

An Interview with Dr. John Upledger, D.O., O.M.M.

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Dr. John Upledger, D.O., O.M.M.
Creator of
CranioSacral Therapy and SomatoEmotional Release
By Dennis Hughes, Share Guide Publishe

Dr. John Upledger is an Osteopathic Physician, Clinical Researcher and developer of two innovative forms of bodywork, CranioSacral Therapy and SomatoEmotional Release. He is a respected educator and author of the excellent and informative book *Your Inner Physician and You*.



Dennis Hughes: For our readers that are unfamiliar with your work, can you give an introductory description of CranioSacral Therapy?

Dr. John Upledger: CranioSacral Therapy is a very soft touch, hands-on method of treatment. It deals with what we have named the craniosacral system which is composed of a membrane that is waterproof that encases the brain and spinal cord and carries within it cerebrospinal fluid. The pressure and volume of the fluid go up and down. That makes it a hydraulic system, which needs to be free to move all the time because the fluid should be moving and bringing nutrients to all the neurons and taking away wastes and so forth. With CranioSacral Therapy, we have several entrees into this system— most of them

through bony attachments or through direction of energy or pulling of fascia—for alleviating any restrictions that might have accumulated due to injuries or illnesses. This therapy improves the health of the brain and spinal cord, which in turn, affects the whole body.

Dennis: Aren't there three layers of membrane?

Dr. John: Yes. The outer layer is called the dura mater and it's the waterproof one. It's kind of tough. It has some elasticity, but not a lot. The middle layer is called the arachnoid membrane and it carries a lot of blood vessels. It interacts between the external dura mater, the outer layer and the internal layer which is called the pia mater, which is the one that follows all the little dents and nooks and crannies in the brain. You probably have seen pictures of the surface of the brain and the pia mater follows all those little dents into the brain.

Dennis: So the pia mater is on the inside of the skull?

Dr. John: They are all inside the cranial wall, all three of them.

Dennis: All three membranes extend from the head down through the spine to the sacrum, right?

Dr. John: That is correct. Part of what's needed for good health and good movement is the three layers need to be able to move independently of each other. If they were stuck together and couldn't glide, you wouldn't be able to bend side to side or forward and backward because you wouldn't have that play in there.

Dennis: So if you do some gentle, regular exercise like swimming, Tai Chi or yoga, that would be good to extend flexibility into later life.

Dr. John: It's quite helpful, yes. The more you get these

membranes mobilized, the healthier you'll be. And of course, that extends through your whole body, ultimately, via the nervous system.

Dennis: The innermost membrane, the pia mater, attaches to the spinal cord?

Dr. John: Yes. It adheres to the spinal cord going down, and the only place it attaches to bone is where the nerve roots of the spinal cord come out laterally or transversely. Then they attach to openings between the vertebrae, but they're not in the spinal canal, they are out there, maybe a half inch or an inch.

Dennis: The outermost layer, what does it attach to, or is it flowing freely?

Dr. John: The outermost layer sometimes is free and sometimes attached. Inside the skull itself, it divides into two layers. One layer becomes the internal lining of the skull wall. Then there are little fibers that attach the second layer to it. The inner layer of it has much more mobility. The fiber is restricted somewhat, but not a lot. It glides back and forth a little bit. It's because of this attachment to the bones that we can actually use skull bones to move the membranes and put forces in there that create release of certain restrictions or adhesions that may have occurred.

Dennis: I read in your book, *Your Inner Physician and You*, that bone actually grows out of the membrane when you are in the womb.

Dr. John: When you are an embryo the surface of the skull itself was all membrane and the bones formed within it. When you are born that is why you have these fontanelles, the soft spots. Those bones haven't grown to fill in the soft spots yet. Actually, at the sutures where bones come together, you might have a gap of an eighth of an inch or even a quarter of an inch wide when you are first born. This is because when you

are delivered your head has to deform coming through the birth canal. So one of your skull bones will override the other in order to make the head narrower to get through narrow places.

Dennis: After you're born your head gradually becomes rounder?

Dr. John: That's exactly where CranioSacral Therapy could start. Heads are supposed to expand and become rounder, as you said, and sometimes they don't. They get stuck, and at a time like that, a good therapist can release that stuck place between two bones where it didn't fully expand in the space of a few minutes. You can take away a lifetime of trouble for that child right at that point.

