

Howard Evans

Forewords by Leon Chaitow & David Peters

A **MYOFASCIAL**
APPROACH TO **Thai**
Massage
East meets West



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Foreword

Back in the mid-1990s, Howard Evans was one of an extraordinary batch of mature students who enrolled for an MA course at the University of Westminster, London, on which I was privileged to be teaching. The course title was 'Therapeutic Bodywork', a sufficiently vague description of the cocktail of methods, modalities and ideas that allowed scope for exploration of many variables.

The culture shock experienced by both the candidates on that course, and the tutors, was profound – and I don't think any of us were untouched by the interaction that ensued, which involved an attempt to integrate disparate approaches, avoiding politically charged designations, such as osteopathic, chiropractic and so on. In the process, I am quite certain that I learned as much from participants on the course – such as Howard – than I ever taught.

And, as the years have passed, it is satisfying to see the process of the continuing synthesis of ideas and methods, evolving – with this book being an example of that process. I suggest that a reading of Howard's book on Thai massage (TM) will produce several simultaneous effects – at least it did so for me.

- Firstly, you will become familiar with an elegant, apparently simple, but potentially profound, approach to bodywork.
- Secondly, you will be exposed to a philosophically integrated way of using manual methods, as these interact with emotion and psychology, while apparently focusing on physical structures.
- And finally, you will be led gently into a familiarity with the author's synthesis of Eastern (Thai, Tibetan, Indian and Chinese) and Western concepts, that have emerged from his own eclectic exposure to Thai Massage, Structural Integration, osteopathic soft tissue manipulation methods, body-centred psychotherapy, Yoga and Traditional Chinese Medicine, and more.

Depending on where you are starting from – whether you are an entry-level student, or a therapist/practitioner already trained in other manual methods/systems/modalities – the way you will understand, and be able to integrate, this particular TM model, will vary. Objectively it seems to me that understanding and applying this model – ideally following hands-on instruction and supervision – can only lead to positive outcomes.

Synchronistic clinical consideration of basic structural features – fascia, muscles, joints – as well as the energetic pathways intrinsic to

Eastern medicine, while also being aware of Western concepts of functionality (posture etc), at the same time that overarching psychological and emotional influences are considered – ensures a virtual alchemical process will be underway – capable of encouraging regeneration and self-regulation on different levels.

In his Preface, Howard mentions my request of him to write an article on the subject that has actually become this book. This request was initially triggered by submission to the journal I edit (*Journal of Bodywork and Movement Therapies*), of several research papers that incorporated Thai yoga massage in the methodology described.

1. A relatively straight-forward paper by [Cowen et al. \(2006\)](#) compared the effects of Thai massage (TM) with standard (Swedish) massage (SM). Fifty-three individuals received a single general massage treatment of one or the other approach. The effects on physiological and psychological variables, including blood pressure, heart rate, range-of-motion, perceived anxiety, and mood, were assessed and compared. There were no differences found between the treatment groups, with significant improvement in resting heart rate, ankle and shoulder mobility, as well as in mood and tension-anxiety levels, in both. Knowing the profound benefits standard massage can offer, both specifically and generally, this was – for me – an impressive pointer towards the relative value of TM. In other words the findings suggest that a single treatment of TM was as effective as SM, on general physiological and psychological outcomes.
2. Sixty-seven adults with non-specific low back pain were randomly assigned to receive either 10 minutes of TM (35 people) or 10 minutes of joint mobilization (32 people). Both groups experienced significant relief of pain. However the TM group demonstrated slightly more beneficial effects than those receiving joint mobilization. ([Mackawan et al. 2007](#))

Not surprisingly these papers triggered curiosity – and Howard's expertise was therefore tapped. As a result this fine text is now available for us all to explore.

Leon Chaitow ND DO
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Preface

In September 2006 Leon Chaitow asked if I would like to write an article about Thai Massage and neuromuscular technique (NMT) for the *Journal of Bodywork & Movement Therapies*, that he edits. Leon had come across a description of Thai Massage which seemed to resonate with some aspects of NMT. As the origins of both systems could be traced to India his curiosity was piqued.

I thought I replied with the perfect excuses. Although my Thai Massage teachers had trained in Thailand I had never been there and did not consider myself to be the best person to comment on this traditional technique.

What is more, while studying soft tissue techniques with Leon in 1995 I had recognised the possibility of developing a more neuromuscular approach to Thai Massage. I also integrated the concept of 'myofascial pathways' derived from the work of Ida Rolf. With this combination I developed a style of Thai Massage that could be described as 'myofascial bodywork'. Thai Massage is more commonly described as 'energy work'.

Alas, my excuses sealed my fate. Leon wanted his article and asked if he might put Elsevier in touch with a view to me writing a book. My plan for a leisurely year was scuppered.

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Acknowledgements

I am grateful to the following people for their part in the creation of this book: Harry McGill and Asokananda for passing me the gift of Thai Massage; the patients who helped me refine my skills; the students who asked too many questions; Leon Chaitow for his generosity as tutor and mentor; Sarena Wolfaard, Sally Davies, Claire Wilson, Claire Bonnett and Sukanthi Sukumar of Elsevier for their trust and support; Lola Gomez who, wrapped in a cloak of invisibility, made the wonderful photographs; Yoko Nomura and Marga Cladera for modelling for the pictures; Barbara, my wife, who helped me through the many times when I was ready to throw the manuscript in the bin.

Introduction

When I first learned Thai Massage in 1992 it was barely known in England. The School of Oriental Massage was the only place offering courses in the UK. Our teachers Harry McGill and Stephen Brooks supplied us with the book *Traditional Thai Massage* published in Thailand by Sombat Tapanya in 1990. This, they imported themselves from Thailand and at that time it was the only book available.

Little did I realise then what an excellent choice of training I was making. After just four weekends of study and plenty of practice I had gained a diploma in Traditional Thai Healing Massage and professional insurance. The 'Life Centre' had just opened in London's Notting Hill and I applied to work there. I was 'auditioned' by the owner and on the basis of that massage I was offered a beautiful place to work.

The novelty of Thai Massage in 1992 guaranteed me plenty of publicity and patients and in a short time I had a thriving practice. I soon came to see that there was an enormous difference between practising in a classroom and practising in a clinic. I offered one-and-a-half-hour sessions and often I was fully booked with six sessions back-to-back. In a short time I had to learn a lot about timing, pacing and efficiency. I realised that many of the techniques, although fun in the classroom, simply did not work on ordinary patients of average flexibility. I pruned my technique until I was left only with the most safe and

effective ones. Two years later I was asked to start teaching Thai Massage at Morley College in London.

My aim back then was not to begin a long-term career as a massage therapist but to find a way of financing my training as a psychotherapist. In 1991 I had happened upon Stanley Keleman's extraordinary book *Emotional Anatomy*. Serendipity led me to Belgium, where I joined a workshop Keleman was leading. There began my interest in bodywork, albeit under the influence of Keleman's 'hands off' approach. I returned to London and signed up for a three-year training in integrative psychotherapy. Practising Thai Massage was supposed to be a way of paying for my training and of 'learning on the job'. Instead, it became my main occupation for 15 years. But then that's its beauty; despite being quite simple to learn it provides a wonderful structure in which to keep on learning. Thai Massage became for me my meditation, my relaxation, my yoga and my tai chi. All of these possibilities are folded into this direct and intimate form of bodywork. Thai Massage also taught me that my strength as a therapist lay not with words but with touch.

There are three main activities involved in the practice of Thai Massage. They are:

- the manipulation of a series of lines known as 'sen';
- the application of passive stretches and postures derived from Hatha Yoga;
- the induction of a deep 'meditation-like' relaxation in the patient.

The balance of these three activities is quite individual and the massage will vary considerably depending on the massage therapist's preferences. Some massage therapists are more attracted to the yoga aspects of the work and offer quite dynamic massage sessions.

Some are drawn more to the stretches, and practise Thai Massage with a 'no pain, no gain' style similar to that found in sports massage.

The approach to Thai Massage covered in this book focuses mainly on the manipulation of the sen and on relaxation. This is the style encouraged by my teachers. One of them, Asokananda (aka Harald Brust), with whom I studied advanced Thai Massage in 1995, says of Thai Massage that it '...always was and is centred around intensive and complete line work' (Brust 1996).

Many people liken the sen used in Thai Massage to the channels used in acupuncture and generalise Thai Massage as a form of 'energy work' similar to Japanese shiatsu or Chinese acupressure (Brust 1990, Mercati 1998, Gold 2007). I had already studied Traditional Chinese Acupuncture with JR Worsley in the early 1980s. Although there were some similarities between the sen used in Thai Massage and the channels used in acupuncture, for me this was a perilous comparison. What it revealed were major shortcomings in our knowledge of the sen.

In Thai Massage there was no sense of a complete system comparable to acupuncture channels and there was no system of diagnosis with which to justify the term 'energy work'. In acupuncture there is a very clear, if difficult to learn, system of diagnosis with which to detect and interpret imbalances in the channel system.

Despite these shortcomings, Thai Massage nevertheless performs well under clinical conditions. In my practice many patients became regulars, finding benefit enough to build Thai Massage into their schedules. Despite claiming to offer no more than relaxation, many patients reported improvements in other aspects of their lives. These improvements included resolution of physical problems, improvement in sleep patterns, clearer thinking, improvement in work and social relationships and more. Although I was smart enough to not claim too much credit I was nevertheless curious to understand just why such a simple massage could have such beneficial effects on my patients.

In 1995 I signed up for a series of 'structural integration' sessions in the hands of a therapist trained by the system's founder, Ida Rolf. Structural integration or 'Rolfing' involves the application of deep, sustained pressure into the body's fascial binding and myofascial planes in order to break up postural habits fixed into the fibre of the fascia. The aim of structural integration is, over a series of ten sessions, to improve the body's orientation to the field of gravity. Energy bound up in maintaining poor posture and balance is freed for living.

Two aspects of the experience strongly influenced my understanding of the practice of Thai Massage. The first of these was the aliveness of the practitioner's contact. I soon came to appreciate that the pressure applied into the fascia of my body was not just dumb force but carried with it a clear sense of the therapist feeling the changes occurring beneath his knuckles. This experience of being felt rather than just worked on offered me a measure by which to judge all future massages. There is a world of difference between receiving a massage from an engaged and present massage therapist and from someone simply doing techniques.

The other aspect was the realisation that many of the fascial planes employed in structural integration were similar to the sen on which I worked while giving Thai Massage. This started a process of exploration as I attempted to integrate the practical techniques I had learned as Thai Massage with the idea of myofascial planes. This book is another step in that process.

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Resources

Asokananda died on Friday, 24 June 2005. The Sunshine Network continues his work and offers Thai Massage courses in the Lahu village where Asokananda made his home and school in Northern Thailand.

<http://www.thaiyogamassage.infothai.com/#thailand>

Past and present

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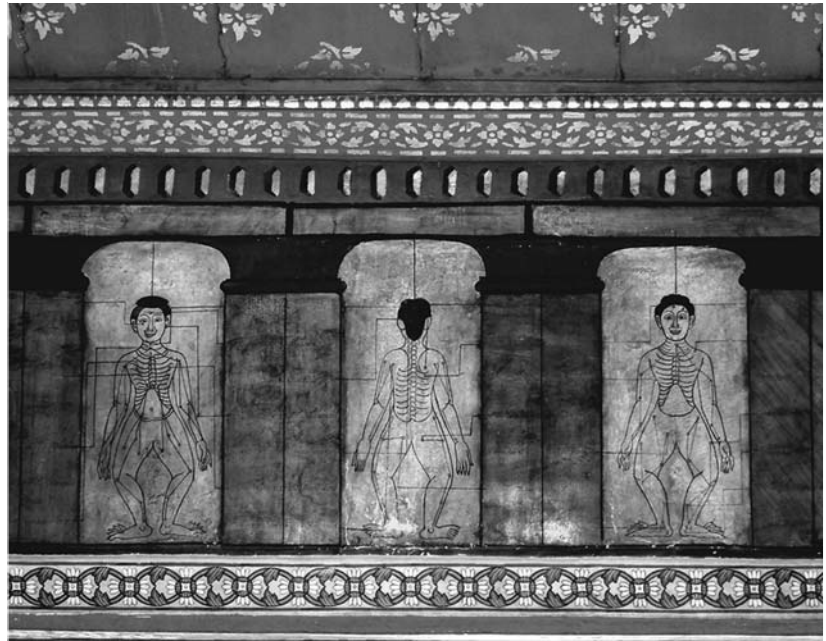
A brief history

Thai Massage is one of the three branches of Traditional Thai Medicine. The others are naturopathic (including dietary) medicine and spiritual practices. Traditional Thai Medicine is intimately entwined with Theravada Buddhism, the esoteric and monastic branch of Buddhism practised in Southeast Asia and Sri Lanka. In Thailand traditional medicine is still generally offered under the auspices of the Buddhist monastic community.

It is not known exactly when Buddhism came to Thailand. Some accounts suggest that Asoka, India's first Emperor, sent missionaries in the second century BC. Asoka embraced Buddhism in response to the terrible cruelty he saw during the conquest of Kalinga. He came to be known as 'The Prince of Peace' ([Kinder & Hilgemann 1978](#)).

A stone inscription from 1292 AD records the declaration of Rama Khamheng, King of Siam, that Buddhism be recognised as the country's official religion ([Gold 2007](#)). Beyond that little more is known.

Fig. 2.1 Three of 60 epigraphs carved on stone at Wat Pho. Reproduced from a photograph by John Glines with permission



When the Burmese invaded Thailand in 1767 they destroyed the old royal capital of Ayutthia and with it most historical and medical texts.

In 1832 King Rama III gathered what fragments of the medical texts survived and had them carved into stone and set into the walls of the Wat Pho, the main Buddhist monastery in Bangkok. These carvings comprise 60 figures and are believed to indicate treatment lines and points on the human body with explanatory notes (Fig. 2.1) (Burst 1990).

Jivaka Kumar Bhaccha

Most Thais venerate the North Indian physician Jivaka Kumar Bhaccha as the father of Thai medicine. The Foundation of Dr Shivaga Komarpaj preserves Jivaka's name in its Thai version. The foundation runs the Old Medical Hospital in Chiang Mai where it offers courses in Thai Massage.

Jivaka Kumar Bhaccha was a member of the community (sangha) that gathered around the Buddha 2500 years ago. His story is included in the Vinaya Pitaka, a Theravadin document that records the life of that original sangha and lists the 227 rules governing monastic life.

According to this account Jivaka's father was King Bimbisara, a contemporary of the Buddha, and the ruler of the Magadha Empire in North India. King Bimbisara was a passionate man who lusted after beautiful women. One day he was travelling by elephant in the countryside when he came upon the house of a wealthy merchant. The merchant was away on business. The merchant's wife, who was alone, saw the king and told him she wished to present him with a garland. The king asked her to come outside but she refused and, instead, requested that the king come inside. When the king entered the house they were both overcome with lust and slept together.

A few months later the merchant's wife went to the king and told him that she bore his child. The king gave her a linen cloth and a ring in acknowledgement of their relationship. He told the merchant's wife 'if a daughter is born, she is yours. If a son is born, bring him to me dressed in the linen and wearing the ring.'

Some time after this meeting the woman received a letter from her husband saying that he would soon be returning home. She was worried as she was now heavy with child. She immediately went to the king and told him of the letter. The king sent a messenger with instructions that the merchant should search for a precious stone before returning home.

The merchant's wife gave birth to a beautiful son, Jivaka Kumar Bhaccha. She dressed him in the king's linen and put the ring on his finger. She went to the palace and left the baby there in a basket. When the king found the child he recognised him as his own son. He gave the child to the care of Zhonu Jigme.

One day the young Jivaka saw a group of people dressed in white. He asked his father who they were. The king told him they were doctors who cured diseases. Jivaka realised his vocation. He asked his father's permission to study under Atreya, the renowned Rishi physician who lived in Taxila. Atreya was the personal physician to Padma dPal, the father of King Bimbisara.

The years of study under Atreya bore fruit and Jivaka stood out as the most brilliant student in his class. It is said that on three occasions he even corrected his teacher. Over time Jivaka became famous as a skilled and competent physician. He grew proud and boasted that he was the supreme physician. He boasted that nobody could cure a somatic disorder, as could he; just as nobody could cure a psychological disorder, as could the Buddha.

Like many of his contemporaries Jivaka went to the Buddha to learn the path by which he could free himself from his suffering. The Buddha taught him extensively but his teachings seemed to have no effect on Jivaka. Realising that Jivaka was unable to perceive the truth, the Buddha sent him to the King of Mountains in the Land of the Snow (the Himalayas) to gather medicinal ingredients. Jivaka was afraid to go alone so the Buddha sent Vajradhara (the primordial Buddha) as his companion.

When Jivaka returned, the Buddha asked him to name the various medicinal ingredients. Although Jivaka could name many, there were others about which he knew nothing. The Buddha named them and gave an extensive explanation of their powers, actions, uses and contraindications.

Cured of his pride, Jivaka realised that the Buddha was indeed the supreme physician and he submitted himself to his teachings. The Buddha then taught Jivaka the four noble truths; the basis of what was to become Theravada Buddhism:

- the truth of suffering (disease);
- the truth of the cause of suffering;
- the truth of freedom from suffering (health);
- the truth of the path (medicine).

It is said that on occasion Jivaka offered his skills as a physician to the Buddha. He also attended his own half-brother, Ajatashatru, who had killed their father, King Bimbisara, in order to seize the throne. King Ajatashatru went on to become a devotee of the Buddha and became patron of the community that gathered around him.

Jivaka was, during his lifetime, three times crowned 'the King of Physicians'. According to legend he finally attained enlightenment and freedom from death ([Rapgay 1981](#)).

Thai Massage today

Until the late 1980s Thai Massage was little known outside of Thailand. Even within the country the traditional medical system to which the massage belonged was losing favour. In common with many of its Asian neighbours, Thailand was embracing a Western model of industrial and economic development and the modern medical system it brought with it.

While Buddhist monks administered most aspects of Traditional Thai Medicine from their monasteries, massage was also practised within families and offered by village practitioners. Formal training in Thai Massage was available through the two main massage schools of Wat Pho in Bangkok and the Old Medical Hospital in Chiang Mai. Village practitioners more often learned their craft through family lines.

Thai Massage is now enjoying a new lease of life in Thailand as well as finding its way into massage centres and hotel spas around the world. This revival owes much to the interest shown by Western travellers, some of whom found their way to the traditional massage schools or studied directly with village massage therapists.

Thai Massage was typically taught as a practical study with little theory to explain the techniques. Despite and possibly because of this lack

of theory some of these early Western students discovered an affinity with the practice and went on to become teachers themselves.

Between 1990 and the present day much has changed in the world of Thai Massage. There are now many more schools offering courses in Thailand as well as around the world. There is now an abundance of books on the subject. 'Thai Reflexology' and 'Thai Head Massage' have emerged as standalone therapies. Even aspects of Thai herbal medicine have entered the mainstream and it is now quite common to see the use of 'Thai herbal compresses' in hotel spas.

Thai Massage has also found its place in the academic world. In 1997 Thai Massage was first offered as a short course within a graduate programme at the University of Westminster in London. In 2005 researchers from the Department of Health, Physical Education and Dance at the City University of New York and the Department of Exercise and Wellness at Arizona State University conducted a study comparing the effect of a single session of either Thai or Swedish massage on mood and tension/anxiety measures (Cowen et al. 2006). Although both Thai and Swedish massage produced significant improvement on these measures they scored equally on effectiveness.

Despite the global reach of Thai Massage there has been little development in understanding the medical system to which the massage belongs. Given that Thai Massage is but a small part of a Buddhist approach to medicine this is, perhaps, not so surprising. Buddha taught Jivaka Kumar that the cause of all suffering, whether physical or mental, is the greed, anger and ignorance generated by the unenlightened mind. Although traditional Buddhist medicine includes naturopathic remedies and physical therapy, of far greater importance is the spiritual teaching and practical guidance offered by the lama physicians of the monastic community. Buddhist medicine is taught within the broader context of Buddhist philosophy and medical intervention is similarly prescribed.

What is known is that Thai Massage is based on the manipulation of treatment lines called 'sen'. These are documented in the stone carvings of Wat Pho. It is generally accepted that these carvings refer to a network of 72 000 lines or channels permeating the body. Ten of these are used for massage. These are known as the 'ten sen'. The lack of a coherent model with which to explain the sen leads many Western practitioners to better-documented systems for information. These include Traditional Chinese Medicine, Ayur-vedic Medicine and Hatha Yoga. Each of these traditions acknowledges a system of channels with similarities to the sen.

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Ten sen – West meets East

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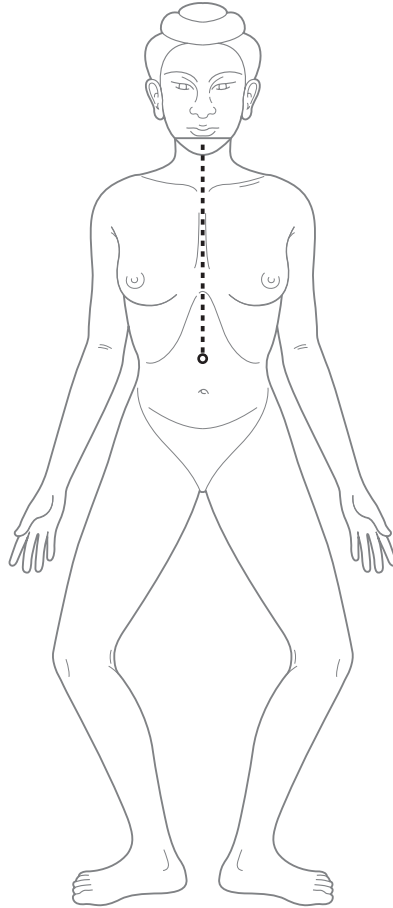
Ten sen

The following descriptions of the pathways of the ten sen are based on those given in the *Handbook for Traditional Thai Massage* issued by the Foundation of Dr Shivaga Komarpaj in Chiang Mai.

1. Sen sumana

Sen sumana (Fig. 3.1) starts at the navel and ascends inside the throat, terminating at the base of the tongue.

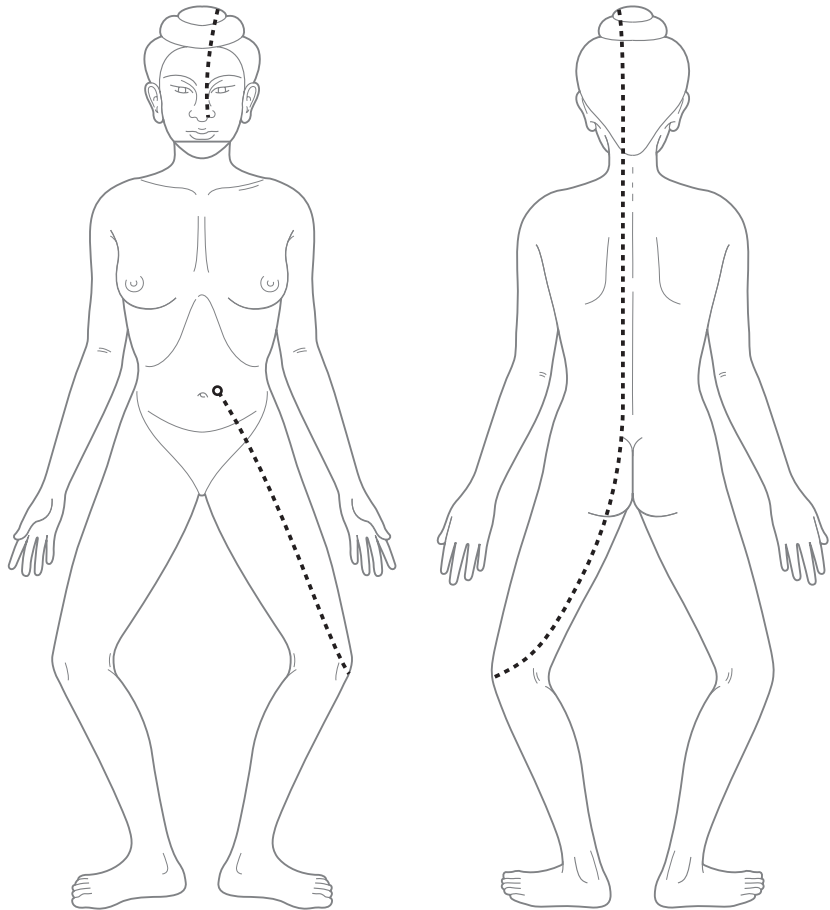
Fig. 3.1 Sen sumana



2. Sen ittha

Sen ittha (Fig. 3.2) starts at the navel and travels down the inside front of the left thigh. It turns around the left knee and travels up the back of the left thigh. The line continues up the left side of the spine and over the top of the head, terminating at the left nostril.

