

bodyreading the meridians

BY THOMAS MYERS



THE SUPERFICIAL FRONT LINE

In the two previous BodyReading columns, we outlined a consistent method of bodyreading postural compensations. Any kind of global visual assessment needs to blend intuitive gestalt with more direct, objective observations—the whole person’s unfolding story is greater than the sum of his or her parts.

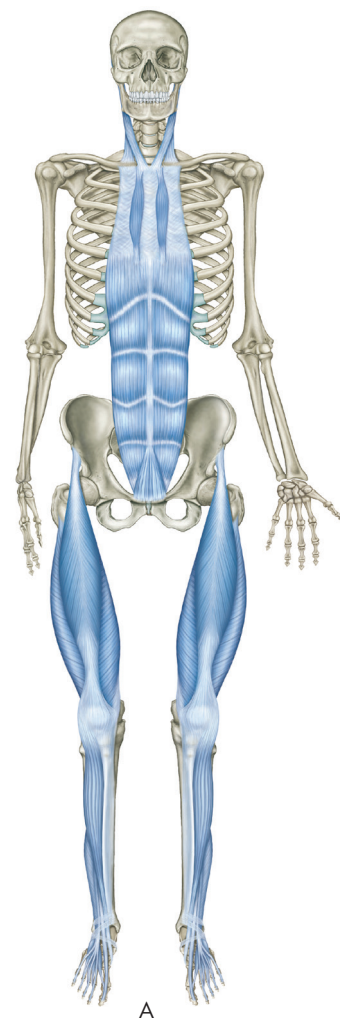
In most iterations of postural/structural/biomechanical models, the parts we think about are alignment of the bones, reach of ligaments or tendons, and tonus or performance of the muscles. In these next installments of the BodyReading series, we will focus on what is termed the Anatomy Trains—coherent chains of myofascial force transmission that allow us to view structural patterning in more holistic and less particulate terms.

This point of view encourages you to include overall fascial tone, as well as specific adhesions within and between adjacent fascial planes, in your clinical thinking and application. But it does not require that you throw away any of your hard-won knowledge about individual muscles—just add in this idea of continuity and glide in the fascial fabric between and around the muscles.

THE SUPERFICIAL FRONT LINE—WHAT IS IT?

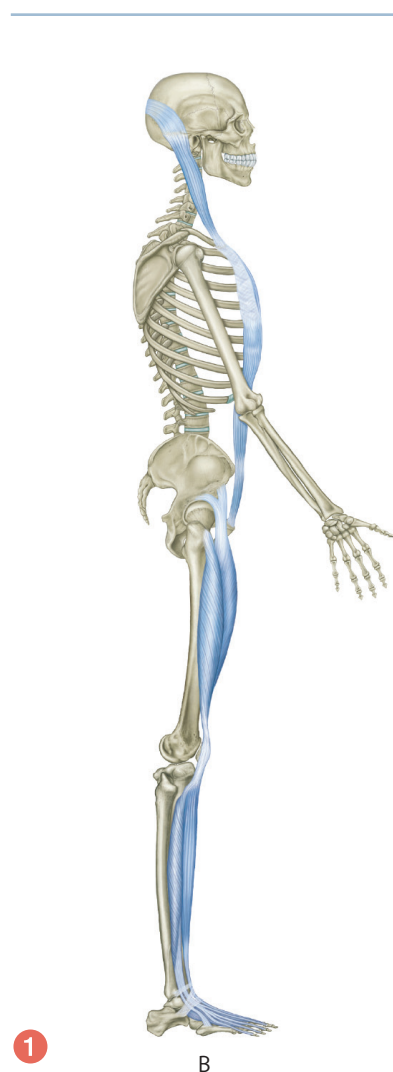
The first continuity we will consider is the Superficial Front Line (SFL), a configuration of fascial and muscular tissues that stretches in two pieces up the ventral side of our body: from the top of the toes to the front of the hip, and from the pubic bone up to the sides of the skull (Images 1A and 1B).