Dennis: When we are adults, it's commonly thought that those different plates of the skull fuse together, which is a myth that you explode in your book. Can you talk a little bit about how we can retain some flexibility in those bones even as an adult?

Dr. John: First of all I would like to clarify this point. British anatomy taught that the bones were fused as you became an adult. Italian anatomy did not. I think that is because British anatomy studied embalmed cadavers. They had been sitting in a laboratory, they had been embalmed, and because of post mortem and chemical changes that occurred, these sutures appeared to be calcified. Italian anatomists worked on fresh cadavers, and they could see that there is a lot of elastic tissue, a lot of blood vessels, and a whole lot of things that are there so that the bones can move, one in relationship to the other.

I didn't know about this difference (between the British and Italians) until I was lecturing in Israel and I was making a strong point before a bunch of doctors about how this systems works and how these bones are not immovable in adults, they are not fused, and nobody really seemed to be really excited about that. Finally after I tried to reiterate it the second

time in different terms, because I thought they didn't understand me, one of the doctors said, "Let me show you something." He pulled out an Italian anatomy book published in 1920. He translated it for me from the Italian, "The bones of the skull do not fuse except under diseased conditions throughout life." So we have that myth in this country because we have studied and drawn our education from British anatomy. We just reinvented the wheel!

Dennis: So this is old school for some Europeans.

Dr. John: Yes. There are a couple of very important points: bone motion needs to continue throughout life, and the slight motion that is there is accommodated because the sutures themselves have elastic and collagen fibers in them so that they allow for some movement (on the order of a millimeter or perhaps a millimeter and a half in some cases). If you look at the formation of the sutures, you can see which way the bones move in relationship to each other. It took us a while to make this discovery—or rediscovery I should say.

At first we just studied the cadavers in the anatomy lab, and it looked like the bones were fused together. But I have a friend who is a neurosurgeon—he would take bone samples across sutures from living people that he was operating on. He'd take a very thin slice, quick freeze it, and overnight it to us in Michigan. And we learned to study these things with different kinds of stains. There was no chemical invasion here at all, no phenol or formaldehyde or anything. We saw the structure of the suture was very capable of movement. Then we measured it on monkeys, and it moved very well on monkeys. Then we found out it was a singular hydraulic system. I would put just a little pressure on the tailbone of the monkey and I could stop the motion of the skullbones. I would do this because of the connection and the hydraulic force that I was able to exert, increasing the hydraulic pressure just a little bit.

Dennis: So sometimes you will work on one area of the body that will actually be treating a problem on another part of the body?

Dr. John: Yes. That's probably going on at least 75% of the time in good CranioSacral Therapy.

Dennis: That reminds me of chiropractic, being that the spine is from the top to the bottom of your torso, and the nerves affect the whole body.

Dr. John: Sure, they do. I am an osteopath, so obviously I've learned spinal manipulation too, and we have a lot in common with chiropractic in that aspect of our education. I don't think there's much argument about that. What I like about the sutural movement is that if the suture does not move, we know there is something wrong. Then we do things to make it start moving. In cranial work, you don't have to work hard, you don't do any thrusting or any sudden pushing. You just resist a movement in the place where it's moving hard, where it has the most motion. Then the hydraulic portion in the inside will open up that stuck suture for you.

Dennis: In your book you state that you use no more than the pressure of a nickel.

Dr. John: That's right. Five grams is what we teach.

Dennis: Then you hold that for a period of time?

Dr. John: Yes. You see, this is a pumping action. The volume of the fluid is going up and down about ten times a minute inside the skull. Cerebrospinal fluid volume—there's the pressure. In any hydraulic system, if you push in one place, the force you use is being broadcast throughout all of the fluid.

Dennis: The heart is pumping your blood, and I understand that there's a rhythm to the spinal fluid, but I sort of saw it as

static, like a brake system. What's making it move?

Dr. John: I'll come to that in a minute. What I was pointing out is that you can use the rise and fall of fluid pressure, and I'll get to how that happens. There's a suture that goes across the top of your head like a pair of earphones would come together. That's the coronal suture. Let's say that it's stuck because your forehead has been jammed backwards because you fell down and you banged your forehead. You jammed that suture together. Now the compensation to allow for the rise and fall of fluid volume inside may be taken up in a suture that runs up along the back of your head from side to side. Now I examine it and find that the two bones, the frontal and the parietal bone, (where you got jammed) are not moving, and the compensation is happening in the suture which is a couple of inches behind that. So if I put my hand on the back one and hold it together with just a little bit of pressure, and then let that pumping action of fluid on the inside work on the suture that's stuck, it will gradually begin to open that suture.