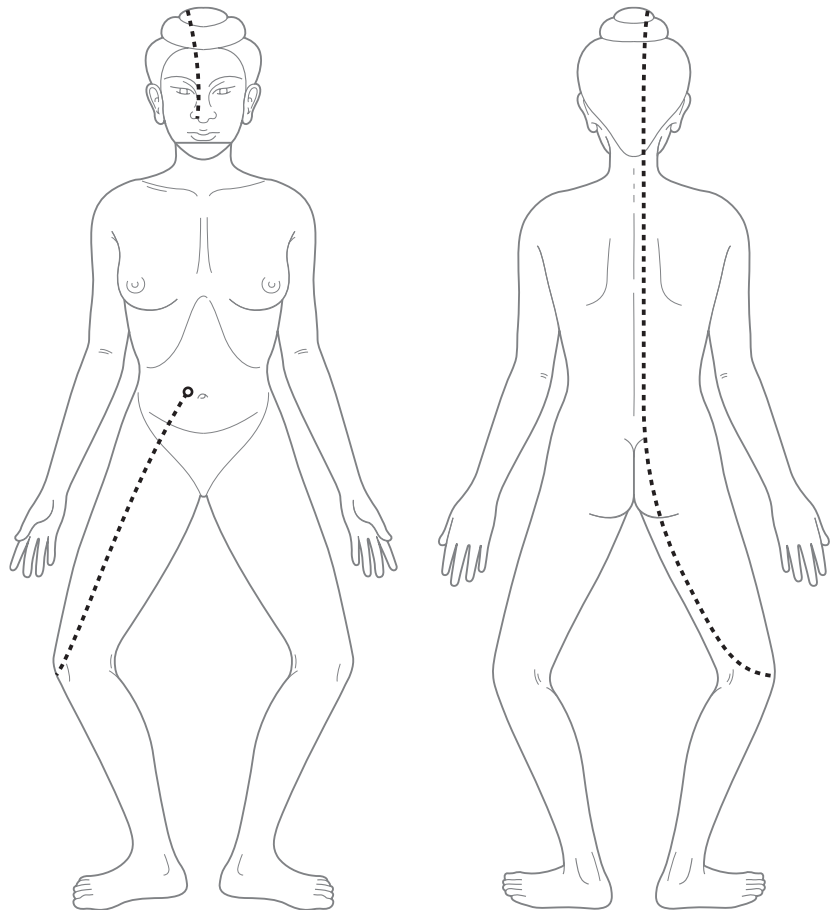
Fig. 3.2 Sen ittha



3. Sen pingkhala

Sen pingkhala (Fig. 3.3) follows the same pathway as sen ittha but on the right side of the body. Sen pingkhala starts at the navel and travels down the inside front of the right thigh. It turns around the right knee and travels up the back of the right thigh. The line continues up the right side of the spine and over the top of the head, terminating at the right nostril.

Fig. 3.3 Sen pingkhala



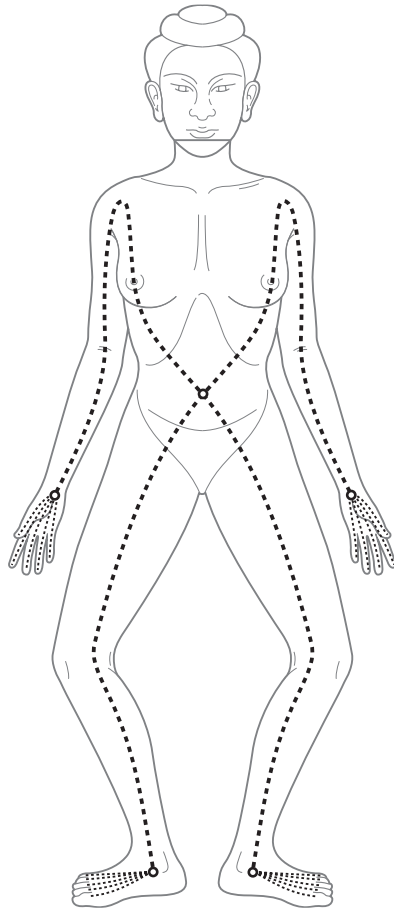
4. Sen kalathari

Sen kalathari (Fig. 3.4) starts at the navel and divides into four branches.

Two branches travel down to the groins and continue down the inside of the legs to the toes.

Two branches travel up to the armpits and then down the inside of the arms to the fingers.

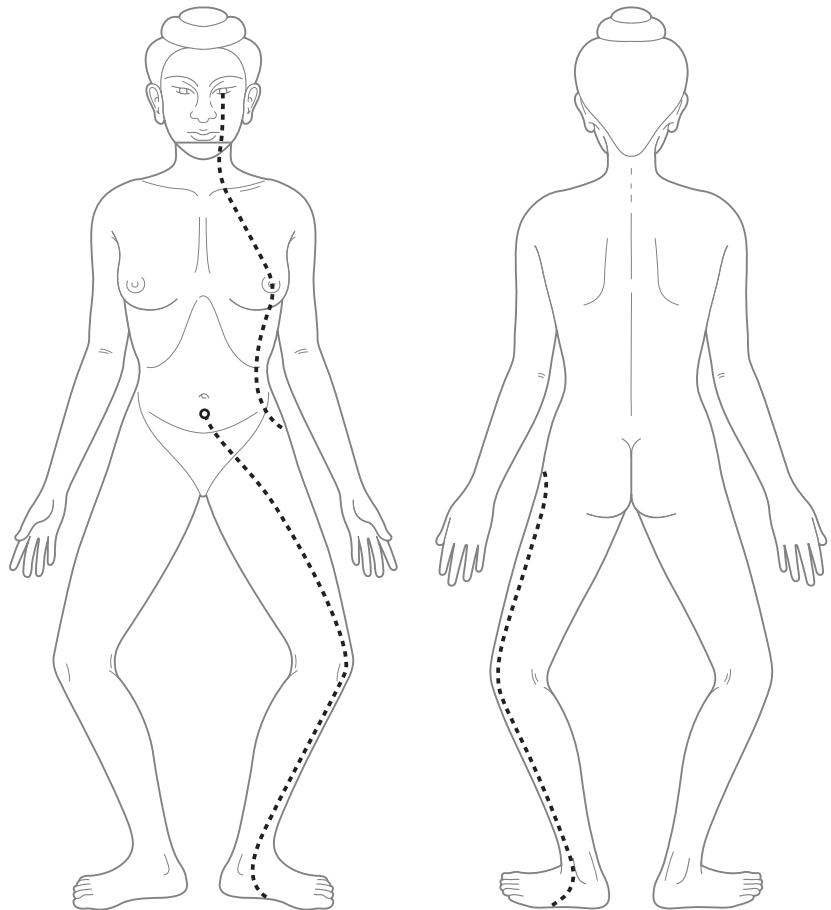
Fig. 3.4 Sen kalathari



5. Sen sahasarangi

Sen sahasarangi (Fig. 3.5) starts at the navel and travels down the inside of the left leg. It crosses the foot and then travels up the outside of the left leg. The line continues up the left side of the abdomen, chest and neck terminating at the left eye.

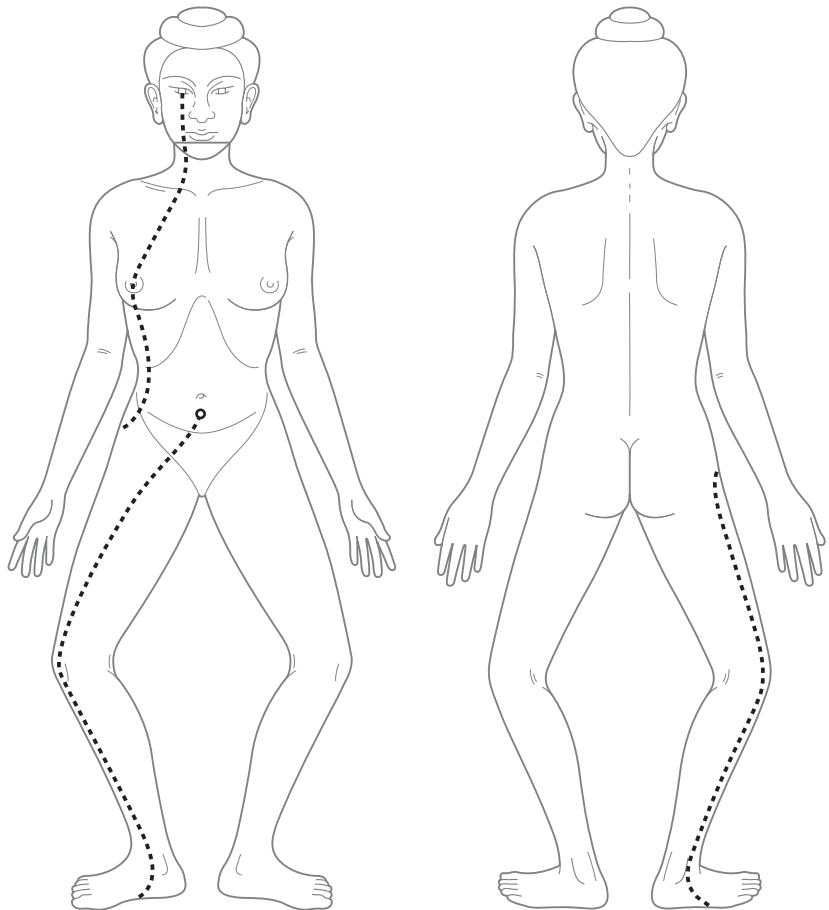
Fig. 3.5 Sen sahasarangi



6. Sen thawari

Sen thawari (Fig. 3.6) follows the same path as sen sahasarangsi but on the right side of the body. Sen thawari starts at the navel and travels down the inside of the right leg. It crosses the foot and then travels up the outside of the right leg. The line continues up the right side of the abdomen, chest and neck terminating at the right eye.

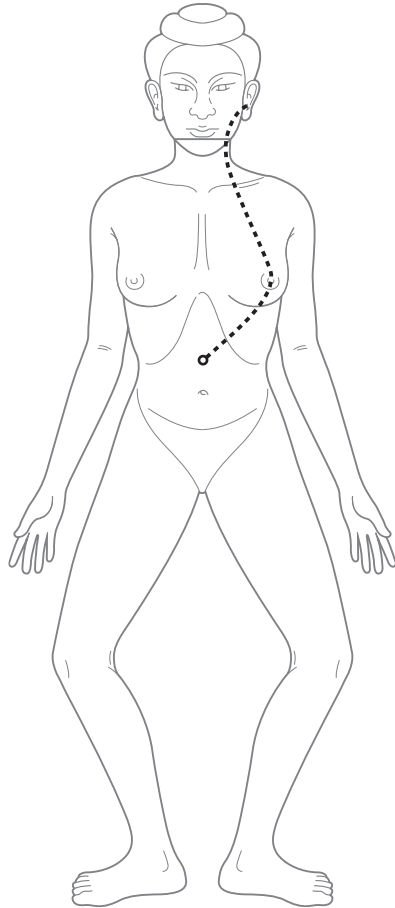
Fig. 3.6 Sen thawari



7. Sen lawusang

Sen lawusang (Fig. 3.7) starts at the navel and travels up the left side of the chest. It continues up the left side of the throat and terminates at the left ear.

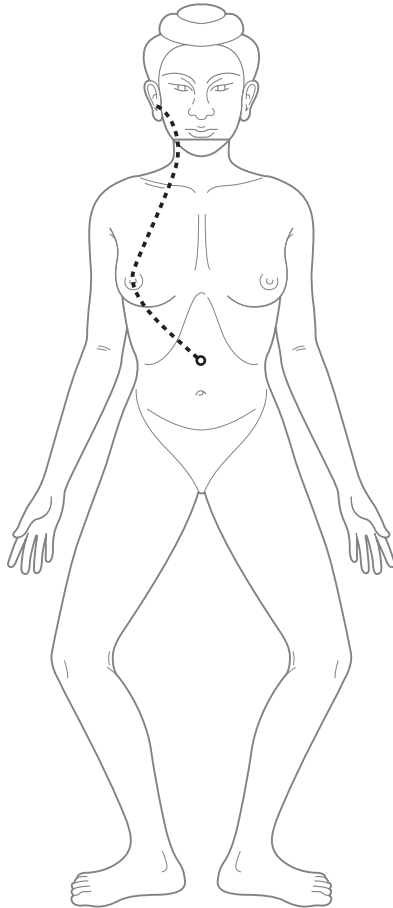
Fig. 3.7 Sen lawusang



8. Sen ulangka

Sen ulangka (Fig. 3.8) follows the same path as sen lawusang but on the right side of the body. Sen ulangka starts at the navel and travels up the right side of the chest. It continues up the right side of the throat and terminates at the right ear.

Fig. 3.8 Sen ulangka

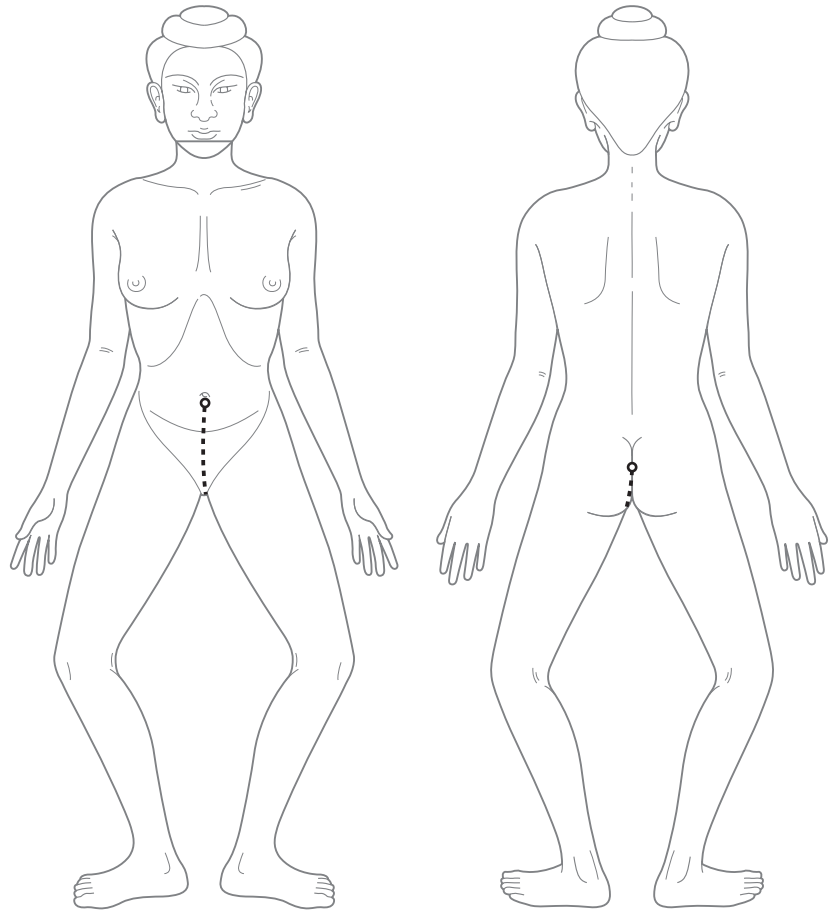


9. Sen nanthakrawat

Sen nanthakrawat (Fig. 3.9) travels down from the navel and divides into two branches:

- sen sukumang terminates at the anus;
- sen sikinee terminates at the urethra.

Fig. 3.9 Sen nanthakrawat

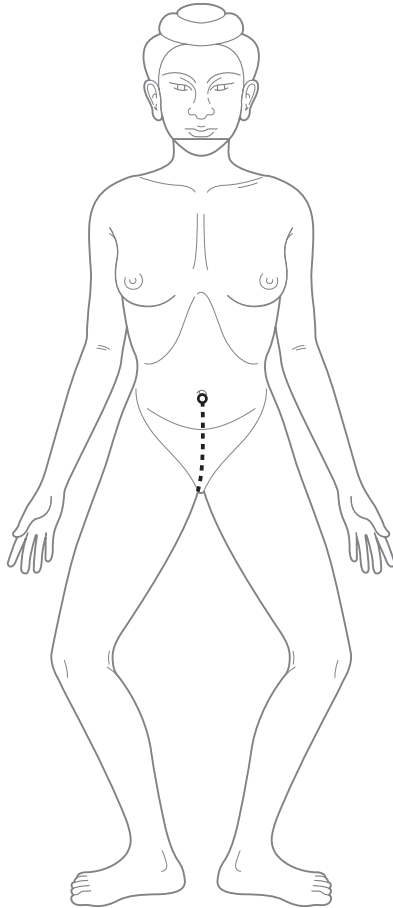


10. Sen khitchanna

Sen khitchanna (Fig. 3.10) starts at the navel and descends to the sexual organs:

- in women the line becomes sen khitcha and terminates at the clitoris;
- in men the line becomes sen pitakun and terminates at the penis.

Fig. 3.10 Sen khitchanna



Apart from these descriptions, little more is known about the nature and function of the ten sen or the system of 72 000 sen to which they belong. It is possible that this knowledge exists within the monasteries of Thailand but it has yet to find translation into English.

Sen and Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) today represents the fruit of 2500 years of development and refinement. Chinese acupuncture, one branch of TCM, first attracted the attention of Western patients and medical professionals in the 1960s. As it proved its effectiveness as a medical intervention it inspired an enormous amount of study and research both in the West and in China in an effort to understand just why this ancient medical system should be so effective.

In common with Traditional Thai Medicine, TCM also includes naturopathic preparations, nutritional advice and manipulative therapy. Traditional Chinese Medicine is based on an anatomical model similar to that used in the West but with the addition of acupuncture channels and treatment points. The channels are used to describe the interconnection of the various functional systems of the body. Until recently this system of channels has been considered alien to Western medicine and to the anatomical and physiological models on which Western medicine is based. Because of occasional similarities, the sen used in Thai Massage are often likened to the channels used in TCM.

In Traditional Chinese Medicine, however, there are not 10 but 14 main channels. There are, in addition, numerous secondary channels. These include connecting channels, muscle channels and cutaneous regions. The connecting channels branch further into minute connecting channels, blood connecting channels and superficial connecting channels (Maciocia 1991). These form an intricate web involved in the distribution of fluids and energies throughout the human body. Although there is no specific reference to 72 000 channels in TCM it seems fair to assume that this web of channels does have something in common with the system of sen referred to in Traditional Thai Medicine.

Sen, Ayur-veda and yoga

Another source of information about Thai Massage is to be found in India. Here in the homeland of Jivaka Kumar, patron of Traditional Thai Medicine, a vast historical record exists. These are known as the Upanishads and the Vedas, and they document the development of the indigenous medical and spiritual system that forms the basis of the Hindu and Buddhist religions. The oldest Upanishads, the

Brhadaranyaka and the Chandogya, have been dated to the eighth century BC, while the Vedas date from 1000 BC (Milne 1995).

Ayur-veda, a naturopathic approach to medicine still practised in India today, dates from the Vedic Period (1800–1000 BC) and is believed by many to be the source of Traditional Thai Medicine. The oldest existing encyclopaedic medical work is the Sushruta-Samhita. Although much of this work was completed in the early Christian era, parts of this collection are pre-Buddhist (Feuerstein 1990, p. 88).

Hatha Yoga, the style of yoga practice most familiar in the West, is documented in a series of Upanishads written between the sixth and fourteenth centuries AD. This period saw the birth and development in India of the philosophy of Tantrism, the aim of which was 'to overcome the dualism between the ultimate Reality (Self) and the conditional reality (ego) by insisting on the continuity between the process of the world and the process of liberation or enlightenment' (Feuerstein 1990, p. 251).

Although for many Westerners Hatha Yoga represents little more than a system of exercise, for its founders it was the distillation of centuries of research. The result is a psycho-spiritual system designed to integrate the spiritual life with the physical reality of the body. Hatha Yoga means 'yoga of the force' and its aim is nothing less than 'the blissful state of ecstatic merging with the Divine' (Feuerstein 1990, p. 246).

In the Yoga-Upanishads we find reference to 'nadis', the Ayurvedic equivalent of the sen. The renowned, contemporary Hatha Yoga teacher, BKS Iyengar, refers to the nadis as channels 'through which nervous energy passes' (Iyengar 1984, p. 117). In common with the Thai system, some of the Yoga-Upanishads refer to 72 000 nadis. Others, however, refer to 350 000. Similarly, some refer to ten important nadis but others refer to 14 or 15 (Motoyama 2003, p. 135).

There are other similarities between the Thai sen and the Ayur-vedic nadis. In both systems three channels are considered to be particularly important. In Thai Massage they are sen sumana, sen ittha and sen pingkhala. In Ayur-veda they are sushumna-nadi, ida-nadi and pingala-nadi. Sen ittha and ida-nadi are in both systems symbolised by the moon and associated with the feminine quality while sen pingkhala and pingala-nadi are symbolised by the sun and associated with the masculine quality.

Hereafter we discover more differences than similarities. In the Thai description, sen sumana starts at the navel and ascends inside the throat, terminating at the base of the tongue. Sen ittha and sen pingkhala are described as lines that run either side of sen sumana and then continue down into the legs. In the yogic tradition these lines are usually depicted as a caduceus. Sushumna-nadi forms a central core while ida-nadi and pingala-nadi weave a double helix, intersecting sushumna-nadi at a series of seven centres along the vertical axis of the body. In Sanskrit these centres are called 'chakras', meaning wheel or vortex. They are thought to relate to nerve plexuses (Motoyama 2003, pp. 197–198).

According to the yogic tradition, sushumna-nadi means ‘the current that is most gracious’ (Feuerstein 1990, p. 260). BKS Iyengar calls it the nadi of fire and locates it inside the spinal column. He says it is the main channel for the flow of nervous energy (Iyengar 1984, p. 439). Although there are some variations, most traditional yogic sources agree that sushumna-nadi begins at the perineum and continues up to a point called ‘Brahman Gate’ at the top of the head (Motoyama 2003, p. 141).

The Yogic tradition goes still deeper, identifying within sushumna-nadi another channel called vajra-nadi and within that yet another called citrini-nadi (Feuerstein 1990, p. 260). According to the Shat-Chakra-Nirupana, written in 1577 by a Bengali guru known as Purananda, there is within citrini-nadi yet another called the Brahma-nadi (Motoyama 2003, p. 164).

It soon becomes clear when reviewing yogic literature that the nadis are part of a complete and complex system involved not only in medicine but also in the development of consciousness. What we know of this system in the West is generally limited to the practice of yoga asanas. According to the yoga Sutras, compiled some time between the second century BC and the second century AD by Patanjali, the asanas are one of the eight disciplines of yogic practice. Hiroshi Motoyama, a Japanese Shinto priest, veteran yoga practitioner and scientist organises these eight disciplines into five groups (Motoyama 2003, p. 32).

TABLE 3.1 The eight disciplines of yoga as organised by Hiroshi Motoyama

| | Aim | Discipline | Activity |
|--------------------|--|------------|-----------------------------|
| Moral training | Purification, harmonisation of the mind | Yama | Abstinence from evil action |
| | | Niyama | Virtuous conduct |
| Physical training | Regulation of vital energy, blood circulation, nervous and muscle function | Asana | Physical postures |
| | | Pranayama | Regulation of the breath |
| Mental training | Breaking through the shell of the self through introversion and control of consciousness | Pratyahara | Withdrawal of the senses |
| | | Dharana | Concentration |
| Spiritual training | Attaining superconsciousness and contact with spiritual beings | Dhyana | Meditation |
| Samadhi | Oneness with the divine | Samadhi | Union of subject and object |

We can see from Table 3.1 that yogic practice is a broad and profound training. Motoyama says of it:

There are those who may claim that it is too grandiose a wish for us humans to become more than human. But it must be stated that this wish is neither impossible nor too dangerous, as long as the correct practices are performed

without error. It should also be added that the guidance of a qualified teacher is essential in case difficulties are encountered along the way.

(Motoyama 2003, p. 29)

In concluding this chapter, Tibetan Medicine should also be mentioned. It too finds its roots in Ayur-veda, although by the seventh century AD the Tibetans were learning from and sharing knowledge with physicians not only from India but also from Nepal, China, Persia and Greece (Rapgay 1985). In the Tibetan system we find once again reference to 72 000 channels, although here referred to as 'tsa' or 'subtle psychic channels' (Clifford 1989).

Traditional Chinese Medicine, Ayur-vedic Medicine, Tibetan Medicine and Traditional Thai Medicine are all very much alive in their country of origin. Curiously, all but Traditional Thai Medicine can be studied in the West. Of Traditional Thai Medicine all that we have in the West is Thai Massage and it carries with it no more than a fragment of the medical system to which it belongs. Ironically, in this may lie its strength. Freed from the weight of a substantial theoretical foundation and from the rigour to be expected of a medical system it nevertheless stands its ground as an excellent massage technique. In the following chapter we will seek to understand why.

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Myofascial pathways – East meets West

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Introduction

When I studied acupuncture in the early 1980s we learned about a system of meridians permeating the human body and involved in the distribution of 'qi'. Acupuncture points along the meridians were used to adjust the balance and distribution of qi using fine needles or heat. Back then we thought of these meridians as invisible channels unknown to Western anatomy and of qi, which translated as breath or vital energy, as a mysterious life force that Western medicine refused to or was unable to acknowledge.

Twenty years on much has changed in our understanding of Traditional Chinese Medicine. In part this is thanks to an extraordinary exchange of knowledge between Western and Eastern medical practitioners and in part because of incredible scientific advances that allow us to observe in the human body what was once only discerned by the senses of our ancient forebears.

