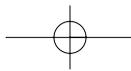
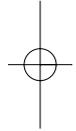
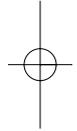
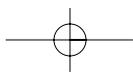


Cranial Manipulation Theory and Practice





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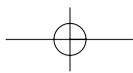
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Project Managers: Wendy Gardiner; Gail Wright

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Cranial Manipulation Theory and Practice

Osseous and soft tissue approaches

SECOND EDITION



With accompanying CD-ROM

Leon Chaitow ND DO

*Registered Osteopathic Practitioner Honorary Fellow,
University of Westminster, London, UK*

With contributions by

Zachary Comeaux DO FAAO

John M McPartland DO

John D Laughlin III

with John D Laughlin IV

Frank O Pederick BAppSci(Chiro) FRMTC(Comm Eng)

Evelyn Skinner DO

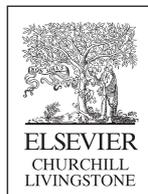
Foreword by

John E Upledger DO OMM

President, The Upledger Institute, Palm Beach Gardens, FL, USA

Illustrations by

Graeme Chambers and **Peter Cox**



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Contents

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Contributors vii

Foreword ix

Preface xi

Acknowledgments xiii

1. A brief historical perspective 1
Leon Chaitow

2. Cranial fundamentals revisited 13
Leon Chaitow

Exercises: refining cranial palpation skills 51

3. Integration with medicine – the scope of cranial work 67
Zachary Comeaux

4. The biodynamic model of osteopathy in the cranial field 93
John M McPartland, Evelyn Skinner

5. Chiropractic in the cranial field 111
Frank O Pederick

6. Cranial movement: mechanical and subtle 139
Leon Chaitow

7. Cranial bones: assessment and manipulation 177
Leon Chaitow

8. Cranial implications of muscular and fascial distress 241
Leon Chaitow

9. Assessment and treatment of key cranially associated muscles 255
Leon Chaitow

10. Positional release and cranial pain and dysfunction 325
Leon Chaitow

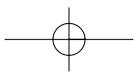
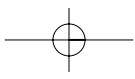
11. Cranial therapy and dentistry 337
John D Laughlin III with John D Laughlin IV

12. Clinical applications of cranial manipulation 367
Leon Chaitow

Appendix 1 Soft tissue manipulation fundamentals 379

Appendix 2 Cranial treatment and the infant 399

Index 407



Contributors

Zachary Comeaux DO FAAO
Associate Professor of Osteopathic Principle and Practice, West Virginia College of Osteopathic Medicine, Lewisburg, West Virginia, USA

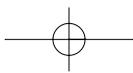
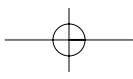
John D Laughlin III DDS
Health Centered Dentistry, Ellworth, WI, USA

John D Laughlin IV BS
Health Centered Dentistry, Ellworth, WI, USA

John M McPartland DO
Associate Professor, School of Osteopathy, UNITEC, Auckland, New Zealand

Frank O Pederick BAppSci(Chiro) FRMTC(CommEng)
Chiropractor (retired), Castlemaine, Victoria, Australia

Evelyn Skinner DO
The Twig Centre, Lower Hutt, Wellington, New Zealand



Foreword

I was honored when Leon Chaitow requested that I write a foreword to this latest edition of his encyclopedic book on cranial (craniosacral) therapy. He would not give me any clue as to what he wanted so I shall simply indulge my creative instincts.

I was in osteopathic college in Kirksville, Missouri when I first heard about cranial osteopathy. What I heard was not necessarily good. In fact, the faculty members who talked about it expressed wishes that cranial osteopathy would evaporate in that it connected quackery to bona fide osteopathy. I was a student and I was working through a three-year fellowship in biochemistry concurrently. This made me very "scientific" and so I chose to believe the "quackery" rumblings about cranial osteopathy. I graduated in 1963 and subsequent to completing an internship at Detroit Osteopathic Hospital I opened a private practice on Clearwater Beach, Florida in October, 1964. I was a very "scientific" osteopathic physician and surgeon.