Anatomy Trains lines can be viewed in three ways: as a line, as a plane, and as a volume. As a line, the SFL can be seen as a railroad track running from station to station (attachment point to attachment point): from the top of the toes under the retinaculum to just under the knee, and from under the knee across the thigh to the front of the hip. The second piece has its first station at the pubic bone, the next at the fifth and sixth rib (the bra line), the next at the top of the sternum, and the final station around the asterion¹ of the skull just behind the top of the ear. One way to define SFL function would be to imagine each of these points getting closer to each other, which taken altogether would have you in a forward bend with your toes hyperextended and your chin running down your shin bones, meaning your upper neck is

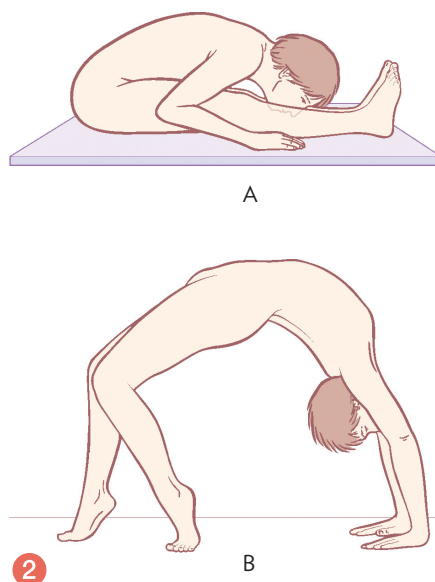


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The Superficial Front Line is a myofascial continuity stretched over the sensitive ventral side of our body.



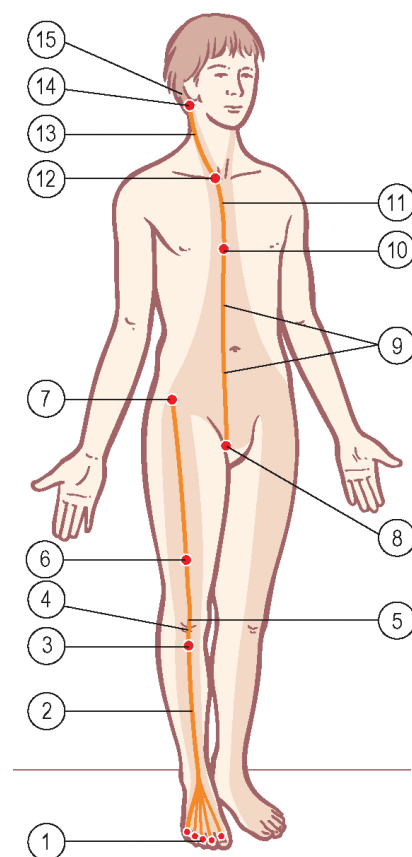
1 A side view of the Superficial Front Line—our protector—shows it running from the pubic bone up along the sides and around the back of the skull.



Contract the Superficial Front Line point to point, and you get something like Image 2A; stretch them away from each other, and you get an upward dog or cobra pose, or similar backbends, Image 2B.

hyperextended (Image 2A). Stretching these points away from each other would produce a cobra pose with toes pointed, or, more strongly, a deep backbend (Image 2B). In both these extremes, the SFL would be interacting with other lines, particularly the Superficial Back Line on the other side of the body (which we will discuss in the next issue) as well as the Lateral, Spiral, and Core lines to follow.