We once referred to qi with a vagueness that feigned superior knowledge and disguised ignorance. It is now understood that qi manifests in

the human body in many forms and with many functions. Its forms include original qi, food qi, gathering qi, true qi, nutritive qi and defensive qi; while its functions include transforming, transporting, holding, raising, protecting and warming (Maciocia 1991). We now understand that qi is not simply a generic 'energy' but a way of describing and understanding the myriad exchanges and transformations occurring within the living body as it converts air, food, water and light into growth, activity and behaviour. James Oschman, a researcher in the field of life energy, has described qi as consisting, 'at least in part, of bioelectric, biomagnetic, biomechanical, and bioacoustic signals moving through collagen fibres, ground substance, and associated layers of water molecules' (Larson 1990, p. 25).

We find a similar concept to qi in the yogic system where it is referred to as 'prana'. Like qi, prana also has a number of different forms and functions. The five primary functions of prana all relate to the breath and it is these aspects that gave rise to pranayama or breath control, one of the eight aspects of yogic practice mentioned in the previous chapter (Feuerstein 1990, p. 258).

The complexities of qi are beyond the capacities of this massage therapist's mind but the medium of transmission is what fascinates this massage therapist's hands. As we have seen, Traditional Chinese Medicine refers to an intricate web of smaller and smaller channels branching from the 14 main channels used in acupuncture. These channels may not have been invisible to our Western eyes so much as overlooked. There is a growing conviction that they relate to the connective tissue network, the ubiquity of which is so complete as to 'connect the various branches of medicine' (Juhan 2003, p. 63).

Connective tissue

Our body comprises four principal types of tissue. These are muscle, nervous tissue, epithelial tissue and connective tissue. Of the four, connective tissue is the most abundant and widely distributed. Connective tissue, along with all skeletal muscles, most smooth muscles, all cardiac muscles, bone, blood and cartilage derives from the embryological mesoderm. Although bone, blood and cartilage are types of connective tissue these three are so specialised that they are usually treated separately from connective tissue proper.

Connective tissue proper comprises a matrix of three basic elements. These are ground substance, fibres and cells. Ground substance is a gel-like fluid with a consistency that ranges from a viscid state to a more fluid state depending on the fibres it contains (Juhan 2003, p. 64). As well as providing support and binding for cells it is also the medium of exchange between cells and blood and is significant in processes such as tissue development, migration, proliferation and metabolism.

The cells of the connective tissue are macrophages, plasma cells, mast cells and fibroblasts. Macrophages provide defence by engulfing

invading bacteria and cellular debris. Plasma cells aid defence through the secretion of antibodies. Mast cells produce histamine, which dilates small blood vessels during the process of defence and repair in response to injury or infection (Tortora & Grabowski 1996, p. 104).

Fibroblasts have a unique place in our cellular world with their ability to migrate anywhere in the body and modify their activities according to local need. Fibroblasts secrete ground substance and synthesise the various fibres that give each type of connective tissue its special quality. These fibres are collagen, elastin and reticular fibres. The type and arrangement of these fibres within the ground substance vary according to location and purpose (Juhan 2003, p. 66).

TABLE 4.1 Summary of the different types of connective tissue excluding blood, cartilage and bone

| Connective tissue types | | | | | | |
|-------------------------|-----------|---|---|--|--|--|
| Type | Subtype | Matrix | Cells within the matrix | Quality | | Location |
| Loose | Areolar | Ground substance with randomly arranged collagen, elastin and reticular fibres. Semifluid | Fibroblasts, macrophages, plasma cells, adipocytes and mast cells | Provides strength, elasticity and support | | Subcutaneous layer of skin. Papillary region of dermis. Mucous membranes. Blood vessels. Nerves. Surrounds body organs |
| | Adipose | Ground substance | Adipocytes that store fats and oils | Provides heat insulation, energy storage, support and protection | | Subcutaneous layer of skin. Surrounds the heart and kidneys. Yellow bone marrow of long bones. Padding around joints. Behind the eyeball in the socket |
| | Reticular | Ground substance with interlacing reticular fibres | Reticular cells | Provides a soft framework (stroma) for some organs and binds together smooth muscle tissue cells | | Stroma of liver, spleen, lymph nodes and red bone marrow |

(Continued)

| TABLE 4.1 Continued | | | | | | |
|-------------------------|-----------------|---|--|--|-------------|---|
| Connective tissue types | | | | | | |
| Type | Subtype | Matrix | Cells within the matrix | Quality | | Location |
| Dense | Dense regular | Ground substance appears shiny white with mostly collagen fibres arranged in parallel bundles | Fibroblasts in rows between the collagen bundles | Provides strong attachments between structures | Tendons | Attach muscle to bone |
| | | | | | Ligaments | Attach bone to bone |
| | | | | | Aponeuroses | Sheet-like tendons attach muscle to muscle or muscle to bone |
| | Dense irregular | Ground substance with mostly collagen fibres arranged randomly | Some fibroblasts | Usually forms in sheets. Provides strength | | Reticular region of dermis of skin. Perichondrium (membrane around cartilage). Periosteum (membrane around bone). Joint capsules. Dura mater. Membrane capsules around kidneys, liver, testes, lymph nodes. Heart valves. Fasciae |
| | Elastic | Ground substance with freely branching elastin fibres | Fibroblasts present in space between fibres | Allows stretching in some organs | | Lung tissues, trachea and bronchial tubes. Walls of elastic arteries. True vocal cords. Suspensory ligament of penis. Ligamenta flava of vertebrae |

There are two general types of connective tissues, loose and dense. Loose connective tissue includes the subtypes of areolar, adipose and reticular. Areolar is the most widely distributed. It contains collagen, elastin and reticular fibres in a loose and random arrangement. This structure suits its role of holding organs and epithelia in place and as

the subcutaneous layer attaching the skin to the underlying tissues and organs (Tortora & Grabowski 1996, p. 107).

Adipose connective tissue is always found in the company of areolar connective tissue. It contains adipocytes, derived from fibroblasts. These cells are adapted for the storage of fats and oils. This makes adipose tissue especially suited to cushioning and supporting organs, thermal insulation, lubrication (primarily in the pericardium) and energy storage.

Reticular connective tissue contains a network of fine interlacing reticular fibres that forms a soft framework known as a 'stroma'; found in the lymph nodes, red bone marrow, liver and spleen (Tortora & Grabowski 1996, p. 108).

Dense connective tissue includes two subtypes, dense regular and dense irregular. Dense regular connective tissue is packed with collagen fibres arranged in parallel bundles. This gives it the great strength necessary for its role of providing attachments between structures. As tendon it attaches muscle to bone and as ligament it attaches bone to bone. Aponeuroses are sheet-like tendons that attach muscle to muscle or muscle to bone.

Dense irregular connective tissue is usually found as sheets. It contains randomly arranged collagen fibres giving it great strength as well as flexibility. This suits its role as the major part of the dermal layer of the skin. It also forms the strong, protective membrane wrapping cartilage, bones, joints, kidneys, liver, testes, lymph nodes and heart valves as well as the dura mater, the membrane that protects the brain and spinal cord (Tortora & Grabowski 1996, p. 109).

Fascia is the general name for the dense, irregular connective tissue layer surrounding muscles, bones and joints. It provides support and protection and gives structure to the body. Ida Rolf says of it, 'fascia forms an intricate web coextensive with the body, central to the body, central to its well-being, central to its performance. Clearly fascial tone, fascial span, is a basic contributing factor to bodily well-being' (Rolf 1989, p. 39).

Fascia consists of three layers: the superficial, the deep and the subserous. The superficial fascia is located directly under the subcutis of the skin. Its functions include the storage of fat and water and it provides passageways for nerves and blood vessels. In some areas of the body, it also houses a layer of skeletal muscle, allowing for movement of the skin.

The deep fascia lies beneath the superficial fascia. It aids muscle movement and, like the superficial fascia, provides passageways for nerves and blood vessels. In some areas of the body, it also provides an attachment site for muscles and acts as a cushioning layer between them.

The subserous fascia lies between the deep fascia and the membranes lining the cavities of the body. There is a potential space between it and the deep fascia that allows for flexibility and movement of the internal organs.

Myofascia extends from the deep fascia as a thin, elastic and dynamic membrane that covers, supports and separates the skeletal muscles. As endomysium it wraps and separates each muscle fibre. As perimysium it wraps each bundle of muscle fibres into a fascicle. As epimysium it wraps each muscle itself. These three varieties of myofascia each contribute collagen fibres to the connective tissue that attaches the muscle either to bone or to other muscles. These attachments may also extend beyond the muscle as tendon or aponeurosis (Tortora & Grabowski 1996, pp. 240–241).

Between adjacent muscles the epimysium provides a protective route for blood vessels, nerves and lymph ducts. The muscles, ideally, act as cushions for these vessels. However, the quality of cushioning depends on the tone of the muscle as well as the dynamism of the myofascial pathways. If the surrounding muscles are hypertonic they will limit the flow of blood and lymphatic fluid through the epimysium and reduce the flow to the surrounding tissue.

Andrew Taylor Still (1828–1917), who in 1874 founded osteopathy, always reminded his students that the physician's task 'was to remove with gentleness all perceived mechanical obstructions to the free-flowing rivers of life (blood, lymph, and cerebro-spinal fluid). Nature would then do the rest' (McPartland & Skinner 2005). Perhaps an ancient appreciation of the significance of myofascia in relation to those rivers of life was what inspired the thousands of years of research and development that has culminated in some of the traditional medical systems still available to us today.

In 1990 Dick Larson, an acupuncturist and Rolfer, wrote a paper discussing the link between the myofascial planes used in structural integration and the channels used in acupuncture and suggested that the ancient Chinese were well aware of the significance of connective tissue in the living body. According to Larson, during the Han Dynasty (206 BC–220 AD) 'Prince Mang ordered physicians and butchers to perform surgery on live political prisoners to measure their organs and to establish the source and route of blood vessels' (Larson 1990, p. 25).

Larson quotes the work of another Rolfer, Stanley Rosenberg, who in 1986 suggested that '...the acupuncture meridians are a map of the planes of fascia. By putting my hands on the meridians in certain ways (other than traditional acupressure), I can produce some predictable improvements in structure, easily and with little effort' (Larson 1990, p. 29).

Kiiko Matsumoto and Stephen Birch, who have done a great deal of research into the relationship between acupuncture channels and connective tissue, suggest that 'Perhaps the fascia, the tissues that cover and line the body and organs, have some special qualities, properties or functions that were recognised by the medical authors of the Han Dynasty' (Larson 1990, p. 26).

Fascia (or, more correctly, connective tissue) does indeed have some special qualities. The first is that it provides a physical means of

communication from the outside of the body to the heart of every cell and from the heart of every cell to the heart of every other cell. Each individual cell contains a cytoskeleton that provides a framework of support, structure and communication for the various cellular and nuclear elements within. Proteins called integrins reach out from the cytoskeleton, across the cell surface to the surrounding connective tissue matrix. At the outermost layer of the skin, tonofilaments reach in from the epidermis and are attached via hemidesmosomes to the dermal connective tissue. From here anchoring fibrils link in to the connective tissue matrix (Oschman 2000, pp. 45–47).

Another of the special qualities of connective tissue is the presence of collagen fibres within the matrix. As shown in Table 4.1, fascia and myofascia are types of dense, irregular connective tissue and as such consist mainly of randomly arranged collagen fibres within the ground substance. Collagen is the 'longest molecule that has ever been isolated' and is 'stronger in tensile strength than steel wire' (Juhan 2003, p. 72), qualities ideal in its role of providing support and connectivity in the body. Collagen is also hollow, which suits its role in circulation and communication. Curiously, it is said that within the collagen tubule is not, as we might expect, lymph or ground substance but cerebrospinal fluid (Juhan 2003, p. 73). If this is true it is evidence of an extraordinary communication from the ventricles in the middle of the brain to, potentially, every cell in the body.

Yoshio Manaka, who died in 1989, contributed much to our modern understanding of acupuncture through scientific research. He did not specifically refer to the connective tissue but said, 'While we can offer no clear description of the body's hardware, we propose that it is better to examine and define the software first' (Manaka 1995, p. 55). Manaka did, however, refer to the 'X-signal system', so called because it could not yet be fully explained, even if he considered it to be 'the biological system that lies at the very heart of acupuncture and moxibustion theory and practice.' He considered it to be a primitive signalling system, as yet unknown to biologists and impossible to explain with neurophysiology because 'it manifests and is manipulated clinically with minute stimuli or influences that cannot be clearly said to affect the nervous system' (Manaka 1995, p. 18). It seems highly likely that the connective tissue plays a major role in this system.

As modern science refines its ability to look and to listen it is discovering ever more extraordinary details about the functioning of the living body. When James Oschman talks of life energy as 'bioelectric, biomagnetic, biomechanical, and bioacoustic signals moving through collagen fibres, ground substance, and associated layers of water molecules' (Larson 1990, p. 25) it is because each of these phenomena has been scientifically shown to be true.

Perhaps here it is worth invoking the spirit of Ida Rolf. In 1964 she started teaching her system of structural integration at Esalen and helped establish it as an important centre for bodywork. There was a

growing interest there in all things Eastern including yoga, meditation, chakras, energies and auras. Perhaps Ida Rolf's work seemed a little prosaic in comparison.

One morning ... Ida Rolf clumped into her living room at Big Sur where about twenty of us were assembled. "Word's going around Esalen that Ida Rolf thinks the body is all there is. Well, I want it known that I think there's more than the body, but the body is all you can get your hands on." – Don Johnson, The Protean Body. (Heller & Henkin 1993)

In Thai Massage the myofascial sen are what we can get our hands on. Helene Langevin and colleagues at the University of Vermont College of Medicine used high-frequency ultrasound scanning acoustic microscopy to study acupuncture channels and the effects of acupuncture needling. Langevin observes that 'Acupuncture points and meridians typically are located between muscles or between a muscle and a tendon or bone' (Langevin et al. 2001, p. 2279). Again we find the connection between acupuncture channels and myofascial pathways.

In one experiment, Langevin et al. explored a phenomenon discussed for more than 2000 years in acupuncture texts and is of great clinical significance to acupuncturists. This phenomenon, known as 'de qi' or 'needle grasp', is described as a tug on the needle 'like a fish biting on a fishing line' (Langevin et al. 2001, p. 2275). Observation showed that, as the acupuncture needle is turned, collagen fibres wind around its shaft. Not only does this explain the tug on the needle but it also suggests that acupuncture achieves some of its effects through mechanical influence on the connective tissue matrix. Langevin says that 'The ancient maps of acupuncture points and meridians may essentially be a guide to insert the needle into connective tissue. Spreading of matrix deformation and cell activation along connective tissue planes thus may mediate acupuncture effects remote from the acupuncture needle site' (Langevin et al. 2001, pp. 2279–2280).

Hiroshi Motoyama draws similar conclusions in his study of yoga practice and the Ayur-vedic nadis. He says, 'I consider the nadis to be essentially equivalent to the meridians of Chinese acupuncture; from my research, it appears that these channels are formed of connective tissue and filled with body fluid' (Motoyama 2003, p. 43).

Perhaps one day we will construct a model with which to explain exactly how traditional medicine such as acupuncture works. Researchers like Manaka, Matsumoto, Motoyama and Langevin call our attention to the connective tissue web as an important part of that model. James Oschman gathers together the research data that show us just how multilayered and complex is the information travelling through the connective tissue web. That web might have 72 000 pathways. It might have 350 000 pathways. It might have as many pathways as cells. In the practice of Thai Massage we have only ten sen but if these refer to

myofascial pathways we have a way of understanding the physical benefits of our work on these lines.

A note on neuromuscular technique (NMT)

In the 1930s in Paris, Dr Dewandchand Varma from India was practising 'pranatherapy' a form of soft tissue manipulation derived from Ayur-vedic medicine. In his book, *The Human Machine*, Dr Varma says:

We have discovered that the circulation of the nervous currents slows down occasionally because of the obstruction caused by adhesions; the muscular fibres harden and the nervous currents can no longer pass through them. We have demonstrated effective and positive methods designed to restore nervous equilibrium which promotes the healthy circulation of blood, so that new tissues begin to be built up again.

Stanley Lief, an American-trained chiropractor and naturopath, heard of Varma's work and travelled to Paris to receive a series of treatments with him. Lief was so impressed by Varma's method and results that he persuaded Varma to teach him. Lief felt that there was room for improvement and worked with his cousin and assistant, Boris Chaitow, to further refine the techniques he had learned. Lief devised the name 'neuromuscular technique' to describe the resulting approach to soft tissue manipulation ([Chaitow 2003](#), pp. 32–33).

The range of techniques now included under the general heading of neuromuscular technique has expanded to include many new and associated techniques. One of these is the 'c-bend', recognised as one of the few ways of modifying connective tissue status and lengthening muscle through a process of 'tension loading'. The technique involves using the thumbs or the heel of the hand to introduce a 'c-bend' into the target muscle, until the first barrier of resistance is met. The barrier is engaged until the therapist feels a release in the tissue. This would typically occur between 5 and 30 seconds. Using this technique encourages muscle lengthening without the risk of initiating a stretch reflex. Although the c-bend can be applied as a series of rapid, snapping thrusts with the intention of breaking up rigid tissue, when its aim is to lengthen muscle the process is slower and smoother ([Chaitow 2003](#), pp. 32–33).

The c-bend enlists the help of the muscle spindles and Golgi tendon receptors within the muscles. The muscle spindles detect and adjust the length of the muscle while the Golgi tendon receptors detect how hard the muscle is working ([Chaitow 2003](#), p. 3). When we apply the c-bend we convince the nervous system that the muscle is under load and this encourages the nervous system to lengthen the muscle. In Thai Massage,

rhythmic manipulation of the sen is a major part of the massage. When we use a myofascial approach to the sen we find that we invariably follow the border of a muscle. As we lean into the myofascial pathway we often find ourselves applying a c-bend to the muscle (Figs 4.1–4.4).

Fig. 4.1 Applying a c-bend to the erector spinae muscle



Fig. 4.2 Applying a c-bend to the trapezius muscle



Fig. 4.3 Applying a c-bend to the rectus femoris muscle



Fig. 4.4 Applying a c-bend to the flexor carpi radialis muscle



Although the application of the c-bend in Thai Massage does not have the aim of breaking up fibrous tissue or of holding the muscle for more than a second at its barrier it does nevertheless have the desired effect of lengthening and softening the muscle.

Compared with other systems of bodywork, Thai Massage can appear to be quite humble and unsophisticated. However, if the sen are indeed myofascial pathways and if we can use those myofascial pathways to soften and lengthen muscle it would seem that this humble massage technique is actually quite profound. We may well be improving the flow of blood as it carries oxygen and nutrients to the cells. We may well be assisting the drainage of lymph as it carries toxins away from the cells. We may

well be reducing the pressure of muscles and connective tissue bindings leaning against the nerves, thereby reducing the extraneous noise flowing through the central nervous system. If this were all we achieved with Thai Massage it would be good enough. Anything more is a bonus.

Dreambody

In his book *Dreambody* Arnold Mindell, a Jungian psychoanalyst and bodyworker, discusses somatisation as the way in which the unconscious communicates through the body. Although Mindell's book is rich with many ideas and influences one comment stood out for me. In defining the dreambody Mindell says, '...in bodywork it appears as the dreamlike process that tries to express itself through uncontrolled body motions' (Mindell 1998).

Many massage therapists will have noticed these uncontrolled movements in their patients. They are the movements that occur when the patient is on the edge of a deep sleep. Once we appreciate their significance we can aim to create the conditions in which the dreambody can do its work. The most important of these is to establish an environment and relationship in which the patient feels safe and comfortable.

In our busy modern world few people know real relaxation. Even the word 'relaxation' has been hijacked by the advertising industry. If we want to see real relaxation we need only to look at a sleeping baby or pet cat or dog. In the wild, a cat or dog would spend most of its time in a state of heightened awareness. It would even sleep with an ear and nostril turned up full. In a good home it soon realises that once the door is closed it is utterly safe.

If we watch the baby or the pet while they sleep we will see the dreambody at work. We will see the little twitches and movements as the dreambody organises and resolves the impressions of the day, before giving in to total relaxation. In the baby we will even see waves of emotional expressions passing quickly across its face.

Our patient's dreambody is finely tuned. It is listening for the signs that we will take good care of it. If we can establish a relationship in which it can emerge we will witness remarkable moments of lucidity, resolution and healing. It is humbling. The thing that stands in the way is our refusal to be humbled and our need to show off our therapeutic cleverness. As a massage technique, Thai Massage goes a long way towards reassuring the patient's dreambody. It is practised on the floor so their body feels no fear of falling. There is no need for the patient to undress. There is no need for diagnostic questions which are often quite intrusive. The dialogue is direct, body-to-body, our patient's dreambody reads our motive. The relationship may be more clear, supportive and undemanding than any other in their life.

If our patient's dreambody does feel safe we might see their eyes slowly rolling from side to side under the lids. We might hear their breathing

settle into a relaxed and natural rhythm. We might notice colour changes in their skin. We might see the lines of their face soften and the shape of their body change, as the muscles quite literally become more fluid. Sometimes we will sense our patient's relaxation deepen still further. We will hear the beginnings of a snore developing in their throat as a pattern of spontaneous movement ripples throughout their entire dreambody. In those brief moments the patient's dreambody reorganises experiences held in its tensions and posture. When this happens it does not need to be talked about. When the dreambody resolves, it resolves entirely.

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The myofascial sen

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Introduction

In Thai Massage all the schools seem to agree that there are ten main lines, but nobody seems to agree on where they run. (Brust 1996)

In the practice of Thai Massage we do not actually use the ten sen as described in Chapter 3. We use, instead, a series of working lines on the legs, arms, back and head. These working lines sometimes correlate to aspects of the ten sen (Fig. 5.1).

Fig. 5.1 General view of all the working lines used in Thai Massage



There are differences of opinion as to where the working lines run and even how many there are. The lines described below are the ones that I teach based on a myofascial approach to Thai Massage. In this case the descriptions are quite specific as they always relate to the physical reality of muscles and bone and the myofascial pathways between them. Students studying in this way soon come to know when their colleague hits or misses the line because the correct line worked well does have a palpable physiological effect.

Leg lines

There are five working lines to be found on each leg. The naming convention used here is the same as that used at the Old Medical Hospital in Chiang Mai (Figs 5.2–5.5).

In Traditional Chinese Medicine, the leg channels relate to the kidneys and bladder, spleen and stomach, liver and gall bladder, and the organs found around and below the respiratory diaphragm. As we work to soften the legs we can bear in mind the possibility that the connections that the ancient Chinese perceived between these organs and the legs are mediated through myofascial channels. We may well notice the diaphragm soften as we work the legs. Perhaps we will hear the change in our patient's breathing when this happens. Perhaps we will hear gurgles as their stomach relaxes.

Typically in Thai Massage the sen are worked with the heel of the hand or with the thumbs. Some teachers suggest pressing with one thumb on top of the other. This is best avoided as it puts too much pressure on the joint of the under thumb.