That's how this works, we are taking the compensation away in one place, reducing it, and that causes the hydraulic force to go to the other place. If you really know how this works and you understand the anatomy, you get so you can direct force all over the place. Now, you want to know what causes the pumping action to occur, am I right?

Dennis: That's the question I have.

Dr. John: What we found out first of all is that the sutures spread and close, as I said, in about ten cycles per minute. Now in the saggital suture, which is the suture that separates the two halves of your skull (it runs front to back down the midline and it starts about four inches above your eyes), there are nerve receptors that stretch and broadcast the stretch. They also have compression receptors so that when the two bones come together and press enough another signal is

sent. The signals go down a nerve trunk we discovered that runs down through that membrane system which separates your brain into right and left parts. It goes into the ventricles of the brain and gives a signal down there. In the ventricle system of the brain is what is called the choroid plexus and that plexus extracts fluid from blood. In other words, it uses osmotic pressure and some active extraction, but blood flows through capillaries on one side of this system and it extracts just the fluid and leaves the cells, so it takes kind of a blood plasma out. Actually, it's a little more selective than that. It doesn't allow all of the ions to pass through. That is the manufacture of cerebrospinal fluid.

Dennis: So cerebrospinal fluid is made from blood.

Dr. John: Correct. It's made from the blood. It is made from the blood at a certain speed. Let's call it "speed 2x." Now there's a constant reabsorption going on of the cerebrospinal fluid back into the bloodstream at the rate of 1x. The reabsorption stuff is located in most of the venous channels in the skull itself. The reabsorption system is called the arachnoid system. The arachnoid reabsorbs the cerebrospinal fluid and puts it back into the blood. Blood comes into the skull, some of the fluid is extracted from it, and it becomes cerebrospinal fluid. At the same time, some of that fluid is being reabsorbed. It's only reabsorbed at "speed 1x," half as fast as it's produced.

Dennis: Different rate of motion, twice the speed.

Dr. John: Yes. Obviously the volume increases, and when it does the suture I talked about on the top of your head is expanding. It has stretch receptors up there. When it stretches to a certain point it sends a signal down that says stop making fluid and then it stops. Reabsorption continues. As the reabsorption then brings the fluid volume down again, the suture begins to close. When it hits the compression receptors, the message goes down to turn the production back

on. What we found is the production is on for about three seconds and off for about three seconds in a normal situation, which gives you about a six-second cycle.

Dennis: That's caused by a pulse in the nervous system?

Dr. John: No, not a pulse in the nervous system. It's caused by the literal physical pressure in the suture either compressing or stretching. The switches that turn on and off control the production turning on and off, and that's what causes the motion to occur.

Dennis: Which is at ten cycles per minute?

Dr. John: Ten or twelve. It varies a little bit from person to person.

Dennis: I thought it was very fascinating, when you mentioned early in your book, *Your Inner Physician and You*, your discovery of this system. I forget the name of the gentleman that you were working on.

Dr. John: Delbert Smith, I owe my whole career to him, I guess!

Dennis: You found something calcified, a coin-sized shape on the outside of his membrane, and you noticed that it had a rhythmic pulse which was different than the breathing machine or the heart rate machine. I thought that was very fascinating&emdash;it had a rhythm but it wasn't related to the other two!

Dr. John: At this particular juncture I could visualize the rhythm of the other two systems and this was different. It stuck in my mind because I could not hold this membrane still for the surgeon to scrape the tumor off. He was pretty upset with me. But he turned out to be the same surgeon that sent us the skull bone samples so that we could prove that sutures could move.

Dennis: So this is a system in the body that's obviously always been there but no one was really aware of?

Dr. John: That's about right. Cranial osteopaths knew about skull bones moving, but they didn't understand this system. I saw this thing in my patient, and I knew that there was something different that I didn't know anything about, and nobody else in the operating room knew anything about it either. Then along comes a piece of literature from the Cranial Osteopathy Academy. When I was in school they were considered kind of offbeat quack types. Most of the people in our college wanted them to hide because they were considered an embarrassment. Everybody knew skull bones didn't move (as far as the school was concerned), but these guys were getting some clinical results: they didn't know why the skull bones were moving, but they knew they were moving. I had the opportunity to see what was making them move during surgery. Most of the guys that did Cranial Osteopathy never did much surgery. Most of them were a bit more elderly, and osteopaths until the 1940's weren't doing much surgery.