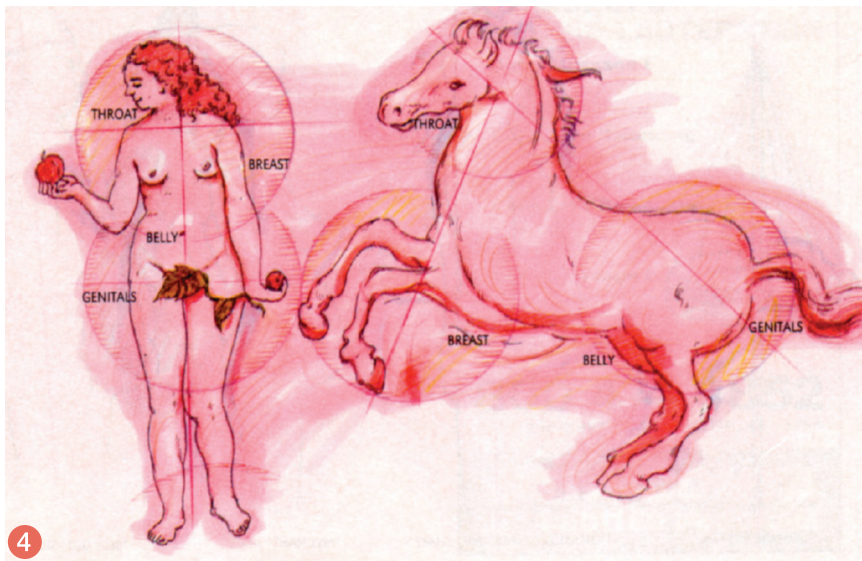
To see the SFL as a fascial plane, imagine that we put plastic cling wrap along the front of the body. Considered this way, the SFL would include the whole front of the body: top of the foot, front of the lower leg (including the fascia on top of the shin bone, a whole bridle of fascia around the knee, and the fascia lata on the front of the thigh). The second piece would stretch from the abdominal fascia arising from the anterior superior iliac spine (ASIS) and pubic bone to the chest and neck fascia (Image 3).



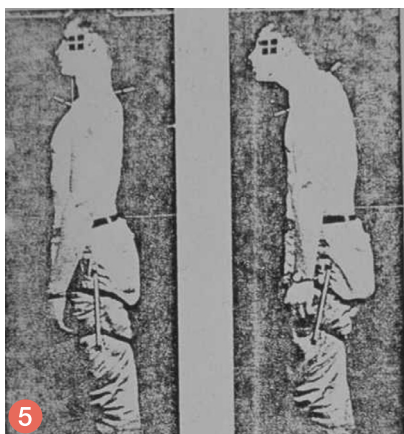
3 The Superficial Front Line diagrammed as a line of pull (from number to number) and as a plane of more superficial fascial fabric (shaded).

Or, we can define the SFL as a volume, as in Image 1—a series of connected muscles running up under this superficial fascial plane from station to station:

- The anterior crural compartment of tibialis anterior and long toe extensors.
- The quadriceps complex.
- The rectus abdominis and accompanying superficial abdominal fascial sheets.
- The pectoral and sternal fascia, along with sternalis if there is one.
- The sternocleidomastoid and its fascial extension up to the asterion on the skull.



4 The Superficial Front Line protects very sensitive areas—the breasts, genitals, groin, soft underbelly, throat—so it is associated with defense against shock and trauma.



5 The startle response can be seen as a sudden shortening of the Superficial Front Line. Here we see a man just before and just after someone fired a blank pistol behind him. Notice how in the right-hand photo the line from the mastoid process to the pubic bone is straightened and short. *Image from Body Awareness in Action (New York: Schocken Books, 1976), by Frank Pierce Jones, 131.*

Whichever way you view it, there is a structural and functional continuity running up the front of the body.

In terms of assessing the health of this line, there is one overriding consideration: the protective nature of the SFL. This line runs along some of the most sensitive bits of the human anatomy: the breasts, genitals, groin, soft underbelly, and the throat (Image 4). The skin over this line is very sensitive; for millennia of our evolutionary history, it was against the ground, listening to the vibes from the earth. Now it is our front, sensing the space into which we are moving.