Fig. 5.2 Lateral view of the leg showing the path of the 1st outside leg line and the 2nd outside leg line

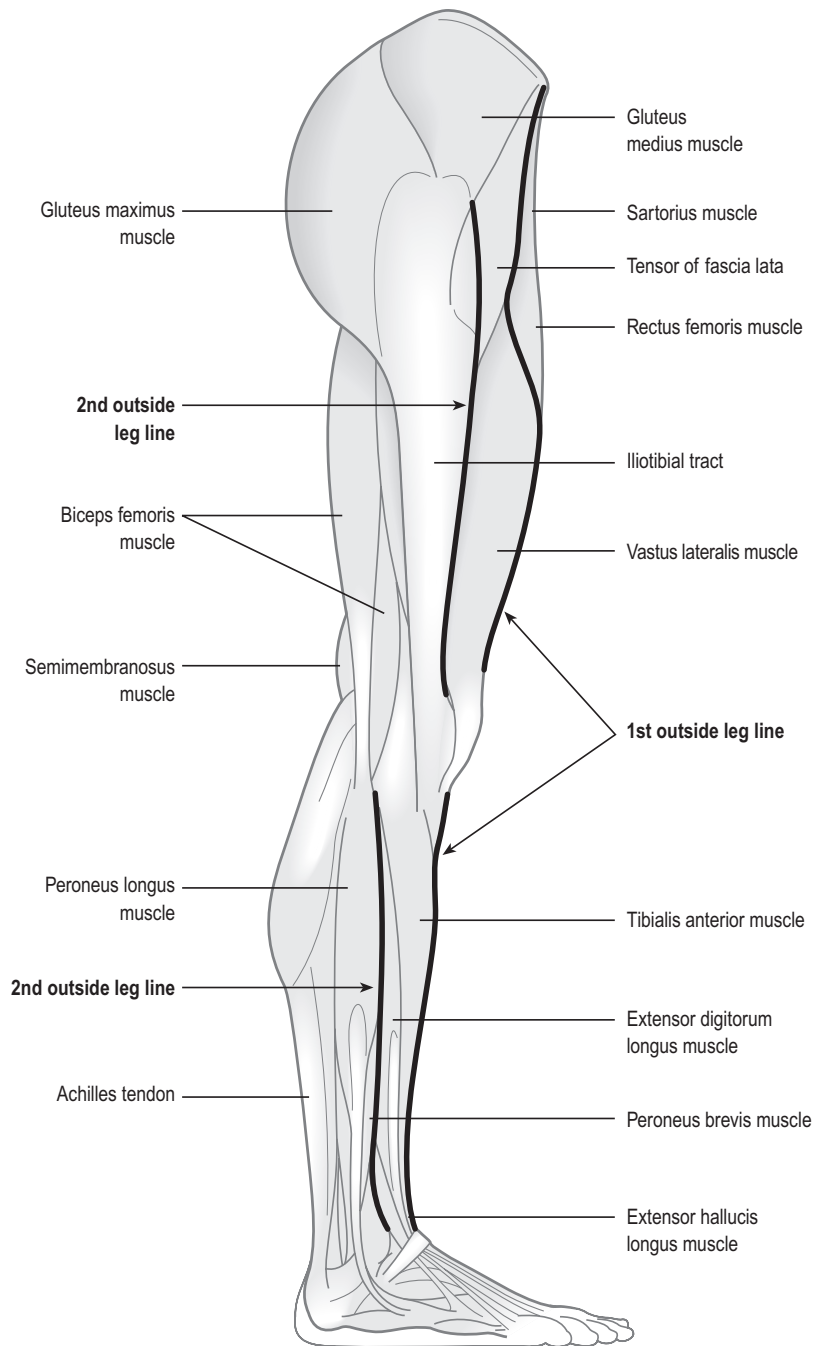


Fig. 5.3 Posterior view of the leg showing the path of the 3rd outside leg line

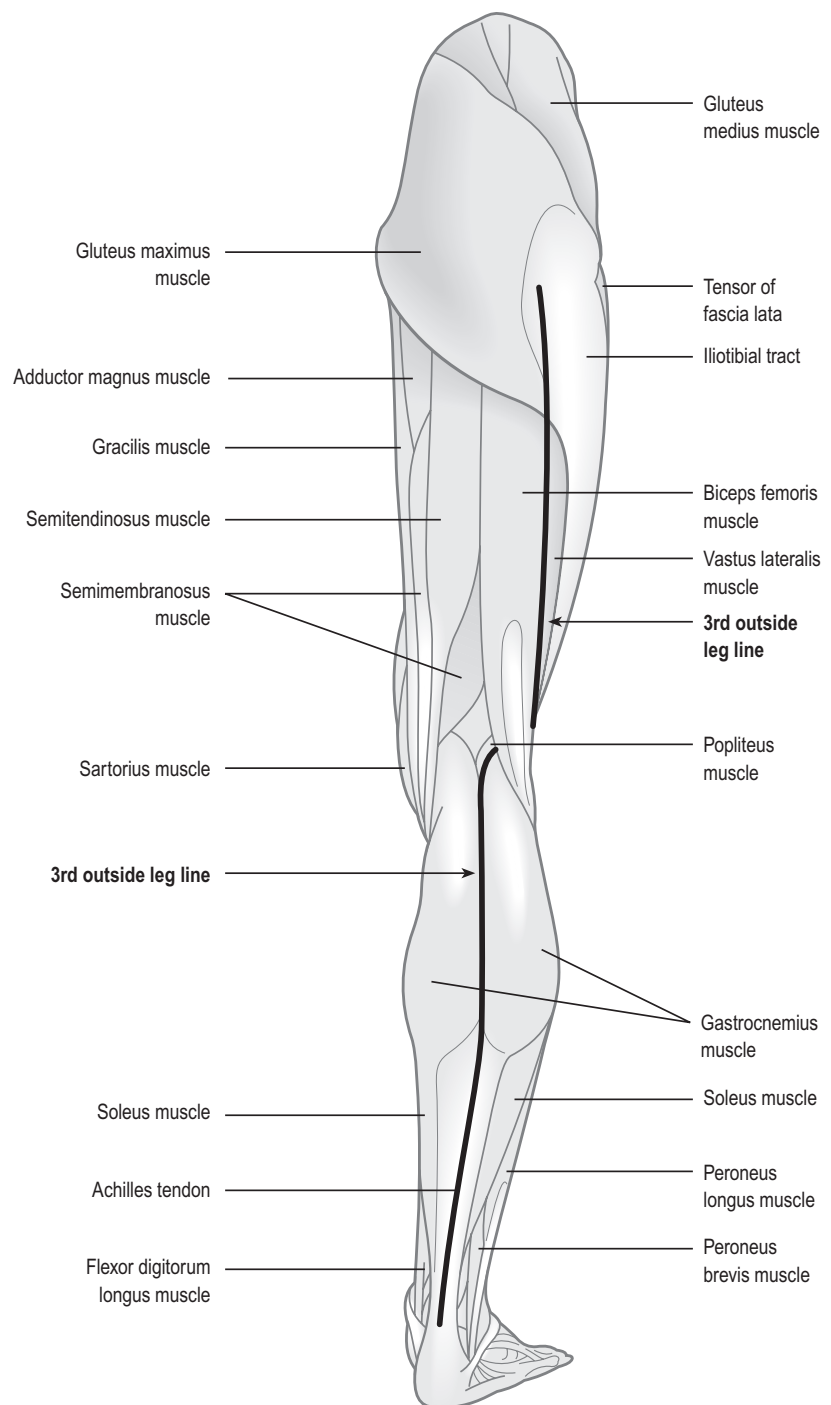


Fig. 5.4 Anterior view of the leg showing the path of the 1st outside leg line and the 1st inside leg line

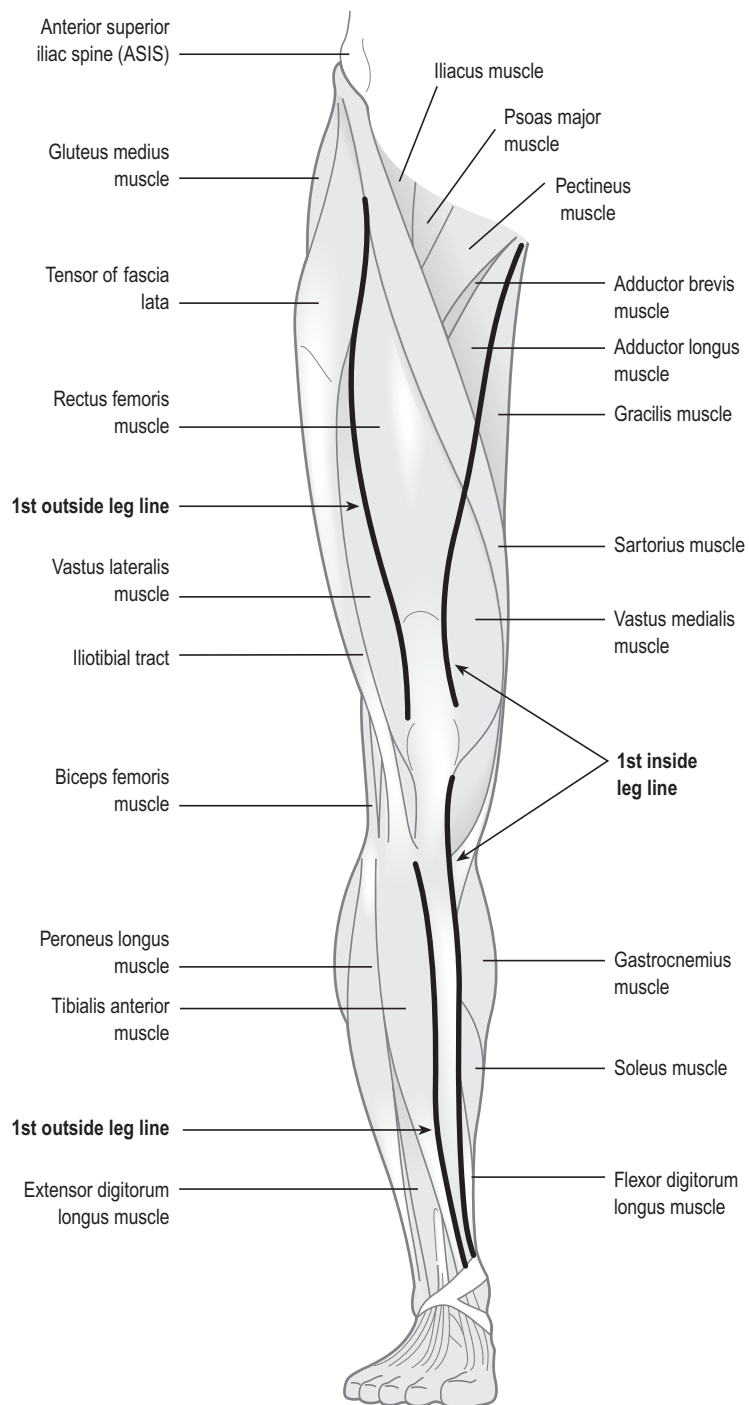
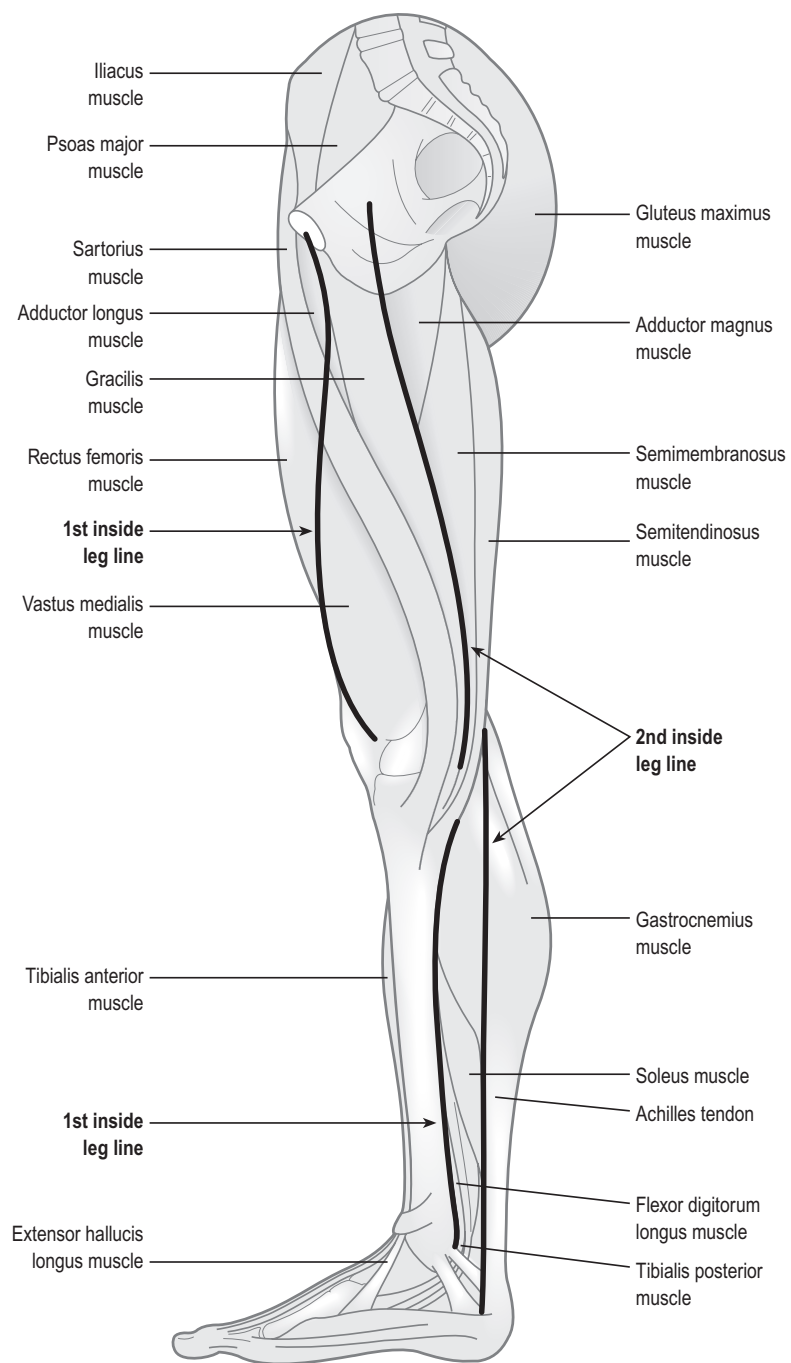


Fig. 5.5 Medial view of the leg showing the path of the 1st inside leg line and the 2nd inside leg line



Usually Thai Massage therapists press into the line to the point where the tissue hardens and resists. They then add a little more pressure. Working from a myofascial perspective requires that we modify this approach. We want to feel our way into the tissue. If we simply press until the tissue hardens there is no room for movement or change in response to our input. If we learn to feel the response in the tissue as we increase our pressure we will find that the tissue shows us the direction it prefers to go. We then follow that direction.

This way of working demands of us a very alive attention with every move we make. There is no repetition of a technique. Every technique has to be rediscovered in the moment. This sounds like a slow process but it is not. Learning to work like this takes a little time but soon the sensation of our massage therapist's body wakes up and we realise that we already know how to do this. This is an inherent understanding. We have a body too and it already knows a lot about massage.

Feet lines

The lines of the feet relate to sen kalathari. They are usually illustrated as five lines on the soles of the feet, radiating from a point in the middle of the heel through to the end of each toe (Fig. 5.6).

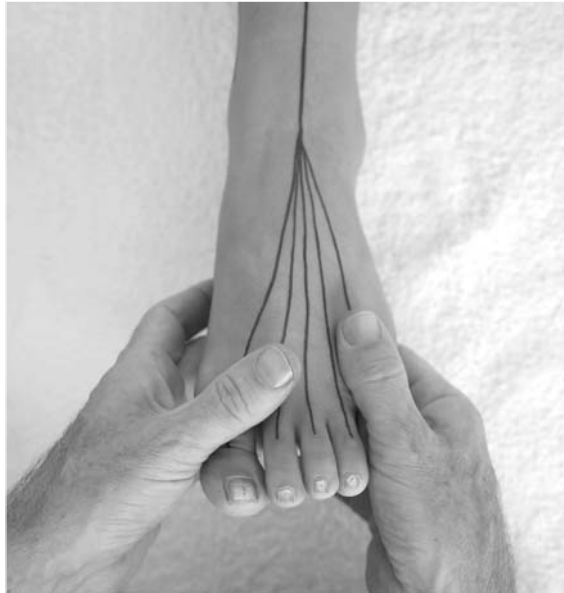
Fig. 5.6 Five working lines on the sole of the foot



Anatomically we can think of these lines as the toe bones reaching deep inside the foot. We can think of the extensor tendons on the upper surface of the foot. We can think of the plantar fasciae and the flexor muscles and tendons on the sole of the foot. There is plenty to work with here. With all this in mind and softness and sensitivity in

our hands we use the sense of the lines, and the structures they relate to, to bring mobility and spaciousness to the entire foot (Fig. 5.7).

Fig. 5.7 Five working lines on the front of the foot



1st outside leg line

On the left side of the body this line is associated with sen sahat-sarangi and on the right side of the body with sen thawari. These lines show some similarity with the pathway of the stomach channels described in Traditional Chinese Medicine.

On the lower leg the line runs from the ankle to the knee along the lateral edge of the tibia, between the bone and the tibialis anterior muscle. As we work this line our aim is to open the myofascial channel by pressing the tibialis anterior muscle down and away from the tibia. We allow our thumbs to rest on the lateral edge of the tibia and then drop into the channel while directing our pressure downwards towards the floor. Each time we travel the line we aim to gain a little more depth (Fig. 5.8).

On the upper leg the 1st outside leg line follows the lateral border of the rectus femoris muscle. We locate the line by feeling for a little dip on the superior and lateral corner of the kneecap. The line begins at this point and continues up to the anterior superior iliac spine (ASIS).

We need to visualise the line connecting these two points, as it is not too obvious until we work it. It is best to begin working the line with the heel of the hand. The movement is directly across the top of the femur. In effect we use the 1st outside leg line to introduce a c-bend along the lateral border of the rectus femoris muscle (Fig. 5.9).

Fig. 5.8 Thumbing the 1st outside leg line on the lower leg

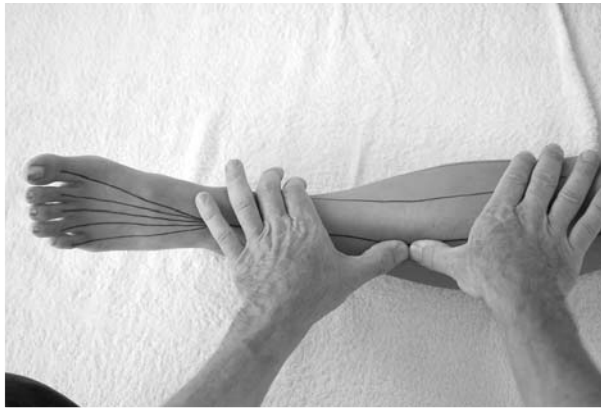


Fig. 5.9 Palming the 1st outside leg line on the upper leg



Once we have a good feeling for the line we can continue to work it using our thumbs. The movement always remains the same. We push the rectus femoris muscle across the top of the femur, c-bending the muscle with our thumbs as we go (Fig. 5.10).

Fig. 5.10 Thumbing the 1st outside leg line on the upper leg



TIP

We never push down towards the bone.

2nd outside leg line

The 2nd outside leg line is associated with sen kalathari on both sides of the body. On the lower leg we find the line by moving our thumbs superior to the lateral malleolus. We soon find ourselves following the anterior border of the peroneus longus muscle. As we move up from the ankle towards the knee we find that we are opening a myofascial channel between the peroneus longus muscle and the tibialis anterior muscle (Fig. 5.11).

Fig. 5.11 Thumbing the 2nd outside leg line on the lower leg



We stop as the tissue hardens just before the knee. In order to find the depth as we work this line we need to push downwards, bending the muscle under the bone. It is tempting to medially rotate the leg to see where our thumbs are working. The rotation will tighten the muscles contrary to our aim of softening them. We do better feeling for, rather than looking for, the lines (Fig. 5.12).

Above the knee we feel for the insertion of the iliotibial tract and follow its anterior border all the way up towards the head of the femur. We work the 2nd outside leg line with the thumbs, pressing the fascial band of the iliotibial tract down and under the femur (Fig. 5.13).

Fig. 5.12 Thumbing the 2nd outside leg line on the lower leg



Fig. 5.13 Thumbing the 2nd outside leg line on the upper leg



3rd outside leg line

The 3rd outside leg line is associated with sen ittha on the left side of the body and with sen pingkhala on the right side. The line begins just above the heel in the centre of the Achilles tendon. As we move up towards the knee, the line deepens as it passes between the two heads of the gastrocnemius muscle and into the soft tissue at the back of the knee. We generally work this line with the leg bent as shown and with our fingers feeling for a deep channel. We use the line to lift and separate the two heads of the gastrocnemius muscle (Fig. 5.14).

To find the 3rd outside leg line above the knee we feel for the lateral hamstring. From there we follow the lateral border of the biceps femoris. This line can be worked either with the heel of the hand or with the thumb. It is usually worked with the patient's leg raised with their foot resting against the massage therapist's belly or hip (Fig. 5.15).

Fig. 5.14 Using both hands to work the 3rd outside leg line on the lower leg



Fig. 5.15 Palming the 3rd outside leg line on the upper leg



1st inside leg line

If necessary, the 1st and 2nd inside leg lines can be worked with the thumbs and the palms in much the same way as the 1st and 2nd outside leg lines. The images that follow show these lines being worked with the leg bent. This is a more efficient method of working.

On the left side of the body the 1st inside leg line is associated with sen ittha and on the right side with sen pingkhala. The line follows the

medial edge of the tibia and passes between the bone and the soleus muscle. We find that the fascial binding associated with this line is often quite tight. We need to be sensitive to avoid hurting our patient (Fig. 5.16).

Fig. 5.16 Thumbing the 1st inside leg line on the lower leg



Above the knee we feel for the little dip at the superior medial corner of the kneecap. From there we follow the medial border of the rectus femoris muscle up towards the groin. We can use this line in conjunction with the 1st outside leg line to lift the rectus femoris muscle away from the femur and, in a long pull, away from the hip joint (Fig. 5.17).

Fig. 5.17 Palming the 1st inside and 1st outside leg lines on the upper leg



2nd inside leg line

The 2nd inside leg line is associated with sen kalathari on both sides of the body. It begins at the ankle on the medial border of the Achilles tendon. As we work the line up towards the knee we find it follows the medial border of the gastrocnemius muscle ([Fig. 5.18](#)).

Fig. 5.18 Thumbing the 2nd inside leg line on the lower leg



Above the knee we feel for the posterior border of the sartorius muscle just above its attachment to the head of the tibia. As we work the line up towards the groin we will find ourselves following the posterior border of the gracilis muscle. This line is best worked with the palms and in conjunction with either the 1st or 2nd outside leg lines, as shown ([Fig. 5.19](#)).

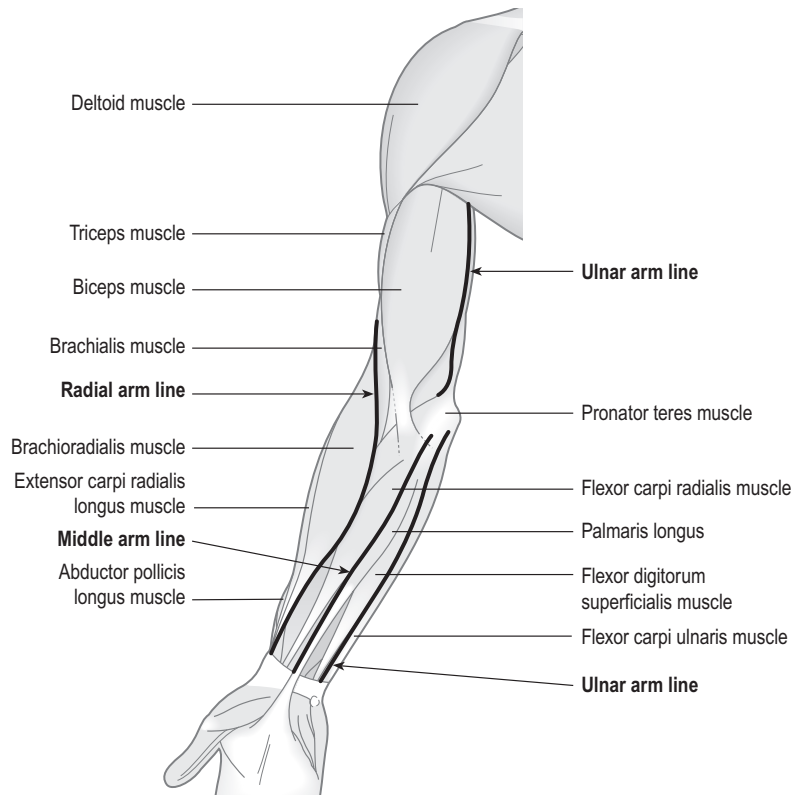
Fig. 5.19 Palming the 2nd inside leg line on the upper leg



Arm lines

Most Thai Massage books describe only one arm line. Here we will refer to it as the middle arm line. Using the myofascial approach it is possible to find three more working lines (Figs 5.20 and 5.21). These offer us an excellent way to work with the muscles of the forearm. This is an area where many people accumulate tensions and yet it often receives scant attention during a massage.

Fig. 5.20 Anterior view of the arm showing the path of the radial arm line, middle arm line and ulnar arm line

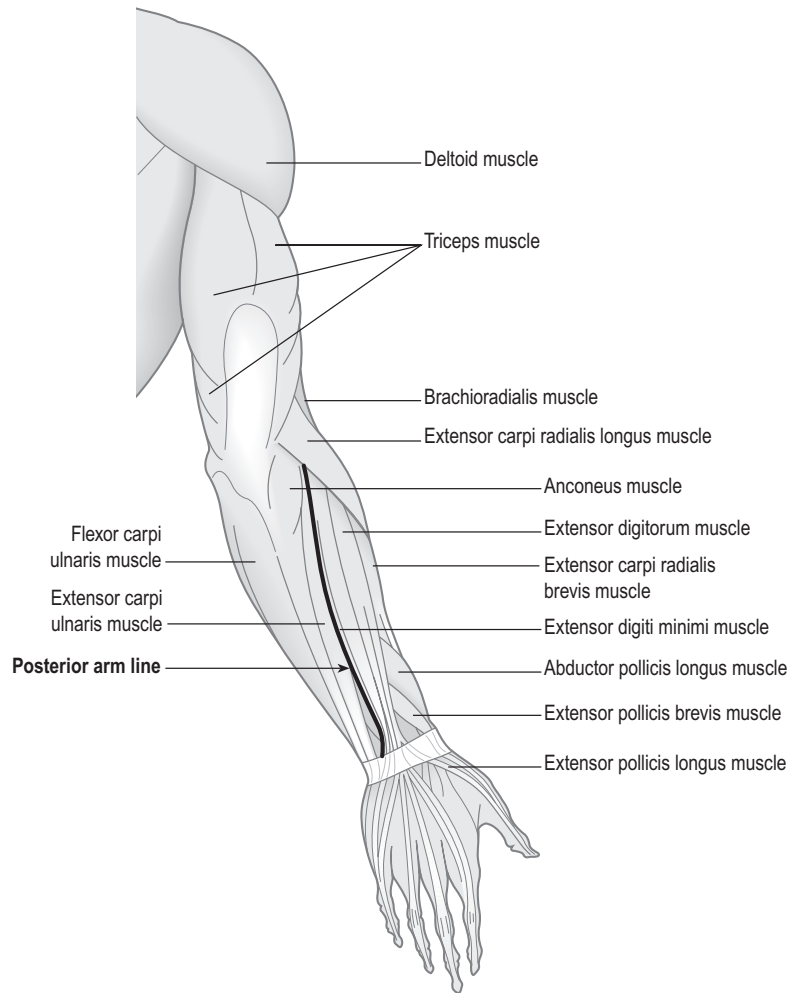


TIP

Great caution should be taken with patients suffering from any form of repetitive strain injury (RSI). If there is any suspicion of inflammation in the nerves or tendons, massage to this area should be avoided and the patient would be well advised to seek medical attention.

