Energetics and Osteopathy

iii elan, accumulation of forces; vital, indispensable, vital, fundamental (French)

iii RF Fulford concurred with this. Chila, AAO Convocation Lecture

iv Wheeless' Textbook of Orthopaedics

v I am not ascribing the motility of primary respiration solely to blood flow, but can the reader imagine a PRM without it?

vi Gravett


viii MERIDIANS CONDUCT LIGHT by Dr. Sergei Pankratov, Moskow Published by Raum and Zeit, Germany, 1991


x E. Bernhardi Journal of the Osteopathic Cranial Academy

xi To see if you agree with my interpretation, check Still’s P&MP and Sutherland’s Bedside Technic in COT

xii Glossary of Osteopathic Terminology

xiii Edward Styles, DO, FAAO, Course Syllabus for Functional Technic

xiv Schooley, Thomas J. of the Osteopathic Cranial Association

xv Osteopathy in the Cranial Field 1st Ed.
Midline Balance I

Lower Body
Cv-6: 2½ finger-breaths below navel.
Gv-4: Place fist in flank. Move knuckles to spine. Replace 3 knuckles with 3 fingers.
Cv-5: 2 finger-breaths down from Cv-6
Cv-4: 2 finger-breaths down from Cv-5
Cv-3: 2½ finger-breaths down from Cv-4

Head and Neck
Gv-20: Lines from top of ears converge to top of your head
Gv-15: At base of skull

Middle Body
Cv-17: Center of breastbone, at level of nipples for a man
Cv-12: Half-way between the bottom of your breastbone and navel
Gv-14: Below the large spinal bump at the base of your neck

Sequencing
Often best to begin with Cv-6 then Gv-4 and then Gv-20. Then return to rest of points below the navel. Next do Cv-17, Cv-12 and finish with Gv-14.

Part of a Plan
Do these meditations/self-massage techniques at least daily and whenever you don’t feel well or experience pain. They will help you retain the benefits of your treatment. After a time you won’t always touch the points. Just touch them in your in your mind’s eye and your energy will follow. As the energy concentrates blood flow follows and your body adjusts itself toward normal.

Procedures
Hold mild pressure and focus mind upon the points until warm. Stay in midline.

- Cv-6: Feel energy expand. Calmly observe each unforced breath reach Cv-6
- Gv-4: Feel neck relax
- Gv-20: Holds your head up without effort.
- Gv-15: Stop looking down
- Cv-4: Feel your mind still
- Cv-17: Stop holding your breath
- Cv-5, 12 and 17 decongests the lower, middle and upper body

Prerequisites
Calm yourself, take your time and feel inside.

Goals
- Maintain the correct sense of where your brain perceives your body to be in space
- Hold to correct posture without effort or force
- Normalize fluid movement: blood, lymph and brain fluids
- Normalize muscle tone and decompress joints
- Get out of pain now or lay foundation for this
Thoracolumbar and Costal Articulation

Procedures

I. Development

a. Modified from techniques and principles from Still and Sutherland

i. Standing technics in Sutherland’s “General Osteopathy”

ii. Still’s principle of suspension found in R&P

iii. Correlated with organs in TCM

II. Procedure for Spine: Coupling T4 or 5 & L2

a. Operator stands to Lt of pt

b. Pt stands 6” from table at ~ waist height. Instruct them to:

c. LEAN OVER and touch table with fingertips and thumbs

i. Some weight must be borne by hands, elbows straight, to achieve suspension of spine

d. TEST spinal extension

i. “Push your chest forward...”

ii. “Lift your collarbones to the ceiling...”
iii. They must stay on heels and not move pelvis forward

e. FIND GREATEST RESTRICTION BETWEEN T4 OR T5

(depends upon meridian division treated in my method—see algorithm)

   i. Contact TP’s with thumb and index fingers with Rt hand
   
   ii. Simultaneously contact L2 with same fingers of Lt hand

f. Instruct pt to:

   i. DROP CHIN TO CHEST
   
   ii. SIT DOWN AND BACK, AS IF FOR CHAIR (1/4 squat*)

III. Procedure for Coupling T3 & L3

   a. Same pt and operator positions
   
   b. Assume contacts on T3 and L3
   
   c. Instruct pt to

      i. LIFT HEAD AND UPPER BACK
      
      ii. LOOK A LITTLE BIT UP THIS TIME

   d. Repeat SQUAT activating force

IV. Procedure for Costal Elements, Example: 5th Rib Right
a. Same operator and pt positions

b. Advance pts Lt foot backwards one-foot length (keep heel down, make sure they bear some weight on each extremity and buckle the Rt knee). This suspends the rib rendering it vulnerable to articulation with only a stabilizing force from the hands of the operator and activating force.

c. Firmly contact rib angle R5 Rt and T5 and T6 Instruct pt to LOOK LEFT, then LOOK RIGHT (and perhaps TURN YOUR NECK)

d. Repeat at T3/R3, other ribs (R3 respond better to head elevation, extending T3. For other ribs drop chin to chest)

e. Retest spinal extension: take care:

   i. Cervical tension may be exacerbated

   ii. A vacuum disc or inter-body compression may not yield to articulating the posterior elements of spine