Given all this, it is no surprise that this line is highly reactive to threat. The startle response can be seen as a strong contraction of the SFL, drawing the mastoid process and the pubic bone closer together (Image 5). This a) presents the less sensitive back to the bully's fist, the policeman's baton, or a predator's teeth, b) protects the spine in a fall, and c) still keeps our eyes and ears up so we can tell what's going on. It is a mammalian response, not just a human one.

Other mammals, however, leave the startle response behind when they perceive the danger is gone. Humans are 100,000 times (count the neurons) more sensitive to our inner self-created environment than we are to our outer surroundings. Uniquely, we humans can maintain the attitude of threat response even years after the original danger is gone, because we re-create it in our minds.

Therefore, the most common bodyread for the SFL is this fear response pattern: a forward head, a sunken chest, a shortened belly, and a tucked-under pelvis. Variations of this response walk into your office every week, more likely every day. Whatever your method of easing this tension, it is a worthwhile goal.

BODYREADING RED FLAGS

Let us work our way upward to these considerations from the bottom. We will use a series of questions to consider issues related to the SFL:

IS THE ARCH FALLEN, THE FOOT PRONATED?

If the arch has fallen and the foot is medially tilted (Image 6), stimulation of the deeper aspect of the tibialis anterior can sometimes awaken the ability of the muscle to better support the arch, in conjunction with exercises, orthotics, or postural adjustments.



6 Fallen arches.

IS THE ANKLE DORSIFLEXED?

The lower leg ideally rests more or less vertically above the foot. If the lower leg is leaning forward as if in a ski boot (Image 7), then perhaps the tissues of the tibialis anterior and long toe extensors are too short, or caught under the retinacula in the crural fascia.



A dorsiflexed leg.

IS THE KNEE HYPEREXTENDED?

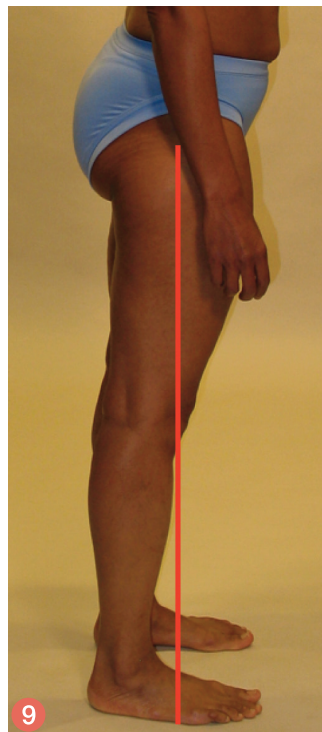
If the knee is held back into hyperextension (Image 8), this is a bodywide pattern, not just a knee aberration, and so needs to be handled globally. We will be addressing this more in the next installment, but the SFL contribution to this pattern is a tight set of quadriceps, particularly the vastus intermedius, so you have to reach down under the rectus femoris in order to free this deep stabilizer.



Hyperextended knees.

IS THE PELVIS AHEAD OF THE FEET?

An anterior shift of the pelvis relative to the feet is a very common pattern in our “on your toes” Western, urbanized world (Image 9). When you drop a plumb line from the greater trochanter, does it fall through the ankle malleoli, or just in front? If it falls well ahead of the ankle, this person needs to find the present moment.

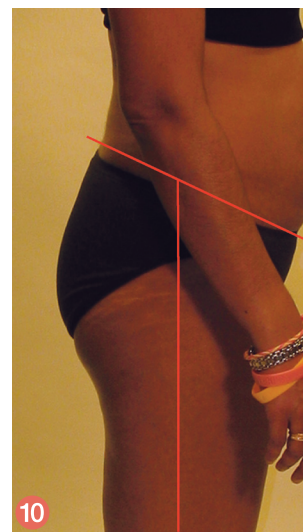


Anterior shift pelvis.

There is reciprocity between this anteriorly shifted pelvis and the feeling of anxiety or being chased. Lifting the tissues of the whole lower SFL from toes to pelvis is very helpful in helping people to re-center themselves in a balanced stance over their feet.