The easiest way to get a sense of the arm lines is to feel for them on our own body. We can explore the movement necessary to find

Fig. 5.21 Posterior view of the arm showing the path of the posterior arm line



softness and mobility in the muscles. We will find that we can use the lines to bend the muscles across the bones. This is a very useful self-massage habit for bodyworkers to develop.

Traditional Chinese Medicine identifies six channels on the hands and arms. These relate to the heart and small intestines, the lungs and the colon and to two functional systems called 'heart protector' and 'three heater'. Heart protector includes the pleural membranes surrounding the heart and lungs while three heater is probably related to the transverse diaphragms and their involvement in the distribution of heat in the three main sections of the torso.

In general terms it helps to imagine the arm lines connecting through myofascial continuities to the structures above and below the respiratory diaphragm. It is quite usual to hear movement in the large and the small intestines as we soften the muscles of the forearm.

Middle arm line

The radial arm line is associated with sen sahatsarangsi on the left side of the body and with sen thawari on the right. It begins at the wrist, between the tendons of palmaris longus and flexor carpi radialis. Rarely, we come across someone with only one of the tendons. In this case we aim for the centre of the wrist as if the other tendon were there. The middle arm line travels superior to the wrist between the palmaris longus muscle and the flexor carpi radialis muscle to the elbow crease (Fig. 5.22).

Fig. 5.22 Thumbing the middle arm line on the lower arm



Ulnar arm line

The ulnar arm line is associated with sen ittha on the left side of the body and with sen pingkhala on the right side. It starts medial to the flexor carpi ulnaris tendon at the crease of the wrist. It follows the myofascial pathway between the flexor carpi ulnaris muscle and the flexor digitorum superficialis muscle. We use the line to bend the flexor digitorum superficialis muscle over the top of the bones of the forearm (Fig. 5.23).

Radial arm line

The radial arm line is associated with sen sahatsarangsi on the left side of the body and with sen thawari of the right. It starts at the crease

Fig. 5.23 Thumbing the ulnar arm line on the lower arm



of the wrist on the medial border of the tendon of the brachioradialis muscle and continues up the medial border of the muscle to the elbow crease. When we manipulate this line we move our thumb medially to find the soft myofascial channel between the brachioradialis muscle and the flexor carpi radialis muscle ([Fig. 5.24](#)).

Fig. 5.24 Thumbing the radial arm line on the lower arm



Posterior arm line

The posterior arm line is associated with sen kalathari on both sides of the body. It is the only line we work on the back of the arm. The line starts at the centre of the wrist crease, between the heads of the ulna and radius bones. As we work up towards the elbow we will find ourselves following the border of the extensor digitorum muscle. As with all the arm lines we have to search for the movement of the muscles in order to find depth without pressing against the bone ([Fig. 5.25](#)).

Fig. 5.25 Thumbing the posterior arm line on the lower arm



The only arm line we work above the elbow is the ulnar arm line, which follows the medial border of the biceps brachii muscle. We use our palm to c-bend the muscle across the top of the bone ([Fig. 5.26](#)).

Fig. 5.26 Using the palm to bend the biceps brachii muscle



Back lines

In common with all the lines used in Thai Massage there are differences in opinion as to where the back lines run. These lines are often equated with the bladder meridians used in acupuncture. Because the arrangement of muscles on the back is so complex and multi-layered it is difficult to say exactly which muscles these lines relate to. That said, however, the lines are easy to find and to use.

Medial back lines

We find two medial back lines, one on either side of the spinal column. The line to the left is associated with sen ittha and the one to the right with sen pingkhala. To locate these lines we allow our thumbs to feel for the spinous processes of the vertebrae and then let them fall off into the two channels either side of the spine (Fig. 5.27).

Fig. 5.27 Using the thumbs on the inside back lines to lift the erector spinae muscle at each vertebra



We can follow these channels with our thumbs from the pelvis to the seventh cervical vertebra, although in practice we usually stop at the lower edge of the scapulae. In general we are following the medial borders of the erector spinae muscle.

Lateral back lines

This second pair of back lines is associated with sen kalathari. We find these lines by moving our thumbs laterally from the medial back lines. We feel our thumbs rise up over a ridge of muscle and fall down into the channel on the other side. In general these lines follow the lateral borders of the erector spinae muscle from the pelvis to the shoulders (Fig. 5.28).

Fig. 5.28 Using the palms on the outside back lines to put a torsion through the erector spinae muscle at each vertebra



We work these lines by walking our palms up the muscle ridge from the pelvis to the lower edge of the scapulae. We aim to exchange the pressure slowly from hand to hand, creating a slight torsion around each vertebra as we go. Once we reach the scapulae we let our thumbs find the medial back lines either side of the spine and move down the spine vertebra by vertebra until we reach the pelvis. At each vertebra we aim to engage the fascia and muscle and push upwards towards the patient's head. It is not unusual to feel or hear a click of release at a vertebra with these movements. We can pretend that we meant it to happen but we should not get hooked into making it happen. Some people click easily and some do not. It is not so important.

We can also work the lateral back lines while kneeling to the side of our patient. In this case we use the heel of our hand against the lateral back line in order to c-bend the erector spinae muscle towards the spinal column. Our other hand rests on the pelvis ([Fig. 5.29](#)).

Fig. 5.29 Using the outside back lines to introduce a c-bend into the erector spinae muscle



When we have worked the lateral back lines on both sides of the spinal column we can take a moment to rest, with one hand across the thoracic spine and the other on the pelvis. We might have a sense of the connection with *sen sumana* (Fig. 5.30).

Fig. 5.30 Resting for a moment with the hands on the sacrum and the thoracic spine



Face lines

On the head we find two pairs of lines that are a continuation of the lines on the back. The medial pair starts at the medial corners of the eyebrows and runs parallel up into the hairline. The lateral pair starts at the centre of the eyebrows and runs parallel up into the hairline. We use these lines to engage with and mobilise the scalp (Fig. 5.31).

Fig. 5.31 Using the face lines to mobilise the forehead



The other face lines again vary according to the teacher and practitioner. I tend to keep the face work quite minimal. This will be covered in Chapter 8.

Working the myofascial sen

There are various ways to work the sen. Usually we use our thumbs or palms. Occasionally we use our knees, elbows or the soles of our feet. Whichever tool we use, the most important thing is that we work with sensitivity. We want to feel what is happening. We want our patient to know that they are being felt. When they feel this they can relax, letting go of the fear that we might hurt or break them.

When we work a line with our thumbs we lean into it with our bodyweight. The effort does not come from our thumbs. If it did we would soon wear out the joints. We lean our bodyweight through our arms and transfer it to our patient via our thumbs. Our arms are relatively straight but they are not locked at the elbows. Our thumbs are relatively straight but they too are not locked. Our shoulders are relaxed. This means we need to take some distance from our patient. It is tempting to get close to the patient so that we can see what we are doing. This is not necessary. We need to feel what we are doing, not see it. Once we can trust our feeling, we can keep our body away from our patient and use our hands and arms in an open and relaxed way. Our patient will feel the spacious quality of our contact.

As we lean into a line we feel for the softening of the tissue. We lean deeper and connect with the elasticity of the fascia. We feel for the movement in the fascia. It may draw our hands up towards our patient's head or down towards their feet. We keep on leaning in and following the natural movement until we meet resistance. We then allow the elasticity of our patient's body to push our thumbs back out the same way they came in. This is the basic movement but it is never the same. As we work the same line we should feel changes in the tissues with each pass we make. We may find ourselves working a little deeper with each pass. We may even feel the elastic pull of the fascia change direction as we work.

In Thai Massage, rhythm is very important. That rhythm is a combination of our action and the response of the patient's tissues to our action. The rhythm arises in the moment and helps the muscle to soften. Muscle tissue consists of cells and fibres organised in a connective tissue web suspended in fluid. This organisation of solid matter suspended, but not dissolved, in fluid is called a colloid. Béchamel sauce is a colloid. Modelling clay is a colloid. Wet sand at the sea's edge is a colloid.

In each case the colloid will behave differently depending on the quality of the contact and rhythm we bring to it. If we want a smooth béchamel sauce we must stir it smoothly as it cooks. If we try to beat it, it will become rigid and resistant. The same goes for the wet sand. We can slowly slide our hands deep into wet sand but if we jab at it with our fingers it will become hard. The same goes for modelling clay. We have to coax it, not force it into the shape we want.

And so it is with muscle. If we want muscle to soften we must bring softness in our contact and find the rhythm that the muscle likes. When we work in this way we will feel the muscle change from a more viscid to a more liquid state. The muscle is expressing a quality common to colloids and called thixotrophy. It is changing its quality in response to the heat of our contact and the rhythm of our movement, just like the béchamel sauce. The resulting softening of the ground substance improves the flow of nutrients to the cells and waste from the cells to the lymphatic system ([Oschman 2000](#)).

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Meditation in movement

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Introduction

Conscience calls me to be myself.

To be myself begins with self-knowledge.

Self-knowledge begins with work on myself.

Work on myself is based on the sensation of myself. (Vaysse 1978)

Vipassana meditation is a practice associated with the Theravada branch of Buddhism found in Thailand, Burma, Sri Lanka, Cambodia and Laos. In the West its best-known teacher is SN Goenka. He translates vipassana as 'seeing things as they really are'. According to Goenka, although the Buddha taught vipassana as a way of living, it was rediscovered rather than invented by him.

The aim of vipassana is the development of a balanced mind full of love and compassion – freed from self-delusion and internally generated suffering. Such a mind would be capable of supporting the four divine states described by the Buddha and aspired to by followers of his teaching.

The Buddha called these divine states metta, karuna, mudita and upekkha. These Pali words are usually translated as: loving kindness, compassion, altruistic joy and equanimity. Thai Massage is traditionally offered with the aim of manifesting these divine states in action.

A modern therapeutic equivalent is, perhaps, 'unconditional positive regard', a term forever identified with Carl Rogers, even if coined by Stanley Standal (Rogers 1992, p. 283). Rogers, a significant figure in the development of 'client-centred' psychotherapy, describes unconditional positive regard as 'an outgoing positive feeling, without reservations, without evaluations'. According to Rogers, research shows that the more a therapist is able to experience this state in relation to the client, the more successful is the therapy likely to be for the client (Rogers 1992, p. 62).

If unconditional positive regard is the aim, vipassana is the process. As a meditation practice it is best learned in a dedicated retreat or monastery and under the guidance of a suitably trained teacher. In the Buddhist tradition, the starting point in the training of a teacher (lama) is total retreat from the world for three years, three months and three days.

As a way of living, however, vipassana is of great value in therapeutic practice. In common with many meditation practices, vipassana begins with the effort of drawing the mind more deeply into relationship with the body. We find this aim not only in sitting meditation but also in the practice of yoga, tai chi, qigong and many martial arts. This understanding is not limited to the East. It is well recognised in the meditative traditions of Christianity. Father Thomas Keating, a Cistercian Monk and advocate of 'centring prayer', suggests that:

... a movement toward our own center is really a movement toward everybody's center, which is the oneness of the ultimate unifying source of all creation. In other words, individuals are bound together by a unifying force which is present but not normally perceived, given the human condition, without the discipline of a practice that penetrates the mystery of ordinary time. (Keating 1990)

Our body is always in the present while our mind tends to wander, flitting from thoughts of the past to projections into the future. If we can draw our attention away from the passage of thoughts into the sensation of our body we will be more present. In the therapeutic relationship our patient will not only perceive this but will benefit from it too.

In his book *Focusing*, Eugene Gendlin discusses the significance of sensation in relation to the practice of psychotherapy. In the 1970s Gendlin and colleagues at the University of Chicago conducted research into the effectiveness of psychotherapy in making a positive difference in the patient's life. They were surprised to discover that they could predict therapeutic outcome by observing the way in which patients organised and related to their experience. The patients who gained most benefit from the therapeutic encounter did something internal that less successful patients did not (Gendlin 1981).

Gendlin went on to demonstrate that this ‘something internal’ could be taught. He calls the process ‘focusing’ and describes the stages involved in his book. The process of focusing is designed to help the patient align an unresolved memory or thought with a ‘felt sense’ in the body. Gendlin discovered that, when a patient achieved this alignment, the thought or memory resolved.

Significant though focusing is, it is a process guided by the words of the therapist and a process that the patient, not the therapist, does. In Thai Massage, where touch is the main form of communication, the massage therapist aims to work with what SN Goenka calls ‘noble silence – that is, silence of body, speech and mind.’ Another form of communication takes place in this silence – perhaps the direct communication between the unconscious of the patient and the unconscious of the therapist that psychoanalysts refer to (Laplanche & Pontalis 1988). Many massage therapists and bodyworkers have come to appreciate that their work is most effective when they enter into an altered state in which their attention is softer and more receptive. The key to finding that state is sensation.

In the practice of Thai Massage it is clear that the more the massage therapist is able to work in this altered state the more the patient relaxes. It is as if the massage therapist models the outcome of the massage. This concept is not however limited to Thai Massage. Practitioners of other bodywork modalities have discovered it too. Dr Milton Trager, founder of the ‘Trager Approach’ to bodywork, referred to ‘Hookup’, which is described as ‘a sense of calm and clear connectedness with one’s body, one’s feelings, and the forces that sustain them.’ Trager insisted that the practitioner must work on developing this state of consciousness in order to stimulate it in someone else (Juhan 2003).

Hugh Milne, an osteopath, talks of ‘glamour’ and says ‘In a glamour, consciousness can work from the crown soul – from a place of complete acceptance, of unconditional love. There is a subtle merging of boundaries between you and the client’ (Milne 1995).

Fritz Smith, the founder of ‘Zero Balancing’ refers to a ‘witness state of observation’ in which the practitioner is ‘uncritical, non-judgemental, expectation-free and uninvolved with an active thought process’ (Smith 1998).

Practising Thai Massage is not an alternative to vipassana training but it is a good place to practise vipassana. As Goenka says, vipassana is intended as a way of living. As massage therapists we can practise working with more sense of our own body in relation to our patient. As massage therapists we should aim to know exactly what it is we intend to do so that we move with certainty and grace. As we work we can accept that we will be distracted by our own thoughts – perhaps our attitude or opinions about our patient, perhaps the ordinary things we forgot to do. This is inevitable, but we can always return to the present, by turning to the sense of our body in movement and our sense of contact with our patient.

We are using our body to work with our patient's body. When we make contact, whether with our hands or elbows or feet or knees the contact should be clear, sensitive and aware. Our patient is reading us throughout the massage. They are deeply aware of where we touch and, more to the point, from where we touch. It is a relationship of trust and our patients will not trust us if they are aware of our hesitations, clumsiness or incongruence. As we communicate our clarity and certainty to our patients they give their body to us and give up their habitual tensions.

For a massage therapist it is a wonderful aim to work towards a sense of selflessness and to search for the qualities in our work through which every patient feels utterly cared for, accepted and loved. We can communicate these qualities through our touch and our presence. We may by moments ourselves feel touched by 'metta' and realise that metta is not something we can do. It is a sensation that can flow through us but only if we relax.

The Metta Sutta

Buddha and his followers took shelter at Savatthi in Jeta's Grove during the rainy season. The tree deities were upset by the presence of the monks. When they discovered that the monks intended to stay for three months they set about trying to frighten them away. The monks were suitably scared and went to Buddha to tell him of their unease. He taught them the Metta Sutta. When the monks practised according to the Buddha's instruction the tree deities were so touched by the power of love they radiated that they decided to leave them to meditate in peace.

This is the Metta Sutta in the original Pali with a translation into English by Acharya Buddharakkhita, founder and president of the Maha Bodhi Society in Bangalore, India.

The Karaniya Metta Sutta

The Hymn of Universal Love

1

Karaniyam atthakusalena
Yan tam santam padam abhisamecca
Sakko uju ca suju ca
Suvaco c'assa mudu anatimani

Who seeks to promote his welfare,
Having glimpsed the state of perfect peace,
Should be able, honest and upright,
Gentle in speech, meek and not proud.

Continues

2

Santussako ca subharo ca
 Appakicco ca sallahukavutti
 Santindriyo ca nipako ca
 Appagabbho kulesu ananugiddho

Contented, he ought to be easy to support,
 Not over-busy, and simple in living.
 Tranquil his senses, let him be prudent,
 And not brazen, nor fawning on families.

3

Na ca khuddam samacare kinci
 Yena viññu pare upavadeyyum
 Sukhino va khemino hontu
 Sabbe satta bhavantu sukhitatta

Also, he must refrain from any action
 That gives the wise reason to reprove him.
 (Then let him cultivate the thought:)
 May all be well and secure,
 May all beings be happy!

4

Ye keci panabhut'atthi
 Tasa va thavara va anavasesa
 Digha va ye mahanta va
 Majjhima rassakanukathula

Whatever living creatures there be,
 Without exception, weak or strong,
 Long, huge or middle-sized,
 Or short, minute or bulky,

5

Dittha va yeva adittha
 Ye ca dure vasanti avidure
 Bhuta va sambhavesi va
 Sabbe satta bhavantu sukhitatta

Whether visible or invisible,
 And those living far or near,
 The born and those seeking birth,
 May all beings be happy!

6

Na paro param nikubbetha
 Natimaññetha katthacinam kanci
 Byarosana patighasañña
 Naññamaññassa dukkham iccheyya

Let none deceive or decry
 His fellow anywhere;
 Let none wish others harm
 In resentment or in hate.

7

Mata yatha niyam puttam
 Ayusa ekaputtam anurakkhe
 Evampi sabbabhutesu
 Manasam bhavaye aparimanam

Just as with her own life
 A mother shields from hurt
 Her own son, her only child,
 Let all-embracing thoughts
 For all beings be yours.

Continues

8

Mettañ ca sabba-lokasmim
 Manasam bhavaye aparimanam
 Uddham adho ca tiriyanca
 Asambadham averam asapattam

Cultivate an all-embracing mind of love
 For all throughout the universe,
 In all its height, depth and breadth –
 Love that is untroubled
 And beyond hatred or enmity.

9

Titthañ caram nisinno va
 Sayano va yavat'assa vigatamiddho
 Etam satim adhittheyya
 Brahman etam viharam idhamahu

As you stand, walk, sit or lie,
 So long as you are awake,
 Pursue this awareness with your might:
 It is deemed the Divine State here.

10

Ditthiñca anupagamma silava
 Dassanena sampanno
 Kamesu vineyya gedham
 Na hi jatu gabbhaseyyam punar eti'ti

Holding no more to wrong beliefs,
 With virtue and vision of the ultimate,
 And having overcome all sensual desire,
 Never in a womb is one born again.

<http://www.accesstosight.org/lib/authors/buddharakkhita/wheel365.html>

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Resources

For information on Vipassana Meditation as taught by S N Goenka: <http://www.dhamma.org/>.

Working with health

Of the 72000 sen permeating the human body, three are considered especially important. They are sen sumana, sen ittha and sen pingkhala. In yoga and Ayur-vedic medicine they are called sushumna-nadi, ida-nadi and pingala-nadi. Tibetan Medicine, which derives from Ayur-veda, identifies three similar channels and calls them tsa-uma, tsa-kyangma and tsa-roma. In Traditional Chinese Medicine they are thought to be the governing vessel, which runs the length of the back of the body, and the two bladder channels either side of it ([Motoyama 2003](#), pp. 136–137).

Despite some similarities there is little agreement across these systems as to where exactly these channels run and what their purpose is. In yoga, Ayur-veda and Tibetan Medicine the two outer channels are described as weaving a double helix around the central channel while in Thai Massage and Traditional Chinese Medicine the outer lines run parallel to the central channel.

The only channel that really does seem to be the same in each tradition is the central channel, although even here there is uncertainty as to whether this is a superficial line on the back of the body or, in some way, related to the spine or the spinal cord. Recent developments in osteopathic theory offer an interesting new view and, possibly, even an anatomical location for this central channel.

In 1899 William Garner Sutherland was studying osteopathy at the school of its founder Andrew Taylor Still. Sutherland was struck by the thought that perhaps the cranial bones did not fuse, as was generally believed, but remained forever mobile at the sutures. From then until the late 1920s he proved this to be so through experiments on his own

head and developed a system for the application of osteopathic technique to the cranial bones.

In the early 1930s Sutherland turned his attention from the cranial bones to the dural membranes within the skull. He perceived a continuity of the membranes from where within the skull they contain and support the brain, down to the sacrum as the dural sheath surrounding and protecting the spinal cord. He described this membrane envelope as 'tadpole like' and named it the 'core link'.

In the late 1930s Sutherland's attention was drawn to a palpable tidal movement expressed by the cerebrospinal fluid surrounding and supporting the central nervous system within the core link. In order to explain this phenomenon he developed the theory of a 'primary respiratory mechanism'. This theory suggests that the living body expresses inhalation and exhalation as waves of movement throughout its fluids. Primary respiration begins during the development of the fetus, long before the lungs are ready to breathe. Sutherland's theory of a primary respiratory mechanism was ultimately based on five palpable phenomena which, collectively, he called the cranial rhythmic impulse. These phenomena are:

1. The brain and the spinal cord exhibit an inherent movement. In the spinal cord this movement is expressed as a snake-like wave of flexion and extension travelling its length. In the brain this movement combines flexion and extension with a widening and narrowing across the ventricles.
2. Cerebrospinal fluid flows towards the head during the inhalation phase of primary respiration and ebbs towards the sacrum during the exhalation phase.
3. The membranes inside the skull and spinal column move in response to the tide-like ebb and flow of cerebrospinal fluid and the wave-like movement of the central nervous system.
4. The bones of the cranium accommodate and respond to these tidal movements through articulation at their sutures.
5. The sacrum responds to these tides of inhalation and exhalation through an involuntary movement of flexion and extension between the ilia of the pelvis.

Sutherland originally thought that contractions and dilations of the ventricles within the brain were the source of the tidal movement through the cerebrospinal fluid. This in turn generated all the other motions of the cranial rhythmic impulse. However, in 1943 he described the 'breath of life', which he sensed as an external force generating all the movements of cranial rhythmic impulse within the body. Sutherland's choice of term was no accident. As a Christian it was natural for him to acknowledge God's presence as the creative force of nature.

In the last years of his life Sutherland abandoned his classical osteopathic techniques altogether and started to work directly with the healing power of the breath of life expressed throughout the fluids of

the body as an ordering force that he called 'potency' (McPartland & Skinner 2005, p. 24).

After his death in 1957, Sutherland's students Rollin Becker and Robert Fulford continued to develop this approach to osteopathy in the cranial field. James Jealous, another osteopath, augmented the work with Eric Blechschmidt's biodynamic theories of embryological development. Blechschmidt suggests that an external force creates the spatial orientation within which the fluids of the embryo organise. This generates an ordering matrix that governs the further development of the embryo. For Jealous and his colleagues this external force is that same breath of life to which Sutherland referred (McPartland & Skinner 2005, p. 27).

Breath of life is, at its simplest, the Western equivalent of Indian prana, Chinese qi and Tibetan rlung. Of course none of these ancient concepts is quite that simple and neither was Sutherland's. Breath of life came to be described in terms of interweaving rhythms. One of these rhythms is known as the 'tide' or the 'long tide'. Franklyn Sills, a pioneer in the field of craniosacral biodynamics, refers to the long tide as 'an expression of the intention of the breath of life to create a human being'. He says that the long tide can be perceived as 'a direct organising intention within and around the patient' (Sills 2001, p. 418).

Sills describes how, during the development of the embryo, the long tide generates two midlines within the neural tube. One of these is the anterior notochord midline. In the fully developed human body it remains as a force that can be sensed as rising through the centre of the vertebral bodies of the spine. The other midline is the posterior fluid midline. In the fully developed body it is to be found in the central canal of the spinal cord and within the ventricle system of the brain (Sills 2004). This is perhaps the location of *sen sumana*, a thread of cerebrospinal fluid and life force at the very core of our physical body. The long tide that generates this midline remains present throughout the life of the body as potency, expressed in a tidal ebb and flow of 100-second cycles. This is the frequency of the breath of life. This is the health at the core of every living system. The force that creates the organising matrix in which the embryo develops becomes the force of healing that remains present throughout the life of the body.

Another rhythm, referred to as the 'mid-tide' is expressed in 24-second cycles. Sills says that, when the practitioner senses the mid-tide within the patient, '*potency, fluids and tissues* can be clearly perceived to be a unity, or a unit of function' (Sills 2001, p. 38). The mid-tide is the rhythm of the fluid body moved by the potency of the breath of life. This movement is primary respiration. The fluid body is breathing with an inhalation of 12 seconds and an exhalation of 12 seconds.

Some osteopaths describe sensing a force with a cycle even slower than the long tide. This force expresses a 300-second cycle of inhalation and exhalation (McPartland & Skinner 2005, p. 24). These interwoven rhythms are perhaps a modern description of the phenomena described by the yogis and referred to in Chapter 3.