V. PRN AT OTHER SPINAL LEVELS- See Axial Articulation Algorithm

   a. Gall Bladder and Liver: only need to add L4
b. Stomach and Spleen requires T2, T7, T10, associated ribs + L5

c. Kidney and Heart: add T12 and associated ribs

*Dr. Lawrence Bellew of our Mid-Atlantic Osteopathic Study Group (MAOSG) added the squat as activating force, a critical addition to the vertebral technique

Christopher Laseter, DO®
Quick Guide to Postural Alignments

Two Bones Up
Two bones = temporal squamae referring to the temporal squama. Go directly cephalad of the acoustic meatus, almost or touching the helix near its upper margin. This is the key to whole posture. It is the first step; except you have to set your feet whether standing or seated. Although not mechanically correct, everything should seem as if hanging in suspension under the temporal squamae.
OMT: Hold the two contacts until Gv-20 returns to its rightful place. Amazingly, holding these two spots can unlock the entire cranium.

Mop Head
Look up and down; securing motion of OA
Put head on top of spinal column

Two Bones Down
Two bones = PSIS; make the belt move downward, not bending the knees
Key to beltline LBP related to L4, so GB/Lr, Te/Lateral Strain, scoliosis.
Caution: if the sacrum and temporals are locked vagal tension may cause syncope.
Lengthen erector spinae and decrease lumbar lordosis
OMT: Touch these two points until Gv-20 (at cranial vertex) ascends back into position. Amazingly, this can unlock the entire cranium.

Two Ribs Up
Two ribs = costochondral junctions at R4-5 interspaces
Lifts thorax and decreases kyphosis
OMT: Use free hand at T4/5; just monitor until Cv-22 (at sternal notch) lifts.

Elbows Out-Shoulders Down
Must get elbows out to drop shoulders and lengthen neck. Repeat several times
OMT: Make space for shoulder to function. To fix shoulders keep head up. Gv-14 (at C/T junction)

Pelvic Floor
Access by going laterally 1” from umbilicus, and 1” down, b/l contact
Lifts pelvic floor
OMT: Use free hand to balance L3; see energetic and fascial changes in sling from L3 to umbilicus (Cv-3, Cv-1)

Diaphragm
Access by going laterally 1” from umbilicus, and 1” up, b/l contact
Lifts diaphragm
OMT: Use free hand to balance L2; lifts sternum at R4 (Cv-17)
Midline Energy & Thought

1) Cv-3

2) Cv-17

3) Cv-22

B/L Manual Contact & Anatomy

Pectineal Line below mid-rectus abdominus “Pelvic Floor”

1” above umbilicus at mid-rectus abdominus “Diaphragm”

Costochondral junction between ribs four and five “Thorax”

4) Gv-20

Temporal squama superior to EAM “Two Bones Up”

Manual Treatment

Operator or patient self-care should be done from below → up starting with “Pelvic Floor”. Instruct patients to hold the indicated areas for 1-3 minutes one or more times per day as the initial effort to retrain the mechanism to hold these areas in balance.

Static or Moving Qigong Meditation/Exercise

Patients should be instructed to work from above → down starting with “Two Bones Up”. Later the patients won’t have to touch these areas. They can merely ‘check in’ mentally. At first they forget instantly upon sitting up after a treatment. Then they need prompting with every change in position or every few seconds. Then when they move so tell them to hold the alignments and walk around the treatment room.

Summary

This treatment or meditation combines the Chinese concepts of an energetic midline with an osteopathic understanding a structural midline. Touch bilateral structures but seek to observe change in the midline. This prevents us from using force. Use balanced tension to secure change in the anatomy but learn to access the movement of energy through direct perception.

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Treatments Patterns for the Spine

OMT for Axial Component of Organ-Meridian Pairs

Osteopathic Energetics Spine Treatment

<table>
<thead>
<tr>
<th>TCM Organ</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Element</th>
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<tbody>
<tr>
<td>Stomach</td>
<td>T5, L2</td>
<td>T3, L3</td>
<td>T7, T10</td>
<td>T2, L5</td>
<td>EARTH</td>
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<tr>
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<td>T3, L3</td>
<td>T12</td>
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<tr>
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<tr>
<td>Triple Energizer</td>
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</table>

*Follow with treatment of ribs at same levels as indicated.

Christopher Laseter, DO

Acupuncture Points for Accessing Congenital Energy (Yuan Qi)

<table>
<thead>
<tr>
<th>Organ</th>
<th>Scaphoid :: LU 9</th>
<th>Urinary Bladder</th>
<th>Cuboid :: UB 64</th>
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<td>Lung</td>
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<tr>
<td>Large Intestine</td>
<td>Trapazoid :: LI 4</td>
<td>Kidney</td>
<td>Navicular :: KD 3</td>
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<td>1st Cuneiform :: ST 42</td>
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<td>Capitate :: PC 7</td>
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<td>Triple Heater</td>
<td>Lunate :: TH 4</td>
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<td>Gall Bladder</td>
<td>3rd Cuneiform :: GB 40</td>
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<tr>
<td>Small</td>
<td>Hamate :: SI 4</td>
<td>Liver</td>
<td>1st Metatarsal :: LV 3</td>
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Intestine

modified from yinyanghouse.com