IS THE PELVIS ANTERIORLY TILTED?

If the pubic bone looks pulled down, or the low back appears short and hiked up, the pelvis may be in an anterior tilt (Image 10). Although the rectus femoris, or the branch lines of the sartorius or tensor fasciae latae (TFL), may contribute to this pattern, pelvic tilt is much more a matter of the core musculature, which we will be dealing with in a later installment. You can release the SFL contribution to this pattern, but do not expect much change until you can release the psoas complex—the anterior adductors, iliacus, and pectineus—as well as the psoas itself.



Anterior tilt pelvis.



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IS THE BELLY SHORT WITH THE CHEST PULLED DOWN?

Again, a short belly—marked by a reduced distance between the sternum and the pubis, and a steeper-than-usual angle to the ribs—can be a combination of SFL tension and Deep Front Line (core) tension (Image 11). Some of these patterns are produced by the protective attitude we saw earlier, and some are produced by too many crunches. Work around the costal arch can help, but often it is the deeper laminae of the abdominal fascia—more associated with the transversus abdominis and umbilicus—that help relieve these patterns.



Front ribs pulled down.

IS BREATHING RESTRICTED IN FRONT?

A common effect of shortness in the SFL is restricted breathing. We have already discussed the SFL as mediator of the startle response, so sometimes it is hard to tell whether the reduced breathing is due to actual tension in the line restricting the excursion of the ribs, or is it the scare that has the person still—perhaps years later—holding their breath? In either case, sympathetic attention to

freeing the tissues and the movement around the front of the sternum, sternocostal joints, and pectoral fascia can only help with respiratory enhancement, and often brings great relief, or even a wave of emotion.

IS THE HEAD FORWARD?

Because the SFL passes from the top of the sternum to behind the ear with the sternocleidomastoid (SCM), shortening and restriction in the SFL in general, or in the SCM in particular, is largely responsible for most head-forward posture. Viewed from the side, if the center of gravity of the head is forward of the center of gravity of the rib cage, then strain is created that can be the genesis of backaches, eyestrain, headaches, and neck pain (Image 12).

Easing the superficial neck fascia back, and lengthening the SCM, along with a little movement reeducation, can put that head back where it belongs.



Head forward posture.

IS HEAD ROTATION RESTRICTED?

In more severe or long-standing head-forward postures, neck rotation may be restricted. How many degrees can they turn their head before the shoulder or ribs start turning? Ideally, the head should turn a full 90 degrees each way without disturbing the shoulder girdle. If it is a meager 25 degrees, get working by stretching and freeing up the various layers of neck myofasciae. Freeing the SFL can ease these restrictions; sometimes, even working the belly, chest, or even the legs will give you increased ease in head rotation.

Of course, the SFL is not alone in controlling the neck and head—many other Anatomy Trains lines pass through the neck to the head. We have to divide the body up to talk about it coherently in these articles, but the Anatomy Trains is just a map—the lived body is the territory. In subsequent issues, we will return to the problem of proper head position and function several times—since it is so crucial to perception, orientation, psychology, and ease of movement. Next issue, we will explore the Superficial Back Line, and open its book to read the secrets. **m&b**

6 Thomas Myers is the author of *Anatomy Trains* (Elsevier, 2009) and *Fascial Release for Structural Balance* (North Atlantic, 2010). Myers studied with Ida Rolf and has practiced integrative bodywork for more than 35 years. He directs *Kinesis*, which offers professional certifications and more than 100 short courses per year worldwide. For more information, visit www.AnatomyTrains.com.

NOTE

1. The asterion is where the temporal, parietal, and occipital bone come together. In other words, three sutures meet here. On the inside of the skull, this is a major attachment point of the tentorium cerebelli. On the outside, it is a major attachment of the sternocleidomastoid fascia above the mastoid process. It can usually be found as a small dimple that fits your fingertip about one inch behind the top of the ear.