According to the yogis, Brahma-nadi resides within citrini-nadi within vajra-nadi within sushumna-nadi. If sushumna-nadi, or *sen sumana*, is the thread of cerebrospinal fluid in the core of our central nervous system then perhaps vajra-nadi, citrini-nadi and Brahma-nadi are the interweaving rhythms now being described in osteopathy and craniosacral therapy. If this is so, then it is no surprise that anatomically they make little sense. Their value emerges only with the appreciation that the practitioner, whether of yoga, of meditation, of craniosacral work, of massage and probably of life in general must work to develop the openness and subtle sensitivity necessary to perceive these rhythms. Perhaps it is for this reason that all traditional meditation practices begin with sensation and relaxation of the body.

During the 1950s, Lizelle Reymond spent four years in North India studying Samkhya Yoga with Sri Anirvan, a Baul Master. She says, 'All spiritual experiences are sensations in the body. They are simply a graded series of sensations, beginning with the solidity of a clod of earth and passing gradually, in full consciousness, through liquidness and the emanation of heat to that of a total vibration before reaching the Void. The road to be travelled is long' (Reymond 1995).

Unlike many other approaches to massage and bodywork the claims and aims of Thai Massage are few. In the absence of a system of diagnosis on which to base a treatment plan the massage therapist is free to focus on relationship, rhythm and relaxation. The process is mutual. The massage therapist and the patient together sink into silence and sensation. In that quietness, slower rhythms often emerge. It might be the slow inhalation and exhalation of primary respiration and the sense of inherent health within it. It might be the long tide and the sense of universal love or compassion it carries. It might the 300-second cycle called by the yogis Brahma-nadi or the breath of god.

When I first set up the Thai Massage module for the University of Westminster in London I had to address the academic realities of assessment protocols. After some struggle I came up with a series of measures for assessing the practical aspects of the massage. These included rhythm, attention, continuity and the safety and comfort of the massage therapist and the patient.

At the highest level, the massage therapist was assessed as capable of meeting all requirements but with the addition of a 'palpable sense of magic in the air'. We all of us knew what that meant and to the great credit of the staff at the University that phrase became the measure of the masterly practitioner of Thai Massage.

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A one-and-a-half-hour routine

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Introduction

Thai Massage includes a vast repertoire of moves. If all were used the massage could go on for more than three hours. In the context of a modern massage practice even a two-hour massage is impractical. For me, both as a giver and as a receiver of massage one and a half hours is ideal. It is not too long and it is not too rushed. The following routine can be completed in just under an hour and a half and offers a complete massage from the toes to the top of the head. The routine is designed for efficiency. In massage terms this means maximum relaxation for the patient with minimum effort from the massage therapist.

This sequence has been refined and tested over many years of teaching and clinical practice. It is suitable for the average patient and avoids many of the more demanding techniques often associated with Thai Massage. These are discussed separately in the following chapter.

Before we begin

As massage therapists we can offer something quite unique in our patient's life. We can offer a quality of touch and attention that they are unlikely to experience anywhere else. We can offer them the time and space in which to completely let go. This is a rare and special opportunity in anybody's life. To achieve this aim we need to establish and maintain a relationship of total trust.

If it is not already clear we need to confirm exactly what our patient will pay and exactly how long the massage will last. In this way we immediately free our patient from two common sources of worry – time and money. It helps to briefly explain the process of the massage. We can tell them that we will start at their feet, work their legs, then their hands and arms and on up to the shoulders and back finishing at their neck and head. We can tell them that there is nothing for them to do except let go and relax.

We can offer our patient a glass of water and the use of the bathroom before we begin. We can also tell them to say if they need to go to the bathroom during the massage. Thai Massage moves a lot of fluid through the body and there is nothing less relaxing for a patient than a full bladder.

We ask our patient to lie face up on the mat. We sit cross-legged at their feet. We tell them that they do not need to talk. We tell them that it's better if they close their eyes and that it's fine if they dream or fall asleep. We suggest that if anything important comes to mind that they need to share to let us know. We ask them to let us know if they experience any discomfort.

Begin with the end in mind

The last position of a Thai Massage is the yoga posture known as the 'corpse pose' or 'shavasana'. In this posture we lie on our back with our arms open at 45° to our body, palms facing up. Our legs are apart and our hips and buttocks relaxed so that our feet fall naturally outwards. One of my yoga teachers insisted that 'shavasana' was the most difficult yoga posture. I used to think he was joking. Now when I see the difference in my patient's body before and after the massage I understand what he means ([Figs 8.1 and 8.2](#)).

We do not need to organise our patient's body to begin with. We just observe how they naturally lie. We observe the relationship of their

Fig. 8.1 Patient before the massage



Fig. 8.2 Patient in the corpse pose at the end of the massage



ankles, their knees, their hips, and their shoulders. We look to see if the legs turn out equally, if their hips rest evenly on the floor. We look to see how their head lies in relation to their shoulders. We do not need to comment on any of this. This is simply curiosity. We are gathering information for the development of our craft. As we work we will aim to keep active this soft and curious observation of our patient. We will also listen for changes in their breathing and for any belly gurgles that give a hint to their relaxation. Sometimes we will be touched by waves of emotions. Again there is no need to comment on this. We are learning to appreciate how our patient's body changes as we work.

Before we start the actual massage we prepare ourselves. We have a long conversation ahead. We need to know that when we start it is with confidence. We briefly turn our attention to the sensation of our own body. This sensation of our body brings us into the present. We might daydream from time to time as we work but we can always return to the sensation of our body – to the present. The more we can feel our own body as we work the more we can relax. The more we can relax as we work the more congruent becomes our communication. We invite relaxation in our patient by modelling it in ourselves.

Working the feet

Our patient's feet tell us everything about the way they organise the rest of their body. The shape and flexibility of the feet reflect the tone of the muscles of the lower leg. The tendons of those muscles extend down around the ankles to create the pulls and tensions that give the feet their arches. If the feet are rigid the muscles of the lower leg must be rigid too. This rigidity is bound to continue on up through the upper legs into the back. If we can soften the tissues and articulations of the feet our work is bound to have an effect throughout the rest of the body.

The Thais suggest five lines on the underside of the foot. We can think of these as the five toes extending as metatarsals deep inside the flesh of the foot. We can think of the plantar fascia on the underside of the foot and of the deeper tendons within (Fig. 8.3).

We gently wrap our palms around the top of our patient's feet. This is the first contact. Our touch is open and receptive. We let our patient's body come to us. We wait for a moment, listening to their feet, listening to their body through their feet. We allow ourselves the sense of continuity from the feet, through the legs to the hips and on up to the diaphragm. We position the feet so they are in line with the ankles; so that the ankles are in line with the knees; so that the knees are in line with the hips. We let our patient's heels rest like fulcra on the floor. We use the long metatarsal bones of the feet as levers. We lean our body weight slowly down through the front of our patient's feet. We watch and feel as the lengthening extends all the way through the front of the legs to the hips (Fig. 8.4).

Fig. 8.3 Five lines on the sole of the foot



Fig. 8.4 Using the feet to lengthen through the front of the legs



Fig. 8.5 Using the feet to lengthen through the back of the legs



Now we wrap our hands around the underside of our patient's feet so they rest against the balls of their toes. We lean our bodyweight slowly into the underside of the feet. We feel the way in which this long stretch continues all the way up the back of our patient's legs to their hips and beyond into the lower back (Fig. 8.5).

TIP

We take care to avoid overextending our patient's toes. The stretch is through the plantar fascia and the back of the legs, not through the toe joints.

We repeat these movements a couple of times. Each time we try to gain more sense of the continuity through our patient's legs. We let our hands feel for the response in our patient's tissues.

TIP

We are inviting and following softening and lengthening not forcing a stretch.

Fig. 8.6 Working the plantar fascia on the sole of the foot



We bring our patient's feet to rest. We suggest a slight turning out through the hips. We take a moment to see if these first movements have made any difference to the shape of our patient's legs.

We now prepare to work on one foot. The rule is to move to his right side first when working with a man and to her left side first when working with a woman. This rule is based on the relationship of sen ittha and sen pingkhala to the central channel sen sumana. Sen pingkhala on the right of sen sumana is associated with the sun's energy and with the masculine quality. Sen ittha on the left side of the sen sumana is associated with the moon's energy and with the feminine quality.

We move both hands to the active foot. We let our thumbs rest on the upper surface of the foot. The upper surface is bony and with little flesh. We do not press hard against it. We use our fingers to work the underside of the foot, softening the plantar fascia and moving all the little joints between the toe bones (Fig. 8.6).

We move our attention to our patient's toes. With our fingers and thumb we contact the little toe where it begins deep inside the foot. The pressure comes from the fingers underneath the foot. The thumb floats on the bony upper surface. We slowly draw away from the foot towards the end of the toe. We adjust our pressure as we move over the joints and gently bring the movement to a close. The aim is to ease a little space into each of the toe joints as we go.

TIP

As we work the toes we keep our distance from our patient and keep our arms long with the elbow and wrist joints relatively open. In this way we can better relax our arms as we work. Our strength comes from the long muscles of our arms not from the little muscles of our fingers and thumbs.

Fig. 8.7 Lengthening the toes



We now move in between the little toe and the next. With the same contact as before we ease through the tissues, pushing the toe bones apart within the foot. We close gently, squeezing through the webbing between the toes. We continue this sequence; toe-by-toe, webbing-by-webbing, changing our working hand as needs be until we finish with the big toe. Our other hand can assist by mobilising our patient's foot to smooth the journey of our working hand (Fig. 8.7).

TIP

Some massage therapists finish each movement by flicking their hand as if shaking off something nasty. This is best avoided. It sends quite a negative message to our patient.

Some Thai massage therapists forcibly crack the toes. Again, this is best avoided. It can be dangerous and it keeps our patient 'on their toes'. We want our patient to relax and trust that we will take good care of them. If we start giving shocks at this point they will never fully let go.

Now that the plantar fascia is softened and the foot bones have been mobilised we slide one hand under the heel of the foot. We use the other hand to grasp the long levers of the metatarsal bones from above. We slowly push the heel up towards the hips while using the toe levers to encourage a lengthening throughout the front of the leg to the hip (Fig. 8.8).

Fig. 8.8 Lengthening through the front of the leg



We reverse the movement to lengthen the back of our patient's leg. As we bring the foot back to the floor we suggest a slight external rotation at the hip ([Fig. 8.9](#)).

Fig. 8.9 Lengthening through the back of the leg



Fig. 8.10 Preparing to work on the legs



We return to the centre, lightly holding both of our patient's feet. We look to see if the work on the foot has made any difference to the shape and position of our patient's leg and pelvis. We take a few seconds to prepare before repeating the entire sequence with the other foot.

When we have finished working both feet we keep contact and take a rest. These rests are well worth savouring. They offer us a moment to:

- check on our own state to make sure that we are still in contact with our own body and not working too hard;
- observe any difference our piece of work has made to the general state of our patient – to their shape, posture, breathing and dreambody;
- prepare ourselves for where we are going next so that we move with certainty and grace;
- renew our sense of listening to our patient's body (Fig. 8.10).

TIP

After receiving feedback from hundreds of students I know that these moments of rest between our activities are often the most profound for our patient. It is as if the patient's body takes a moment to organise the effect of the work – something it cannot do if we keep on working without a break. Very often we will feel our patient slip deeper into their dreambody.

Working the legs

A colleague studied with Pichet Boonthume, a well-known massage master in Thailand. He insisted that the most important part of the

massage was the work on the legs. He told his students to work the legs until they became like jelly.

Some Thai Massage practitioners move from leg to leg as they work the leg lines. In this sequence we work one leg at a time completing all the sen work before moving to the other leg. The reasons for this are:

- we are aiming for maximum relaxation with minimum effort. Working in this way means that the massage therapist does not have to move around so much;
- if we minimise our movements we become less visible to our patient. If our patient is less occupied with our activity their attention turns inwards towards their own inner life;
- when we have finished working one leg in its entirety it should look and feel markedly different to the other. This offers an extraordinary piece of information to the patient's system as well as a sense of satisfaction and completion for the massage therapist.

As with the feet, the rule is to start with the right leg of a man and the left leg of a woman. Without breaking contact we move to the side of our patient and position ourselves at the mid-point of their lower leg.

TIP

It is best to rest on one knee at arm's length from our patient. This allows us to work with long, relaxed arms and open joints. The strength comes from the movement of our body and not from the effort of our arms.

Starting at the patient's heel we feel for the beginning of the 2nd outside leg line. Using both thumbs side by side we lean our body-weight into the myofascial channel. We feel for the softening of the tissues that lets our thumbs sink deeper. We feel for the movement of the fascia and follow that movement as we sink deeper (Fig. 8.11).

Fig. 8.11 Working the 2nd outside leg line



TIP

The fascia may draw us up towards our patient's head or down towards their feet. We follow the movement that is there. Our technique is only half the story. The other half comes from our patient's body as it shows us how to do the technique.

We continue working up the 2nd outside leg line towards the knee. When the tissue becomes bony we change direction and work down the line again towards the ankle. In the course of a massage it is sufficient to work the line four times with the thumbs returning to their starting position at the heel. Each pass aims for a little more depth in the channel and a little more softness in the tissues.

We now move to the 1st outside leg line. We feel for the outer edge of the shinbone just above the ankle. We let our thumbs rest on the bone and then drop off, drawing the tissue into the myofascial channel beside the bone. As before, we move up the leg towards the knee. Each time we sink into the channel we feel for the softening of the tissue and the natural movement of the fascia. We let our thumbs follow this movement into its preferred direction. We release our pressure slowly, leaving the body in the same way in which we entered ([Fig. 8.12](#)).

When the channel becomes bony near the knee we change direction and work back down towards the ankle. We work the line five times so that our final pass takes us to the knee. We rest for a moment and prepare to move to the upper leg.

Resting one hand on our patient's leg we move position so that we sit mid-way along our patient's thigh. We feel for the route of the 1st

Fig. 8.12 Working the 1st outside leg line



outside leg line on the upper leg. We begin by feeling for the little dip at the superior lateral border of the patella. We then feel for the anterior superior iliac spine (ASIS) of the pelvis. The line is not where we would like it to be so we must keep these two landmarks in mind and visualise the line between them. It is best to start with palming.

One hand stabilises the patient's leg below the knee while the other hand works the line. We place the heel of our hand over the visualised line. We need to direct our pressure horizontally across the top of the femur. We can only do this successfully with a great deal of attention in our working hand. We want to use the contact with the line to introduce a c-bend into the rectus femoris muscle.

TIP

We are not pushing into the muscle. We are lengthening and softening the muscle by bending it, as if bending a green twig ([Fig. 8.13](#)).

Fig. 8.13 Palming the 1st outside leg line on the upper leg



Fig. 8.14 Thumbing the 1st outside leg line on the upper leg



As we bend the muscle we feel for its response. At the point where the tissue hardens and resists we let it push us out. We are feeling for the elasticity in the fascial fibres. Sometimes we achieve only a millimetre or two of movement but that is enough. Every body is different.

Once we have a sense of where the line runs we continue to work it with our thumbs side by side. At each position we use the line to introduce a bend in the muscle. At the point of resistance we allow the muscle to push us back out. In this way a rhythm develops – the rhythm of our technique responding to the movement of the muscle. We work the line in four passes, finishing back at our patient's knee (Fig. 8.14).

We now turn our attention to the 2nd outside leg line. We feel with our thumbs for the anterior edge of the iliotibial band. We press downwards, bending the fascia as if we could roll it under the femur. As before, we follow the movement until we feel resistance and then we allow the elasticity in the tissues to push us out. We continue along this line until the tissue hardens around the hip. We then reverse direction back down towards the knee. We work this line four times, finishing at the knee (Fig. 8.15).

Now, while still at the side of our patient's body we lift their leg, bringing the knee up and the foot to the floor so that there is a 90° angle at the knee.

TIP

This angle is important. At 90° the leg is stable and the muscles are at their most relaxed. If the angle is less than 90° the muscles are compressed. If it is more the position feels unstable for the patient and they have to engage their muscles to support the leg.

Fig. 8.15 Thumbing the 2nd outside leg line on the upper leg



Fig. 8.16 Working with the bent leg



While holding onto our patient's leg for support we move position so we are kneeling with our knees either side of our patient's foot. We keep hold of our patient's leg at the knee so that they do not need to support it themselves. We arrange our knees so that our patient's ankle bones are held firmly in the soft creases of our knees ([Fig. 8.16](#)).

We are kneeling low. In this position we can do more work on the leg lines of our patient's lower leg. Now we have some advantages in this work. In response to gravity the muscles are hanging from the leg and because of the position they have less need for tension.

Fig. 8.17 Working the 2nd outside leg line



We begin by using the thumb of our lateral hand to work a little deeper into the 2nd outside leg line. We travel downwards from the knee working the line only where it is comfortable for our hand to work (Fig. 8.17).

We then let our fingers find the 3rd outside leg line at the back of our patient's lower leg. This is the channel in between the two heads of the gastrocnemius. We use the channel to pull the lateral head of the gastrocnemius out from the mid-line. We will find that there is a natural tendency to lift the muscle as we draw it out. We then combine our movements, pushing in with our thumb on the 2nd outside leg line and pulling out with our fingers in the 3rd outside leg line. When we find the natural rhythm of the muscle it becomes more fluid than solid and, under the effect of gravity, begins to hang like liquid from the bones (Fig. 8.18).

We can at this point revisit the 1st outside leg line using our thumb to push into the channel between the muscle and bone (Fig. 8.19).

Fig. 8.18 Working the 2nd and 3rd outside leg lines



Fig. 8.19 Working the 1st outside leg line with the leg bent



Fig. 8.20 Working the 1st inside leg line



We now turn our attention to the inside leg lines. Although it is possible to work these lines with the leg straight, when we work with the leg bent we can achieve more effect more quickly. We support our patient's knee with our lateral hand and work the lines with our medial hand. On the inside of our patient's leg we use our thumb to feel for the 1st inside leg line between the medial edge of the tibia and the muscle (Fig. 8.20).

TIP

This line tends to be more tightly bound than the other leg lines. We cannot push very deep before we feel resistance. We must work with care to avoid causing discomfort.

Once we have worked the line a couple of times with our thumbs we allow our fingers to find the 3rd outside leg line between the heads of the gastrocnemius muscle. As before we search for a rhythmic movement, pulling the gastrocnemius muscle medially with our fingers and pushing the 1st inside leg line with our thumbs (Fig. 8.21).

Fig. 8.21 Working the 1st inside and 3rd outside leg lines



TIP

Although it is also possible to work the 2nd inside leg line in this position it is often so close to the 1st inside leg line that we cannot differentiate one from the other.

We finish the sequence on the lower leg with the fingers of both our hands working the 3rd outside leg line. In this position we can lift and separate the two heads of the gastrocnemius muscle. We can search for a wave of movement in the muscle as it becomes more liquid in response to our attention ([Fig. 8.22](#)).

We change our position so that we are kneeling high and holding our patient's lower leg between our thighs. We can now work the leg lines of the upper leg. We begin by working both the 1st inside and 1st outside leg lines together. We contact these lines where they begin just above the knee by grasping them between the heels of our hands. Our aim is to use these lines to draw the rectus femoris muscle away from the hip joint. We need to keep a great deal of sensitivity in our hands to work these lines without slipping off.

Fig. 8.22 Working with both hands on the 3rd outside leg line



At each position we contact the lines and press inwards until the muscle softens between our hands. We then lift the muscle away from the femur and slowly draw it away from the hip. We will find that there is a long movement possible. It feels as if the muscle continues up beyond the hip towards the diaphragm. We work these lines three or four times, each time searching for a little more softness and length ([Figs 8.23 and 8.24](#)).

We now adjust our hand positions so we are relating to the 2nd outside and 1st inside leg lines. With the same sensitive contact we turn the muscle of the thigh medially around the femur and then draw it away from the hip. When we reach the limit of movement we allow the muscles to show us how to return. We work these lines three or four times ([Fig. 8.25](#)).

We change our hand positions to work with the 2nd inside and 1st outside leg lines. This time we connect with the lines and use them to rotate the muscles of the thigh laterally as we draw them away from the hip joint. We work these lines three or four times ([Fig. 8.26](#)).

We return to working the 1st inside and 1st outside leg lines. If we have done our work well the muscles should be much more fluid.

Fig. 8.23 Working the 1st inside and 1st outside leg lines



Fig. 8.24 Working the 1st inside and 1st outside leg lines



Fig. 8.25 Working with the 1st inside and 2nd outside leg lines



Fig. 8.26 Working with the 2nd inside and 1st outside leg lines



Fig. 8.27 Using the 1st inside and 1st outside leg lines to lift the muscle



We can now use our contact to lift the rectus femoris muscle away from the femur and away from the hip (Fig. 8.27).

Now we lift our patient's foot and rest it against either our belly or our pelvis – whichever we find most comfortable. We hold onto our patient's leg for balance and lift our lateral leg, placing the foot on the floor to the side of our patient's hip joint. We move our medial knee close to but not touching our patient's groin. In this position we can work the 3rd outside leg line as it continues up the thigh. We will use the heel of our lateral hand to do this while our medial hand continues to support our patient's knee (Fig. 8.28).

For the first pass of this line we aim to soften the muscle using our palm. We work up from our patient's knee to the hip joint and then back down the line to the knee.

TIP

The strength of this movement does not come from our arm but from the weight of our body leaning through our arm. It is a strong movement but with little effort on our part.

Fig. 8.28 Working the 3rd outside leg line with the palm



For the next pass we lean our body weight through our patient's foot, increasing the stretch through the back of their thigh as we work the line again with our palm (Fig. 8.29).

TIP

We should not overstretch the back of our patient's leg otherwise we will lose the softness we have gained in the muscle. We use this position to soften and lengthen the muscle not to compress it.

We lift our patient's leg up so that the femur is vertical to the floor and the lower leg is bent at 90° at the knee. We hold onto our patient's knee with our medial hand and to their ankle with our lateral hand. Using our patient for balance we lower ourselves to the floor.

TIP

It is important that we extend our arms as we sit back so that our patient's leg remains exactly where it is. We do not want to lose the position and let our patient's leg travel with us.

Fig. 8.29 Deepening the stretch on the 3rd outside leg line



Once we are sitting comfortably we lift our lateral foot and find a soft place for our toes in between the hamstrings at the back of our patient's knee. We use this contact to encourage our patient to slowly drop their leg laterally, opening their hip wide ([Fig. 8.30](#)).

TIP

This position can feel quite exposed for some patients and they may resist dropping their leg to the floor. Our work is to communicate trust through our contact so that our patient lets go. Occasionally a patient cannot let go. In this case we work with their leg raised.

Once our patient's hip is open we tuck their lateral foot into the back of our lateral knee. We keep the foot in place by holding around the back of the ankle. We then release our medial leg and bring our

Fig. 8.30 Preparing to walk on the patient's thigh



Fig. 8.31 Final position for walking on the back of the thigh



foot to the back of our patient's thigh. This will be our working leg. We take hold of the front of our patient's other ankle with our spare hand. If we need to, we adjust our position but without losing the open posture we have put our patient into. We want our working leg to be long, but not quite locked at the knee. This way we can work strongly but with little effort ([Fig. 8.31](#)).

We use the arch of our foot to contact the muscle at the back of our patient's thigh. We need to be sensitive with our foot. If we soften our foot our patient's muscle will respond to our softness with

Fig. 8.32 Walking on the thigh



softness. When we feel this happen we increase the pressure through our foot. We will find that the muscle tends naturally to roll upwards around the femur. When we reach the limit of movement we allow our patient's muscle to push us back out the way we came in.

In this position we walk on the back of our patient's thigh from the knee towards the groin and back again, following the long rhythm given by the muscle. Our hand positions on our patient's ankles must be firm but yielding, allowing our patient's body to move and adjust with the pressure (Fig. 8.32).

TIP

Done well this is a wonderful way to work the thigh. No other massage technique offers such an effective way in which to exert such a strong pressure on these muscles. We will also find this to be a good exercise for our own legs.

When we have walked up and down the thigh two or three times we release our working foot. Using the foot behind our patient's knee and our hand around the ankle we bring the leg up so that the femur is vertical to the floor and the lower leg is bent at 90° at the knee.

TIP

If we make this move quickly it does not require much effort, no matter how large our patient's leg. Once the leg is in position we no longer have much weight to hold.

We now use the ball of the big toe of our lateral foot to press into the gluteus maximus. We aim to locate the soft place just beyond the greater trochanter of the femur. We then unfold our patient's leg while supporting their knee and ankle, all the while pressing deeper into the soft tissue with our toes ([Fig. 8.33](#)).

When our patient's leg is straight, we gently pull it with both our hands on the ankle while pushing away with our active toes. This is a long, slow lengthening through the whole side of our patient's body. We can watch and feel our patient's body as we release our toes from their buttock. We will see their pelvis drop deep into the floor and feel the way in which the leg naturally rolls outwards. We follow this movement through the leg bringing the foot to the floor with the hip at its most open.

We now return to centre, making contact with both our patient's ankles. When we look at the two legs, the worked leg should appear markedly different. We can expect to see the hip and the knee more laterally rotated. We can expect to see the pelvis closer to the floor on the

Fig. 8.33 Releasing the hip



worked side. We can expect to see the thigh muscles wider and flatter as if more liquid against the floor. It is not surprising if the worked leg is longer by a centimetre or more. After all, we have loosened the muscles either side of all the joints, literally creating more space in the joints.