In 1972 I met the cerebrospinal rhythmical fluid wave first-hand. This introduction was to change my life. I was assisting Dr. James Tyler on a neurosurgical procedure wherein we were to surgically remove a calcified plaque from the posterior aspect of the external surface of the dura mater. The plaque was about the size of a dime and was located at the level of the 3rd and 4th cervical vertebrae. My job was to hold the dura mater very still with a pair of forceps while Dr. Tyler scraped the plaque off of the dural membrane without interrupting its integrity. I could not hold the membrane still. It continuously moved towards and away from me rhythmically. The patient was on a ventilation apparatus, the rhythm of which did *not* correlate with the move-

ments of the dural membrane, nor did the monitored cardiac rhythm. This dural membrane rhythm was a different and independent rhythm. Dr. Tyler became rather irritated with my inability and I was feeling embarrassed and incompetent. Neither Dr. Tyler, the anesthesiologist, the intern nor the nurse had any explanations for that which was proving me incompetent. I stewed over this observation of the unknown for about a month and could find no acceptable answer for this renegade rhythm.

About a month after this surgical experience I noted an announcement in the *Journal of the American Osteopathic Association* (JAOA) that there would be a five-day seminar given by the Cranial Academy in St. Louis. It dawned on me that perhaps I had viewed with my own eyes the cranial rhythmical impulse (CRI) so I attended the conference. The speakers presented all the anatomy and concepts that were needed for me to be able to manipulate skull bones when I returned to Clearwater Beach.

I shared with Dr. Tyler what I had learned and how it integrated with my inability to immobilize the dural membrane. His mind was open. He asked me to treat his office nurse's seven-year-old son who had three previous tympanotomies and was scheduled for a fourth in a week. I worked on his temporal bones, his ear drained via the eustachian tube and he did not have another tympanotomy over the next few years that I was in contact with his mother.

Next Dr. Tyler asked me to try my new approach on a World War II veteran who had forgotten his ear muffs in 1944 while standing aboard battleship next to a big cannon that was fired. Since that time he had severe non-stop headache and tinnitus. I

x FOREWORD

mobilized his temporal bones and while I was doing this, his headache and tinnitus stopped, never to return.

These two clinical experiences silenced my previous scientific skepticism which was nurtured at the Kirksville College. Dr. Tyler suggested that I start scrubbing with him on craniotomies. I started doing this about twice a week. I observed, helped and learned during these surgeries. Dr. Tyler had me treat his craniotomy patients, most of whom were brain tumors. I knew what was going on inside the cranium because I was there during surgery. I treated these post-op patients daily beginning on day one after surgery. Dr. Tyler was very happy because he had much improved recovery rates, with almost no post-op complications and no surgically induced mortalities. This was enough to convince my "scientific" self that we were onto something. The word about what Dr. Tyler and I were doing and I was invited to join the faculty of the Biomechanics Research Department at Michigan State University. I did so in July, 1975. Here we investigated and proved the existence of the

craniosacral system. We published a lot of our work, and I found myself frequently working with biophysicists who seemed to have very open minds.

While I was at Michigan State I was informed by professional researchers that it takes about 25 years for the conventional medical community to accept new concepts. Our contributions to the research and clinical outcomes at Michigan State University have largely been published in peer-reviewed journals and as craniosacral therapy is now coming into acceptance, the prediction seems qualitatively correct.

Leon Chaitow has created an encyclopedia of cranial and craniosacral therapy. Dr. Chaitow has thoroughly described the many pathways of investigation and treatment development that have led to the concepts and applications of cranial/craniosacral therapy. This is a book that every practitioner of this work will find of interest. It will be a very useful reference source and should be on the practitioner's bookshelf.