So what happened was, I took a position they had offered me at Michigan State to research several things. I researched Kirlian photography, acupuncture and Cranial Osteopathy. We came up with how this whole thing works and actually the Cranial Academy didn't like the idea because it was like heresy against the mainstream of their organization. My job was to put a scientific basis underneath it and either prove it or disprove it. That's what our dean wanted me to do. I proved it was there, but it was different from what they thought it was. So, we did discover this system as it is, and we called it the craniosacral system.

Dennis: It's also worth mentioning here for our readers that you began in private practice, but you did spend nearly a decade as a clinical researcher and professor of biomechanics at Michigan State University. After that you founded your institute?

Dr. John: Well, I was in private practice for almost twelve years in Clearwater Beach, Florida before I was in Michigan. This is where I saw Delbert Smith. Then I went up to Michigan State in 1975. They offered me this job as a clinician/researcher and I accepted it and was up there for over 8 years. Later on I was teaching at the Metiger Foundation in Topeka, and one of the people from Unity Church heard me there and asked me would I like to start a model holistic health center there for Unity Churches. So I took that job for three years. Then we started our own institute after that, in 1985 in Palm Beach Gardens, Florida.

Dennis: In CranioSacral Therapy, how are evaluation and treatment carried out?

Dr. John: Our treatment is all done hands-on, and our evaluation is all done hands-on. There's an example I can talk about where the patient doesn't have any problem with sharing. Perhaps you remember an Olympic diver, Mary Ellen Clark. She won the bronze medal on the high platform in Atlanta. Mary Ellen was suffering from vertigo (dizziness), which is common to high divers. She had been all over the country. She came to see me in September in hopes that she could make a comeback. She had to lay off diving for about four months prior to that. So I evaluated her and I'm looking for stuck places in the craniosacral rhythm or the way it broadcast through the body. Her problem is dizziness, so she's been treated by all kinds of ear, nose and throat specialists and other doctors, but nothing worked. She couldn't dive. So I scanned her body as we would do in a craniosacral examination. What I found out was a lot of the problem was coming from the lower end down at the sacrum and up the dural tube (of that tube of membrane) into the head and then restricting the right temporal bone. This in turn was causing her to get dizzy, because your balance mechanisms are located in the temporal bone. The normal mobility of 10-12 cycles per minute motion was restricted in that temporal bone. Now, it wouldn't do any good to move the

temporal bone if you don't get the reason why it's stuck. That came from down in her lower back. Tracing from her lower back what I wound up with is she had an old injury in her left knee that was coming muscle-wise and fascia-wise up into her low back, restricting her sacrum. That was compromising the activity of her craniosacral system, which in turn was screwing up her temporal bone and making her dizzy. I got her knee fixed and then everything else was a piece of cake, and she was back to diving again. And then she won the bronze medal at the Olympics.

Dennis: That's excellent! How does this relate to "tissue memory" and what you call the "energy cyst?"

Dr. John: When I was at Michigan State I did a lot of work with physicists, biophysicists particularly. While I was working there, one of the things we did was we had Wednesday morning meetings and we had five clinicians and twenty-two PhD's from a wide variety of scientific backgrounds. We had already gone through the suture movement business and we had the hydraulic system pretty well taken care of. Working with these patients I said, "You know, I feel like there is an energy transference between the patient and myself when I am working with them." Part of that is because you have your hands still on them. You use maybe a little pressure on one finger, and then you move this or that, but your hand stays essentially in the same place, so that the hand/skin contact on a patient (or through the hair) is pretty constant. At the same time, I am doing research with Kirlian photography.

What I was doing was taking Kirlian pictures of my fingers and my patients fingers on the same place before and after every session. I did this for a couple of years. What I noticed was, let's say you came in with severe back pain and I worked on you, the first Kirlian picture you would probably have very weak coronas or defective coronas, which is the name for the broadcast of the energy out. I might have strong ones, but at the end of the session maybe you got strong or full corona and

I got more defective. It would look like I lost some energy to you. Now the question becomes—and I threw this at the physicists—can we measure that kind of energy transference? For a week or two the physicists ignored this question, and then I kind of insulted them and told them if they knew what they were doing, they would be able to answer this. This guy Carney got real angry with me and said he would come work with me to prove I was an idiot.