TIP

In these moments of observation our patient will be struck by the difference in sensation in their legs. The worked leg will feel softer and longer. Their nervous system will play with this new information and the other leg will begin to change even before we touch it.

We now repeat the entire leg sequence on the other side. One of the beauties of Thai Massage is the way in which we, as practitioners, learn to mirror our techniques so that both sides of our body work equally. I am sure this process balances the two hemispheres of our brain as we work and helps bring about the state of calm and presence discussed in Chapter 6.

When we finish working both legs we return to our starting position at the feet. As always we take a moment to tune in again with our patient, to appreciate what we have done and to prepare for our next piece of work (Fig. 8.34).

For the first time in the massage we break contact with our patient. We are going to move to their hands. It feels better to stand up and walk there rather than shuffle or crawl. This gives us a moment to prepare and it gives our patient a moment to experience themselves alone with their new legs.

Fig. 8.34 Resting after completing the legs



Working the hands and arms

When we work with the hands and arms the same rule as before applies on which side to work first. At this point, however, I break the rule. I work everybody's left side first because I want to finish on their right side without having to make an extra journey.

Give or take a bone or two, working the hand is very similar to working the feet. In this case most of the work will involve softening the muscles of the palm. As with the feet, we appreciate that the palm reflects the tensions of the muscles above the wrist.

We arrange our patient's arm so that it is at 45° to their trunk with the palm facing up. At this angle the shoulder is at its most comfortable. We sit cross-legged facing directly along the line of our patient's arm. We want to keep their hand as close to the floor as possible so that we reduce any stresses in the arm by keeping all the joints open and in line.

We let our fingers rest between the underside of our patient's hand and the floor. We use our thumbs to soften and mobilise the flesh of the palm, encouraging movement between all the bones of the hand. Our pressure is not hard. It encourages softness by modelling softness. Our contact is with the hand but we keep in mind a vision of the fascial continuity through to the shoulder (Fig. 8.35).

We will now work the fingers one by one. We feel for the metacarpal of the little finger deep within the flesh of the palm. We draw out along the bones from the hand to the end of the finger, adjusting our pressure as we travel over joints and knuckles. We aim to introduce a little space in each joint as we go (Fig. 8.36).

Fig. 8.35 Softening the palm of the hand



Fig. 8.36 Lengthening the fingers



We then move to the webbing between the fingers introducing a little more space between the metacarpals of adjacent fingers. We ease our contact at the webbing, squeezing out through that sensitive place.

TIP

Some massage therapists twist the fingers or introduce strong stretches across the webbing. Others aim to squeeze the blood to the top of the finger. I prefer to avoid these techniques, as they can feel quite uncomfortable compared with any value they may have.

When we have worked the hand finger-by-finger and webbing-by-webbing and completed our work on the thumb we intertwine our fingers with our patient's fingers, bringing our webbing into close contact with theirs (Fig. 8.37). We all know the special quality of the webbing between our fingers. Why else is it so satisfying to stretch our own entwined fingers or to entwine our fingers with one we love?

In this hold we do not need to stretch our patient's hand. We need only to sensitively and softly make the hold. Perhaps we will feel the

Fig. 8.37 Holding hands, webbing to webbing



Fig. 8.38 Sensing the connection from the hand to the heart



continuity from where we hold on up the arm through the fascial and fluid body to the pericardium and heart ([Fig. 8.38](#)).

We can rest in this hold for some moments. If we have developed a fine sense of tracking our patient's state we will notice that most people fall deeper into their dreambody at this point.

Fig. 8.39 Working the sen on the forearm



We gently release and begin work on the sen of the forearm. We can find three lines to work on the anterior arm and one on the posterior aspect. We need to practise manipulating these lines on our own arms. We can learn how to search for the direction of movement that gives the greatest softness and depth in the lines (Fig. 8.39).

Generally I work up and down the middle arm line first from wrist to elbow crease and then up and down the ulnar arm line and the radial arm line. In practice we may find ourselves drawn to work more on one line to try to soften tensions we find there.

This work on the arm lines is a soft and fluid work and very rewarding both for the patient and for the massage therapist when we feel just how much the muscles of the forearm can soften.

We work the posterior arm line last. Although the line is not visible as it is under the arm we do not need to turn the arm to see it. We locate the line by resting our thumb on the medial side of the radial bone and rolling off the bone into the channel between the radius and ulna bones.

We now bring our patient's arm out so that it is at 90° to their body. We bend their elbow so that their upper arm is on the floor and their lower arm vertical to the floor. We hold them by the palm of the

hand using our lateral arm. This position releases any tension in the biceps muscles. We can use the palm of our medial hand to massage the biceps, effectively rolling the muscle across the top of the humerus (Fig. 8.40).

We now swap our holding hands, taking the palm of our patient's hand with our medial hand. We use our lateral hand to slip under our patient's upper arm and bring it down to 45° to their body (Fig. 8.41).

Fig. 8.40 Working the margin of the biceps



Fig. 8.41 Positioning the arm



We continue to hold their lower arm so that it is vertical to the ground. We will now 'weigh' our patient's arm. I mean this literally. For many patients it is difficult to let go of the shoulder muscles and allow someone else to take the weight of the arm. Many therapists try to persuade patients to do this by shaking or wagging the arm. In this exercise we will aim to lift the patient's arm with a clear intention of feeling the weight.

We do this slowly, sensing the way in which we take up the slack in the tissues and joints until we feel the weight of the arm. We then slowly lower the arm again onto the fingers of our other hand where it is positioned under our patient's upper arm. As we lower the arm we feel for the first contact, perhaps of the fabric of a shirt or of the skin. We continue to slowly lower our patient's arm and feel the weight of the muscle softening as it contacts our fingers. Finally we feel the weight of the bone sinking through the muscle onto our fingers.

We repeat this exchange of weight, each time moving our lateral hand up our patient's humerus towards the shoulder and each time trying to sense the weight we lift and the weight we lower onto our fingers (Fig. 8.42).

Finally we find that our fingers fall off the end of the humerus into the soft tissue of the shoulder joint. At this point we raise our fingers, engaging with the shoulder joint and, using this contact, we pull the joint out away from the body and down towards the feet. We unfold

Fig. 8.42 Weighing the arm



Fig. 8.43 Leaning into the shoulder joints



the lower arm until we are holding our patient's hand on the floor with their arm at 45° to their body. We now use the thenar eminence of our lateral hand to lean into the soft tissue just below our patient's shoulder joint while releasing our other hand (Fig. 8.43).

TIP

We need to lean in slowly and sensitively, allowing our patient's shoulder joint to find a comfortable new position. We will also find that as our patient exhales there will be a little more softening of the tissues. There is no actual pressure into the shoulder joint. Our palm merely wraps over the joint.

When we have finished one arm we slowly disengage and prepare to move to the other side. This is another good opportunity to stand up and walk. We should walk round the feet rather than the head of our patient and then sit in preparation for working the other hand and arm. We now repeat the entire sequence.

When we have finished working the second arm and leaned into the shoulder we bring both our hands into play, working both of our patient's shoulders. This movement is a little like the padding of a cat. We exchange the pressure from side to side, from shoulder to shoulder. We can drop our thumbs beneath our patient's collar bones and repeat the movement. We are searching for a little more mobility where the collarbones meet the sternum (Fig. 8.44).

We now bring the palm of our medial hand to rest lightly on our patient's sternum. This is a listening hand, not a working hand. We may have a sense of our patient's heart beneath the bone. We may have a sense of our hand rising and falling with our patient's breathing (Fig. 8.45).

Fig. 8.44 Articulating the collar bones



Fig. 8.45 Hand on heart



After a few breaths we move our hands to softly hold either side of the rib cage. We return to the padding movement we used on the shoulders. Our aim is to rock the ribs from side to side. This is a very small and gentle movement that encourages articulation in the rib cage. We may rest, holding the rib cage for a couple of breaths ([Fig. 8.46](#)).

Fig. 8.46 Articulating the patient's rib cage



Fig. 8.47 Resting at the respiratory diaphragm



We continue this rocking movement rib-by-rib down towards our patient's feet. When we feel our hands have reached the last rib we rest. At this point we are holding our patient's diaphragm between our hands. Without imposing anything we allow our hands to follow our patient's breathing for a few breaths (Fig. 8.47).

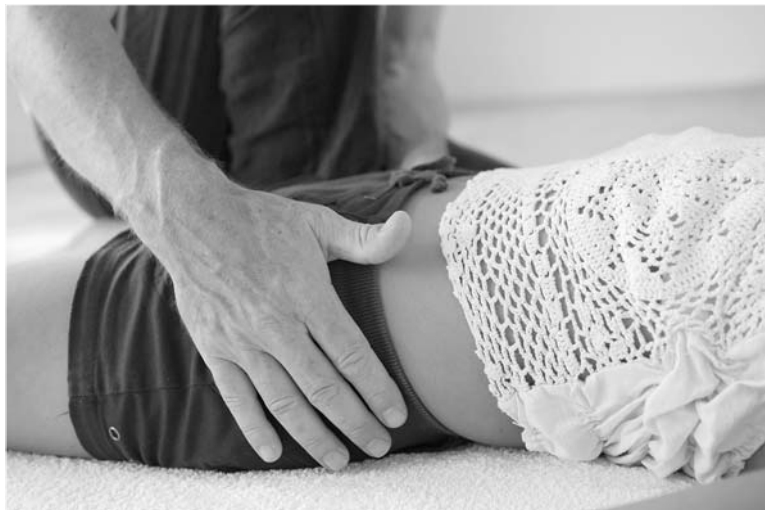
We now bring our medial hand to rest on our patient's belly. As with the hand on the heart, the contact is light and listening. We will often feel the intestines move and hear them gurgle as they relax in response to the respectful quality of our touch. Although Thai Massage offers techniques for applying deeper pressure to the belly I believe that such strong and invasive work should be left to the hands of osteopaths trained in visceral diagnosis and manipulation (Fig. 8.48).

From the belly we can return to the rib cage, rocking our hands from side to side down the ribs and belly until they come to rest at the hips. Again we can rest for a couple of breaths in this hold (Fig. 8.49).

Fig. 8.48 Listening to the belly



Fig. 8.49 Holding the patient's hips



Working with the patient lying on their side

Thai Massage offers a wonderful way to work the shoulder and back – with the patient lying on their side. This position offers us the possibility of working with muscles in motion. We lift our patient's arm up and across their upper chest while giving a little nudge to the pelvis. We ask our patient to roll onto their side. We don't need to move them. We just show them the easiest way to move.

Once our patient is lying on their side we position them in the 'recovery position' by bringing their upper leg up, so it forms a 90° angle at the hip and a 90° angle at the knee. We then straighten their lower leg. If our patient begins to roll forward as we work we can always bring them up by pulling back from the front of the pelvis. We might like to offer a pillow for their head to reduce the tension on the trapezius muscles.

We now slide one hand under their upper arm and wrap it around the front of the shoulder joint. We want the full weight of their arm to rest on our forearm. Our forearm in turn lightly rests on their latissimus dorsi muscle. This hand will provide movement in our patient's shoulder joint. This hand will also sense its contact with their pectoralis major muscle. Our other hand will work the trapezius and rhomboid muscles around the medial edge of our patient's shoulder blade (Fig. 8.50).

Fig. 8.50 Preparing to work on the shoulder



The work on the shoulder combines movement of the entire shoulder girdle with softening of the muscles. This is an active search. Our fingers at the back of our patient will search for the softness in the trapezius and rhomboid muscles. This will allow our other hand to fold the scapula back and over our working fingers. Our contact must be soft and fluid. If our fingers are hard our patient's body will respond with hard.

TIP

We should bear in mind that even a millimetre of extra movement may be enough. If the patient's shoulders are very rigid it is better to take our time about this rather than risk pain and tissue damage and a patient who doesn't want to come back ([Figs 8.51–8.54](#)).

We now move on to the muscles of the back. We swap hands so that the hand that was working on the trapezius and rhomboid muscles now wraps around the front of our patient's shoulder. The other hand will work along the spine from just below the scapula to the edge of the pelvis. We will use our thumb and the heel of our hand to work down the spine vertebra by vertebra. At each point our working hand aims to soften the erector spinae muscle and to support the spine. The other hand draws our patient back using their shoulder. Our aim is to introduce a little rotation into our patient's spine, vertebra by vertebra.

Fig. 8.51 Massaging and articulating the shoulder



Fig. 8.52 Massaging and articulating the shoulder



Fig. 8.53 Massaging and articulating the shoulder

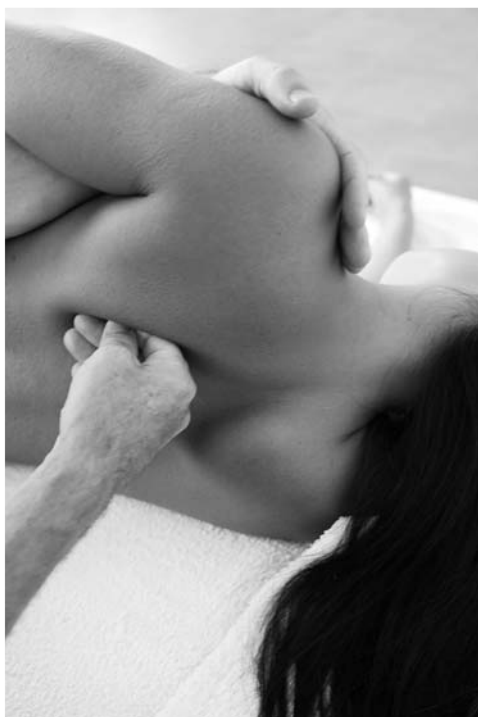


Fig. 8.54 Massaging and articulating the shoulder



Fig. 8.55 Massaging the back muscles



TIP

This move does not involve force. We are coaxing rotation into our patient's spine by softening the muscles that hold the spine in its habitual posture (Fig. 8.55).

When we reach the pelvis we can repeat the movement back up the spine. With each pass we aim for more softness and more rotation. We can now bring our patient's arm back, holding it at the wrist, and repeat the movement using the upper arm to coax even more rotation in the spine. If we have a large patient we can now swap our hand for our foot to give a little more strength to our work (Fig. 8.56).

Fig. 8.56 Walking on the back with spinal rotation



TIP

We do not use force to pull our patient's arm back. The contact is soft and is used simply to bring movement to our patient's body.

Once we have softened our patient's back we stand up, still holding our patient's arm by the wrist. Our other hand reaches forward and takes the patient's upper leg by the front of the ankle. We now draw our patient back so that the front of their body forms a bow shape.

We use our contact with our patient to balance ourselves. We raise one leg and use our foot to connect with our patient's gluteus maximus. Our aim is to fix their pelvis and the end of the femur at the greater trochanter. We draw our patient's leg back against the fixed point of our foot in their buttock. The more we draw the leg back the deeper our foot presses into the buttock. The purpose of this move is to stretch the muscles on the front of our patient's leg and indirectly to stretch the psoas muscle (Fig. 8.57).

TIP

We do not pull on our patient's arm. We hold it simply to stabilise their position. If we cannot persuade our patient to soften their buttock and give us the weight of their leg this move is better left elegantly incomplete.

Fig. 8.57 Stretching the psoas muscles



Fig. 8.58 Beginning of a spinal twist



We now fold our patient's upper leg back into its original recovery position with the upper leg at 90° at the hip and the lower leg at 90° at the knee. We lower their leg to the floor and slide our foot under their knee. Our other leg steps in against their sacrum ([Fig. 8.58](#)).

We bring our patient's upper arm out at 90° from their body with the palm facing up, using its weight to encourage them to turn into a spinal rotation ([Fig. 8.59](#)).

Fig. 8.59 Continuation of a spinal twist



TIP

We should avoid this move if the patient is rigid and if we have failed to achieve any rotation when we massaged their back.

Once our patient is in rotation we allow their outstretched hand to touch the floor and then bring our hand to their shoulder and the other to the edge of their pelvis. We now tune into the movement of our patient's body as they breathe. When our patient inhales we will feel their shoulder pressing up against our hand. As they exhale we will feel their body soften a little. At this point we encourage our patient to relax a little more into the rotation.

TIP

The spinal rotation is not about force. By following our patient's breath we show them how to relax into the posture. We follow to the limit of our patient's possibility rather than trying to push them beyond it.

After the spinal twist we will repeat the entire sequence with our patient lying on their other side. We need only tell our patient to roll to the other side and with a little nudge to the pelvis show them the best way to do this.

When we have finished working our patient on both sides we can work with them lying face down. I often skip this part as we have already worked their back and shoulders in the best possible way.

Although working with the patient prone does offer some useful techniques it is not comfortable for everyone. There are at least three good reasons not to work in this position:

- if the patient is tight in the trapezius it is not comfortable for them to lie prone with their neck strongly rotated;
- if our patient has breasts she may not be comfortable lying in this position for long. In this case we should certainly avoid putting a lot of pressure on her back;
- if we don't have too much time left to complete the massage.

In any of these cases we can skip to the next section and work with the patient sitting.

Working with the patient prone

In this position we can work the back lines again. The traditional method is to raise our patient's lower legs and sit on their feet. We should externally rotate our patient's feet so they rest across the top of our thighs rather than on our buttocks ([Fig. 8.60](#)).

Fig. 8.60 Sitting on the patient's feet



Once we are comfortably in position we will use the heels of our hands to walk up the erector spinae muscles either side of our patient's spine. The aim is to exchange our pressure slowly from hand to hand in order to create a slight torsion in the muscles either side of the vertebra ([Fig. 8.61](#)).

We stop when we reach the lower edge of the scapulae. From this point we use our thumbs to lean into the myofascial channels between

Fig. 8.61 Creating torsion around the vertebra



the erector spinae muscles and the spinous processes. At each vertebra we connect with the tissue and then drop our body weight through our thumbs, pushing the tissue up towards our patient's head. As we do this we also use our connection with our patient's feet, pushing the feet towards the buttocks. This provides a stretch through the front of our patient's thighs and indirectly through their psoas muscles. With this movement we find that we are softening the muscles both on the interior and the exterior of the patient's spine.

If our patient is not very flexible we can avoid sitting on their feet. For some people the stretch through the front of the thighs is just too much and can be painful. In this case we can still do the work on the back by standing with our feet either side of our patient's hips and leaning in through our arms.

Once we have softened the muscles of the back we can move to the hips and the buttocks. For this work we will sit under our patient's thigh. We need to keep our own legs close to the floor so as not to displace our patient's pelvis too much (Fig. 8.62).

We will work the gluteus maximus muscle using our forearm. We need to bring our attention to our forearm. We cannot force our way into the muscle. We lean our bodyweight in through the forearm, all the time feeling for response and softening in the muscles. We will work the area of muscle in between the edge of the pelvis, the border of the sacrum and the greater trochanter of the femur.

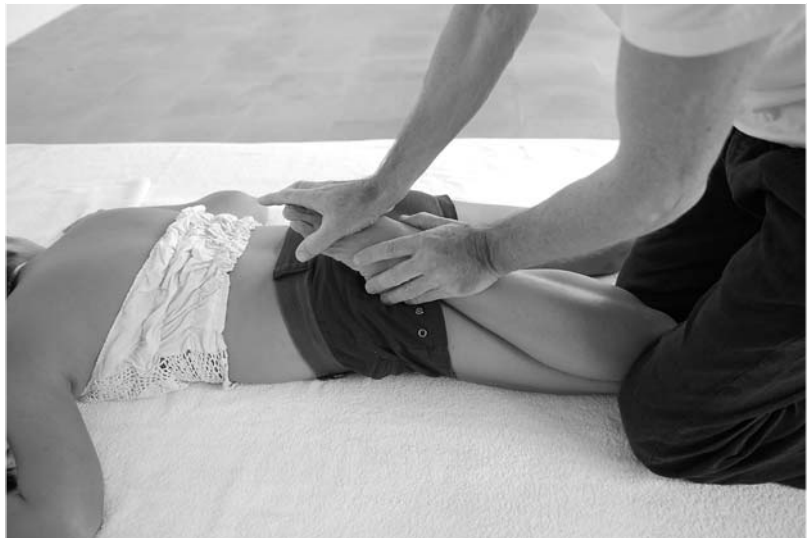
TIP

Because of the position there is a risk of strain on the practitioner's lower back. We can balance this to some degree by adding our other arm, leaning on the working arm. If this doesn't help the technique is best avoided.

Fig. 8.62 Massaging the buttock



Fig. 8.63 Stretching the front of the patient's thigh



Once we have softened one buttock we release ourselves by lifting the patient's leg by the ankle and sliding out. We then bring our patient's knee to the floor while still holding on to the ankle. We can now stretch through the front of our patient's thigh by pushing their foot towards their buttock ([Fig. 8.63](#)).

If our patient is flexible and their foot easily reaches their buttock we can increase the stretch by putting our hand or forearm into the back of their knee and then stretching again ([Fig. 8.64](#)).

Fig. 8.64 Increasing the stretch through the front of the thigh



Fig. 8.65 Stretching the psoas muscle



We now stretch through the front of our patient's thigh and, indirectly, through their psoas. We do this by leaning our fist into our patient's buttock, pinning their pelvis to the floor. Our other hand will lift our patient's leg by the knee, stretching the leg as we deepen the pressure through the pelvis ([Fig. 8.65](#)).

We now bring our patient's leg to the floor and repeat the entire sequence on the other side.

TIP

With this series of stretches it is best to go in strong but avoid holding the position for long.

When we have worked both sides we ask our patient to roll onto their back. We take their ankles and fold their legs into a cross-legged position, holding them in place against our lower legs. We ask our patient to hold onto our hands. We bring their body into a forward bend by lifting them by the arms while maintaining the pressure against their legs (Fig. 8.66).

Fig. 8.66 Bringing the patient into a forward bend

**TIP**

It is important when lifting our patient in this way that we slacken our grip. This will oblige our patient to tighten their grip on our hands. In this way our patient will take care of their own wrists and we will not risk straining their joints.

Working with the patient sitting

We shuffle back little by little until our patient is sitting cross-legged. Using their arms we bring them into a forward stretch. If they are comfortable we place their hands on the floor and then move round to their back where we can encourage a little more forward movement (Fig. 8.67).

Fig. 8.67 Encouraging a forward flexion of the patient's spine



TIP

Many patients will be unable to bend forward very much. We do not need to force the issue. A little more movement than is habitual is good enough for them. If we work regularly with a patient we can expect to see more flexibility develop.

In Thai Massage there is a whole sequence of moves that can be done with the patient sitting. In this general sequence I actually do very little. I do, however, always bring them up into sitting. There is something quite special for a patient to suddenly be vertical during a massage. Also, what little I do in this position can have quite a profound effect on their habitual posture.

We stand up behind our patient. We press our knees together and position them either side of the spine, just below the lower edge of the scapulae. We reach forward and take our patient's wrists. We ask them to clasp their hands behind their neck. We then lean forward, draping

Fig. 8.68 Encouraging a backward flexion of the patient's spine



our arms in front of our patient's folded elbows. We draw them back, encouraging a backward flexion in the spine around the fulcra of our knees (Fig. 8.68).

We need to have awareness in our knees and encourage our patient to soften their muscles where our knees touch their back. Similarly our contact with our patient's arms must be sensitive so that they can open across the front of their chest. This is an invitation to trust and let go. It is not a fight.

We release our patient's arms and bring them backwards, using them for support as we sit on the floor behind them. We need enough distance to place our feet on our patient's back with our legs long but not locked. Still holding our patient's wrists we place our feet side by side either side of their spine and just below their scapulae. We now use our feet to encourage a softening of the erector spinae muscles on our patient's back while using their arms to encourage a backward flexion. We continue down the spine, dropping our feet vertebra by vertebra, encouraging a backward flexion at each point of contact. This is a rhythmic process that involves relaxation and movement not force (Fig. 8.69).

Fig. 8.69 Continuing to encourage backward flexion down the length of the patient's spine



TIP

Many people have not experienced a backward flexion of their spine since they were children. Our work is to establish a safe contact in which they can explore this movement. If necessary we explain our aim and coach them into letting go. If it doesn't work, don't struggle.

When our feet have worked all the way down our patient's spine they will come to rest on the floor with the soles supporting their sacrum. At this point we release our patient's wrists, motioning their arms forward. They will work out where to put them. In this position we can push our patient's pelvis forward and hold for a few seconds.

TIP

Many people who work in offices are unable to sit with their back straight. Often their pelvis collapses backwards because the muscles of their lower back are weak. In this position we can, for a few seconds, give them the experience of sitting well.

We lean forward and rest a hand against our patient's back. This stops them collapsing while we remove our feet. We are going to roll our patient back so that they are lying face up. We prepare by taking a little more distance while still leaning on our patient. We then tell our patient very specifically to 'roll back down' while touching the middle

Fig. 8.70 Preparing to massage the neck and head



of their back. These instructions make sure they roll rather than collapse like a board. We aim to catch our patient's head with the palm of one hand before it touches the floor. We use the other hand to encourage their shoulders to drop and their arms to open at 45° from their body with the palms up. If our patient has reverted to habit in the way they organise their legs we can remind them that they can be more relaxed and open. We may choose to go and adjust them if necessary. Once our patient's body is organised into the corpse asana we lower their head gently to the floor (Fig. 8.70).