John E Upledger

Preface

My formal/informal training in the use of cranial methods took place over a seven- to eight-year period, starting in the late 1960s and ending around 1974. Over that period a group of approximately 20 colleagues, mainly UK-based osteopaths but also other health-care professionals, including French physiotherapists, met about once every 6 weeks for weekends of intensive training with the late, great, Denis Brookes DO.

Often those weekends took place in his home town of Shrewsbury, as well as in various locations scattered around England. They involved both social gatherings as well as workshops and study-group sessions in which we worked on each other as we learned to apply the methods that Denis taught. He was an old school DO, having worked in the USA with many of the pioneers of early osteopathic cranial development, and so the model of cranial methodology that this group taught was largely structurally oriented. It also included some methods (V-Spread for instance) that lacked coherent biomechanical explanations, which left a sense of slightly uncomfortable confusion as to just what was happening.

Over the decades, a greater understanding of just what may be happening when cranial methods are applied has emerged – as outlined in Chapters 1 to 4 in particular. These chapters provide background details of the apparent schism between the mechanistic and the biodynamic models and methods. In truth, though, there are probably more similarities than differences in technique between biomechanical and biodynamic cranial work, although underlying explanations as to the physio-

logical mechanisms involved are very different, as will become clear.

Taking a different model entirely may help to explain why these differences should not necessarily be seen as a negative.

When you palpate an area of tenderness and tension in someone's musculature, you might readily locate areas that demonstrate differences from surrounding tissue, involving perhaps altered tone, sensitivity and tissue texture. Applied pressure to such an area would have a number of predictable effects including: compression of mechanoreceptors – inducing modification of pain perception via the gate mechanism; the release of local analgesic endorphins and possibly brain enkephalins; creation of a local ischemic effect that would allow a flushing of fresh oxygenated blood on release of the pressure; and a mechanical stretching of the tissues under pressure. In other words, from a Western medical perspective, there would be neurological, endocrine, circulatory and mechanical effects deriving from applied pressure.

Now if virtually the same pressure was being applied by someone trained in traditional Chinese medicine methods, such as shiatsu (acupressure), exactly the same influences would be taking place; however, the explanations arising from TCM would involve energy (chi) movement or obstruction. Which of these explanations is correct? Is it neurology, fluid movement, stretching, hormonal change or energy movement? Or is it all of these, and possibly unknown others as well?

Translate this to a cranial treatment setting and we can see that while the model, the story, the

explanation, may differ, the effect of applied cranial treatment might be precisely the same, whether the practitioner's thoughts as to the underlying mechanisms involve fluid-electric/energy concepts or biomechanics and fascial release.

When cranial treatment is applied, almost all instruction asks for a sense of centeredness, stillness, focus, and applied intent. As will be seen (see Chapter 4 in particular on the topic of entrainment) a combination of a calm, unhurried, compassionate, physical contact from a caring practitioner/therapist almost certainly has a therapeutic benefit of its own.

On the other hand, at times, pure biomechanics enters the frame, as will be seen in the discussions of dental and facial influences.

Much cranial methodology has emerged from particular personal philosophies and beliefs, based on the work of individuals such as Upledger, Jealous and DeJarnette (see Chapter 5 for more on

this theme). Today the expert, the authority, needs to base instruction and information on as much objective fact as possible; and in the absence of research evidence, clinical experience must of course inform opinion, but this carries less weight in modern health care than in the past.

As the healing professions move away from authority-based approaches toward evidence-based practice, a merging of what can be shown by research and clinical audit to be safe and effective should take place. What I have tried to do in this book is to explain the various philosophies and methods, to offer what explanations already exist, and so to begin the process that will eventually unite apparently disparate ideas and methods.

Leon Chaitow
Corfu, Greece 2005

Acknowledgments

It is traditional for authors to offer thanks to those closest to them for encouragement and for putting up with neglect. The reason for this tradition can only be understood by those who have been through the process, and it is one that I will not break. Alkmini, my wonderful wife of 33 years, has yet again endured the writing and editing process with unfailing humor and thoughtfulness. For this, my enduring thanks and gratitude.

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