Working the neck and head

There are many variations for working on the head and neck. Some people use pinching or slapping on the face and rubbing and hair tugging on the scalp. Personally I prefer to keep the work simple. By now, despite having been sitting for a minute or two my patient is very relaxed. I do not want to start shocking them back into consciousness now. Also, many patients spend a lot of money on their hair and do not like to have it all ruffled up.

I like to keep work on the muscles of the neck to a minimum. This is a sensitive and complex area of the body. Serious problems in the neck are better left to more highly trained practitioners. The main focus of our work on the neck is on the trapezius muscles as they continue up from the shoulders to attach at the back of the skull. We have already done a great deal of work on the mid- and lower section of

these muscles through our work on the shoulders. At this point in the massage we will simply finish the work.

We contact the trapezius muscles by sliding our fingers underneath the neck, with our fingertips touching the spinous processes of the cervical vertebrae. We start as far down towards the shoulders as possible. To begin we simply lift the muscle, letting it rest on our fingers. We exert just enough pressure for the muscle to feel like fluid on our fingers. We can let the muscle rest on our fingers as we slowly lower them towards the floor. It will feel as if the muscle follows us down – drawn down by gravity (Fig. 8.71).

We lift the muscle just enough for it to soften against our fingers and then draw it up towards the back of the head. We gently release and slide our fingers up one vertebra and repeat the movement. We continue up until our fingers reach the occiput. We repeat this series of movements a couple more times, each time aiming for more softness and fluidity in the muscle. We finish by wrapping the whole of one palm around the back of our patient's neck, allowing all the muscle to rest on our hand. We slowly let our hand sink towards the floor, inviting the muscles to sink with us.

Fig. 8.71 Lifting the trapezius



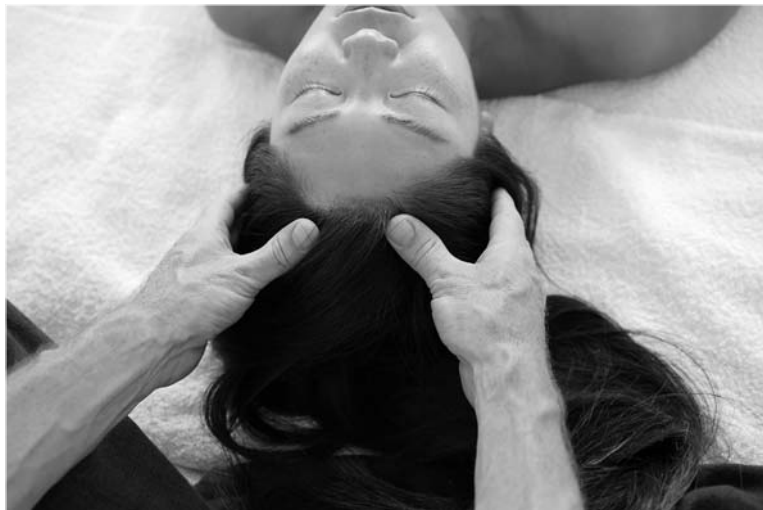
We move to the face and scalp. We bring our thumbs together on two parallel lines that begin at the medial borders of the eyebrows. We draw the brow up with our thumbs towards the hairline. Once at the hairline we use our thumbs to rock the scalp forward and back. Our pressure is just enough to engage with the scalp. We travel back through the scalp, rocking forwards and backwards as we go. We stop when our thumbs are no longer comfortable (Fig. 8.72).

We return to a second pair of parallel lines, which begin at the centre of the eyebrows. Again we draw the brow up with our thumbs until we reach the hairline. Once at the hairline we use the contact of our thumbs to rock the scalp from side to side, moving back through the scalp centimetre by centimetre (Fig. 8.73).

Fig. 8.72 Massaging the forehead



Fig. 8.73 Rocking the scalp from side to side



We bring our fingers to the temples and introduce a small rotation to the scalp. We move back along the scalp, rotating at each point of contact (Fig. 8.74).

We bring our thumbs to the lower edge of the orbit just below our patient's eyes. We come in slowly so that our contact does not come as a shock. We use our thumbs to trace the lines of the orbits out and up into the hairline, gently drawing the face upwards as we go (Fig. 8.75).

Fig. 8.74 Rotating the scalp



Fig. 8.75 Tracing the contours of the eyes



We bring our thumbs to the corners of the nostrils and draw the face out and upwards by following the line of the upper jaw (Fig. 8.76).

We bring our thumbs and fingers together at the chin and follow the line of the lower jaw outwards and upwards towards the scalp (Fig. 8.77).

Now we turn to the ears. Our fingers rest behind the ears where they attach to the skull while our thumbs work gently to massage and unfold them (Fig. 8.78).

Finally, we allow our palms to rest just beneath our patient's neck where it joins the occiput. This is the softest of contacts. Our hands are open like petals. There is barely any contact at all – just a sense of cradling (Fig. 8.79).

Fig. 8.76 Massaging the muscles around the upper jaw



Fig. 8.77 Massaging the muscles around the lower jaw



Fig. 8.78 Massaging the patient's ears



Fig. 8.79 Cradling the patient's head



After a few moments we disengage, bringing our hands out through the top of our patient's atmosphere and moving our body back a little. It is always nice to rest for half a minute or so, leaving our patient to sense themselves in their own space and separating ourselves from our patient. After an hour and a half I always find it difficult to speak so the first thing I say is 'ok'. I can always say ok.

Additional techniques and techniques to avoid

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General contraindications

Thai Massage is not medicine. Its aim is relaxation. This can be very beneficial and even healing but it is not an alternative to medical care. When we begin to practise massage the safest approach is to only work on healthy people. As we gain confidence in our practice we might choose to work with patients with medical conditions. In this case we should only do so with the knowledge and blessing of the patient's doctor. In our practice we might come across patients where something seems wrong. It is our duty to encourage our patient to seek appropriate medical advice.

The routines that I teach and practise use techniques that are as safe as can be and are suited to patients with an ordinary level of flexibility. There are many more techniques. Often these are presented as 'advanced'. More often they are simply variations on a theme. Sometimes they are fun to do in class or with friends. Sometimes they are just plain dangerous.

The blood stop – just don't do it!

The blood stop involves applying pressure to major blood vessels to reduce blood supply to a chosen area. The theory behind the technique is that it produces a backpressure which, when released, clears away dead cells that have been loosened during the massage. This technique is commonly applied to the femoral arteries supplying the legs. It is less commonly applied to the axillary arteries supplying the arms. It is rarely applied to the common carotid artery supplying the head.

All variations should be avoided. In the UK, many insurers will only offer insurance to Thai massage therapists who agree to avoid this technique. The reason is quite simple. We have no idea of the state of our patient's cardiovascular system. They may be harbouring undiagnosed weaknesses or clots. Better that it is not our technique that reveals them.

Applied yoga asanas

Thai Massage includes the application of yoga asanas. Depending on the practitioner this is a more or less important part of the overall massage. I tend to teach and use very few of the applied yoga postures. The few I use regularly have already been covered in Chapter 8. The following techniques I use occasionally. There are others that I consider too challenging for the patient and/or the practitioner so I disregard them altogether. I prefer that my patients do their own yoga practice and just come to me for the massage.

Spinal twists and spinal adjustments

There are at least four variations on the spinal twist. The one we have already looked at in Chapter 8 (Fig. 8.59) is the best as it is the patient's own body weight that initiates the rotation in their spine. We do not push the patient's body and if it is clear that they lack the flexibility or the willingness to turn we do not continue.

When we make contact it is simply to draw the patient's attention to the way their body tightens a little with inhalation and relaxes a little with exhalation. They learn to breath their way into the rotation (Fig. 9.1).

Fig. 9.1 Applying the spinal twist



Sometimes a patient easily rotates and both their shoulders rest comfortably on the floor. In this case it is possible to increase the rotation by taking the patient by the wrist of the lower arm, asking them to hold on to our wrist and drawing their body up from the floor. Another variation involves physically pulling the patient into a spinal twist.

Both of these variations are best avoided. An imposed rotation may be painful for the patient and encourage a defensive tightening that undoes all the relaxation of the massage. It may also be dangerous if the patient's spine is already under duress. It is worth remembering that most spinal disc ruptures come as a complete surprise and occur with seemingly insignificant efforts. Strong manipulation of the spine is better left to osteopaths and chiropractors who are trained and equipped to assess the risk before manipulating.

A safer variation on the spinal twist can be used when we have brought our patient into the sitting position. In this case we ask our patient to clasp their hands behind their head. We weave our hands under and through our patient's arms and hold them at the wrists. In this hold we are completely in charge of our patient's posture. We bring their spine into vertical alignment and apply a rotation until we first meet resistance. Our knee rests lightly on the opposite thigh to support their posture (Fig. 9.2).

If our patient moves comfortably into the rotation we can apply a side-bend. We bring them back to the centre until they are sitting with a straight spine. Using the same hold and continuing to rest our knee on our patient's leg we bring their body over into a side-bend. This is not forced. We just guide our patient into the posture, supporting them as they go and lengthening our arms so that we don't get dragged down with them (Fig. 9.3).

Fig. 9.2 Applying the sitting spinal twist



Fig. 9.3 Applying the side-bend



We bring our patient back up from the side-bend and re-establish their verticality. We rotate their body until they are facing their knee. We then gently guide our patient down into a forward bend. Again, this is without force (Fig. 9.4).

Fig. 9.4 Applying the forward bend



We repeat the entire sequence on the other side, changing our leg so that we support our patient's thigh on the opposite side to the movements.

The plough

The plough is a deceptive yoga asana. It looks simple and familiar – perhaps remembered from childhood play. In yoga classes we all imagine we can do it and it is a wonderful source of work for the osteopaths and chiropractors. If done at all during yoga practice this posture should be reserved until the end when the body is warm and soft (Fig. 9.5).

Fig. 9.5 The plough in Hatha Yoga, adapted from an image featured in *Hinduism Today*, with permission



As a yoga asana the plough should be practised slowly and with much attention. The first sign of pain should be the signal to stop and slowly unravel from the posture. Although the plough can be applied to the patient it is best avoided. It can put too much of the pressure on their cervical spine.

Cobra stretches

The cobra stretches are one of the most familiar images of Thai Massage, gracing the pages of many a book or article on the subject (Fig. 9.6). As such, how can I not include them, even if I rarely use them in practice? This is a valuable yoga posture best practised in the yoga class. There are a number of variations but this is the one I prefer, as it is the most controlled and safe. We would apply this stretch at the end of the sequence working with the patient lying prone. We stand in between our patient's legs at about the level of their knees and slowly kneel down, until our knees rest at the top of our patient's thighs. Half of our weight rests on our patient's thighs and the rest on the floor through our toes.

Fig. 9.6 The cobra in Hatha Yoga, adapted from an image featured in *Hinduism Today*, with permission



We lean forward and take our patient's wrists. We present our wrists to their hands and ask them to hold on. We bring ourselves up into a high kneeling position. We medially rotate our patient's arms to open up their shoulder blades. We then lean back, lifting our patient with our arms straight (Fig. 9.7).

TIP

The lift comes from our body weight not from our arm muscles. As we lift we slacken the grip on our patient's wrists. This obliges them to hold on more strongly. In this way we avoid the risk of injuring our patient's wrists.

Fig. 9.7 Beginning to apply the cobra stretch



Before we go any further we need to ask a couple of questions. Can our patient go any further without pain or injury? Can we lift our patient any further without risk of injuring our own back? If we feel confident we continue, slowly bringing our patient into the cobra stretch until we meet the first resistance. We hold for a few moments before reversing out ([Fig. 9.8](#)).

TIP

If we cannot lift our patient because they are too heavy or too resistant or too stiff we rest a moment where we are and then slowly reverse out. There is no shame in this. For this patient, at this time, the movement is good enough.

Fig. 9.8 Continuation of the applied cobra stretch



TIP

Sometimes our patient knows this stretch from yoga and starts 'doing' it. We must ask them to let go and relax into the movement. It has a very different quality.

The following variation is stronger and opens our patient across the front of the chest and shoulders. It really is only suited to regular yoga practitioners (Fig. 9.9).

Fig. 9.9 Variation of the applied cobra stretch



Walking on the back

We have already looked at the best version of walking on the back in Chapter 8 (see Fig. 8.69). In this case the patient is sitting and we use our feet and their arms to introduce a backward flexion into their spine, vertebra by vertebra from beneath the scapulae down to the pelvis (Fig. 9.10).

Fig. 9.10 Walking on the back



The more literal version is best left to small practitioners and large patients and benefits from a low ceiling or a rope or a chair for the practitioner to balance with.

Forward bends

The forward bends are always worth doing and are especially recommended after applying a cobra stretch. We have already looked at the first two versions in Chapter 8. In the first we apply a little forward bend before we bring our patient up into a sitting position (Fig. 9.11).

We continue by bringing our patient forward with their arms outstretched and the palms of their hands on the floor. We move round behind our patient and lean on them a little to add to the stretch (Fig. 9.12).

Fig. 9.11 Applying a forward bend



Fig. 9.12 Applying a sitting forward bend



In this variation we bring our patient's legs up the front of our body and then lift them as before with a hand-to-hand grip. It is best to do this stretch once, release and then arrange the patient into cross-legged lying to repeat the stretch before bringing them up into a sitting position (Fig. 9.13).

Fig. 9.13 Applying a straight leg forward bend



TIP

Sometimes this one just doesn't work. If the patient's legs are too long and in your face or resting on your breasts (if you're a woman) just forget it and fold the patient's legs into a cross-legged position.

From time to time we will work with very large or very rigid people. Much as I like to bring my patient into the sitting position it is not always worth the struggle. I am perfectly at liberty to forget the sitting position altogether or to ask my patient to sit themselves up.

Kidney stretch

The kidney stretch, like the cobra stretch, has too much association with Thai Massage to miss, even if I use it rarely. It offers a strong stretch through the inside of the patient's spine and on up to the diaphragm. This stretch does need some strength from the massage therapist and a lot of trust and flexibility from the patient. If either are lacking it is not worth trying.

Usually we do this stretch after either the lying forward bend or the straight leg forward bend. We let our patient's arms rest on the floor. We take them by the ankles with their legs bent at the knees. We step in close so that our toes are just under our patient's buttocks. We splay our feet apart and press our knees strongly together. We hold our patient's feet together and rest them against our knees. This must be a soft contact. If, when we worked on a patient's feet, we found them to be rigid in spite of our best efforts we would not even try this stretch.

With our patient's feet resting on our knees we wrap our arms around their upper legs and hold tightly. We squeeze everything together – our knees, our patient's knees, their feet and our arms. If everything feels strong and stable we use our arms to lift our patient up, so they are standing on our knees.

TIP

If we feel any resistance or rigidity in our patient or we feel that the lift is hard work we reverse out smoothly and move on (Fig. 9.14).

If all is going well, we continue. We pull our patient up as far as possible. We keep pulling through our arms as we bend our knees, sending our backside straight down towards the ground. This brings our patient even higher up onto our knees (Fig. 9.15).

Fig. 9.14 Beginning of the kidney stretch



Fig. 9.15 Continuation of the kidney stretch



TIP

When we reverse out of this stretch we must take great care of our patient's neck by stepping back little by little as we lower their body to the floor. This avoids putting too much compression on their cervical spine.

Working as a massage therapist

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Introduction

Since 1994 I have taught Thai Massage to hundreds of students. Many of these were already practising some other form of therapy. Some observations and questions have recurred over the years. Some of them are addressed here.

One of the more worrying observations is the number of massage therapists destroying their own body and career with poor technique or poorly executed technique. One of the pleasures of teaching Thai Massage is that it thoroughly addresses the massage therapist's use of their own body. Thai Massage techniques are taught so that the massage therapist uses bodyweight rather than strength. All Thai Massage techniques are designed for ambidextrous use. This means that the massage therapist develops both sides of their body equally. This ambidextrous practice also seems to centre the hemispheres of the massage therapist's brain and brings calmness to the work.

The following are observations developed over the years. They are not truths and they may change in the light of further experience.

Practising massage as a craft

During my years of practising and teaching Thai Massage I began to think of massage as a craft. The practice of a craft epitomises the expression of individual style with the development of a 'less is more' approach to work. Our patient doesn't relax because of all the hard work that we do. Our patient relaxes because of the quality, depth and attention we bring to our work. When we practise with a sense of researching our craft our work becomes endlessly rewarding and never repetitive. It is a fascinating aim to see how quickly we can bring our patient into relaxation and with how little effort.

Pruning our techniques

The reason why there are so many massage techniques is because none of them actually works. What does work is a decent technique applied by intelligent hands. The technique itself is nothing. The communication and relationship skills of the practitioner are everything. Just because we are shown a technique in class doesn't mean we have to do it. If a technique doesn't suit our body we should reject it. If we don't enjoy receiving a technique we should reject it. We need to build a repertoire of techniques that represents us. They will carry our confidence and sensitivity to our patient and our patient will relax into our work.

Getting massage

The best place to learn about massage is from the hands of another massage therapist. We will often learn more about what doesn't work than what does but the experience will enhance our practice. When we do find a good massage therapist we should book a regular session and let our body absorb their knowledge. When other massage therapists come to us regularly we should take it as a great vote of confidence.

Building a practice

These days there is plenty of work for a good massage therapist. Magazines and newspapers are always running articles about the benefits of massage. Spas and health centres seem to be opening everywhere. Although these are useful places to refine our practice they often pay poorly and overwork their massage therapists. We need to take time to build our own patient list. The simplest way is to start with friends and their friends and to practise talking clearly about our work.

It really is worth paying for a decent business card. Everybody we meet is longing for a good massage. They are just one step away from booking a session. If we arouse their interest when they ask us what we do, a business card helps them take the next step.

Working with family and friends

I love to work with my family and friends. I charge nothing to my family and offer a good discount to my friends. I am quite flattered that they come to me. The cardinal rule in working with friends and family is to book the session exactly as with any other patient and avoid turning it into a social event.

Managing our practice

It is important to think about the kind of practice we want. Mine has always been quite haphazard. I don't like to be booked up all the time and I'm happy not to know what next week has in store. This is quite an insecure way to work but it suits my nature and has allowed me to enjoy an interesting life.

I know a massage therapist who runs the very opposite kind of practice. She has two slots in the morning and two in the afternoon. She never works evenings or weekends and always eats lunch. Her patients

have to reserve their place and pay if they fail to turn up. She is always fully booked and operates a waiting list. She knows exactly how much she will earn each week.

I recently heard of a massage therapist in London who sees only two people each day and works five days a week. She charges less for a session than most London spas but for her 15 hours work each week she still earns much more than the average wage for the UK. She sounds very wise.

Managing our patients

After a good massage a new patient will often ask when they should come back. I spent years avoiding giving a straight answer. This is not very professional. The patient asks because they trust us to give a professional recommendation. The truth is that regular massage is a good thing. The body learns how to relax and relaxes more deeply with each session. The patient needs to find a frequency that suits their income. Once a week is fine. Once a month is fine. Regularity is more important than frequency.

Questions and notes

In my experience, the more questions a practitioner asks the less experience they have. The last time I went to see a GP she asked only one question: 'So what seems to be the problem?' I have heard of massage therapists asking new patients all kinds of very personal questions. I have heard this from patients who didn't go back to them. If we don't have a diagnostic training there is little point in asking many questions. To begin with we need only ask enough to meet the requirements of our professional body. Beyond that we can ask, 'is there anything else I should know?' We can then leave our patient to tell us if anything important comes to mind. They may tell us more but they need time to develop their trust in us.

Aim

I have one aim when I practise massage and that is the complete relaxation of my patient. This aim is so clear and I have practised so much that I can almost guarantee that every session will be a success. If that is all I achieve I feel that I have earned my money. Any other benefit that the patient gets is pure bonus.

Of the sessions that will not be a success they are so rare and particular that I can now predict them from the first moments of the massage. Occasionally, with some people it just doesn't work.

Music

I never use music when I work because I find it distracting. It occupies some of my mind and more importantly it occupies my patient's mind. When I practise I want to find the natural rhythm of my patient's body and not be led by the rhythm of the music. I want to be able to hear the air change around me as I work. I want my patient to hear the changes in the sound of their inner world.

Talking

I don't talk when I receive a massage and I don't like to talk when I'm giving a massage. When I begin a session I suggest that my patient closes their eyes. I tell them that there is no need to talk but if something comes up that they feel is important to let me know. I leave the door open, but not too wide.

Some patients need to talk. If that is the case I let them do it. I listen but I don't converse. When I start working on the hands and arms I enter a more intimate zone. Often they close their eyes and stop talking then. When I start working on the patient's shoulders and chest even the most resilient chatterer will close their eyes and stop. I know this. I've seen it so many times that I don't worry if my patient needs to talk.

Self observation

This is such an important part of our work. The unobserved body does extraordinary things – like crossing legs or slumping in chairs or leaning into one hip or locking one shoulder. Many of the physical problems people suffer from are caused by poor postures, repeated day by day in the dark. Massage therapists are as bad as anyone else and very often apply their technique to the detriment of their own body. When I practise massage I think of it like tai chi. I challenge myself to be more present, more aware, more relaxed and more fluid with every session I give.

Pacing

Most massage therapists really need to slow down. When I teach massage therapists I see the relief when they realise that they can slow

down and still be effective. So many massage therapists are working like crazy doing their techniques over and over again as if quantity represents quality. In a Thai Massage class the pace is slow and attentive. Massage therapists feel their body relaxing without all the usual pummelling and their practice is never the same again.

Demanding patients

I have two levels of pressure, the pressure I like and a little bit more. If a patient asks for more pressure I will give that little bit extra. If the patient still wants more pressure I tell them very kindly that this is my technique. I explain that I'm sure they will be able to find someone stronger but for the moment they should relax and enjoy what I do. Too many massage therapists hurt themselves trying to please demanding patients.

Some patients are just too big or too solid and we have to accept that we cannot please them. We don't have to feel ashamed or apologetic. We just have to make sure that the patient doesn't come back to us again. Big patients should go to big massage therapists.

We will not be to everyone's liking. If we are confident of our work it doesn't matter. If a patient doesn't like what we do we can even help them to find someone more suitable. Our practice should be filled by patients who like what we do and who we enjoy working with.

Relationship

The massage relationship is very interesting. I have patients who I have worked with since I started. Some were already friends and some have become friends. Many more know me only through my work. We are growing older together and still know very little about each other. I have had many patients who fascinated me – perhaps because they were rich, or beautiful, or powerful, or famous or charismatic. No matter the temptation I still keep my mouth shut and quietly do the work they are paying me for. Patients don't usually come to a massage therapist because they need a friend.

Money

I had a patient who belonged to a private members' club in London. He joined when it first opened and 20 years on he still paid the same annual fee while newcomers paid much more. I adopted this system.

For existing patients I never put up the fee. I still have patients who have been with me since I started. These are the people who helped me develop and helped me build my practice. They deserve a lower rate. At some point they have all insisted on paying more. I really appreciate that.

Using this system means that when I want to increase my fees I can increase them a lot. If I told a regular patient that my fee was going up by 20% they would probably balk and possibly not return. A new patient doesn't know any different. They just know the fee and can decide for themselves if it represents good value.

Sex

As a man I have rarely had to deal with the sexual advances of a patient. The only times have been from men. It is very disturbing and I sympathise with female massage therapists who have to deal with it more often. One massage therapist I know told me that it is important to avoid eye contact during the massage. When a male patient tries to look her in the eye as she works she knows that it is usually the beginning of a seduction. Dealing with attempted seduction is one of the more unfortunate aspects of our work. We just have to learn to resolve it quickly and not get too upset.

Worse than seductive patients are seductive massage therapists. I have had occasional massages that have left me feeling confused as to whether the massage therapist was touching me inappropriately or just being clumsy. We should never leave our patient feeling confused. It is harmful to the patient and harmful to the reputation of our work.

Breathing

Breathing is complex and fascinating. It is wonderful to feel a patient's breathing change as we work. Sometimes there is a sigh. Sometimes there is a pause. Then the breathing starts again with a wholly new rhythm. We may notice patients whose breathing is odd. It is better not to intervene unless we are properly trained. There are therapists who specialise in breathing if we need to make a referral.

When I'm massaging I do aim to keep breathing. Sometimes I use my breath specifically to prepare for a stronger movement. Our body has a little more force and focus on the exhalation. I am discreet in this. I have had a few massages where the massage therapist is clearly practising some breathing technique. I don't mind that they use their technique but I prefer that they don't make a big deal of it.

Tracking the patient

Unfortunately this very important part of our work is rarely taught. If we don't know where our patient is on a scale of relaxation we cannot know if we are doing a decent job. We can begin by noticing the obvious signs such as eye movement, breathing and intestinal gurgles. If we learn to relax as we work we can begin to tune into our patient's inner state. With practice we might begin to sense the slower life rhythms mentioned in Chapter 7. That's when our work becomes really fascinating.

Invisibility

A massage is all about the patient. My aim is to become invisible. I do not want my patient to be occupied by my breathing or my smell or the sound of my movement. The only aspect of me that should concern my patient is the work that I do with them. If I need attention for myself I can pay another massage therapist for it. In this respect the best advice comes from Bruce Lee:

*Empty your mind. Be formless, shapeless – like water.
Now you put water into a cup, it becomes the cup.
You put water into a bottle, it becomes the bottle...
Be water my friend.*

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