Anyhow, he started watching me with all of the patients. He was there all the time. “What did you do that for, why’d you do this, why’d you do that?” Ultimately, we wound up studying and making recordings of full body electrical potential, tuning out such things as electro-myographic stuff. What we were looking for was the body potential of fluctuations, considering that the body has a bag full of electrolyte conductors and the skin is the insulator that keeps it inside. When I do certain things, just by positional changes or modifying the cranial rhythm by compressing one area that’s moving too much, that kind of thing, it would change the electrical potential of the total body as we were measuring way down in the lower limbs. What he taught me to realize was when I found the right position with a patient to reduce the pain or to take that pain away, the electrical potential that he was measuring would drop when I got in exactly the right place. If I kept it there long enough the electrical potential would start to come up a little bit.

He said, “How did you know how to find that place?” It took a lot of introspection, but finally I discovered that when I found exactly the place that took the pain away, the craniosacral rhythm stopped. It stopped at the same time that the body electrical potential would drop. What we discovered here was that there is a change in electrical potential when I find exactly the right position. Now how did I find the position? Well, my answer to that was that I just followed the body’s tendency. What we found out over a lot of arduous work

was that if I was very skillful and very sensitive, I could find the position. I would go with that body to a position that alleviated the pain. It was the body that was taking me there. Then we found out those were the positions that the injury had occurred in initially. It happened over and over again. These were mostly Worker's Compensation patients, and they were mostly work injuries that I was working with at the time.

Dennis: So the body is telling you the past injuries?

Dr. John: Yes. The patient would say, "Gee, that's exactly the same position I was in when I fell down and hurt my back!" I didn't know that. Carney didn't know that. The patient didn't even know it until he got into the position. So we called that "tissue memory" because the muscles are taking us exactly where we need to go. When we get there, the path of injury is a straight line. In other words, if I fall down on my tailbone on a step, the force of me hitting the step goes into my body in a straight line. But when my body is straight, that line is bent. The energy can't come back out again around a curve or around a 90 degree angle.

When I get the body in exactly the right position, that straight line is once again reestablished, and now the energy can come back out the straight line. We found out when we measured it with thermography that we would get one or two degrees centigrade increase in heat while the body was releasing and at the same time during that period of heat release, the millivoltage was down and flat and I had a stop in the craniosacral rhythm. When the heat started diminishing, the cranio-rhythm started again and the electrical potential came back up—not usually as high as it was before, but back up to maybe halfway to where it was before. We got a correlation between all three of those things. So I learned lot of physics then. Carney started bringing books home from the library and said, "You learn this, and THEN I can talk to you." I really appreciated it. He was a good teacher.

Anyway, we decided that what's probably going on here is we have a chaotic energy that comes in—this energy from the blow comes into the body and it's disorganizing. Your body may dissipate it and then you don't have an ongoing injury. If the body can dissipate that foreign energy when it comes in, fine, you'll be all well and the tissues heal in maybe a week or two. It's those injuries that last that are the problem. You fall on your tailbone and you never get better.

Dennis: The deeper injuries?

Dr. John: The injury happened at such a time or such a way that your body was unable to dissipate that foreign energy—so it concentrates it into the smallest possible ball. When we find the pathway that the ball will exit, then the pain is gone. We call the compression into the ball an "energy cyst." Actually, Elmer Green from Metiger called it that. I was describing it as "entropy" and he said, "You are describing an energy cyst," and that's more correct. The tissues remember how to take you there, and when you get to the right place, it's like the body tissues are saying, "If you'll do this with me, I know how I can get this thing out of here." If you follow the body and do it very sensitively, it will take you to exactly the right position, the energy cyst comes out, and that thing that's been giving you trouble for the last five years is gone.

Dennis: That's remarkable. And you are testing for this with Kirlian photography and other instruments?

Dr. John: Yes. With Carney we did a polygraph reading. It was before big computerized things were available. We used to do a cardiac monitor and a breathing monitor and then a total body electrical potential monitor in both limbs. We had electrodes. I decided arbitrarily to put them about three inches above the kneecaps on each side and then ground each one on the same side at the top of the foot. That way we were as far away from brain electricity and heart electricity as we could get.

Carney made a special instrument that would add the negative and positive fluctuations. He tuned out what most electromyographers would term "noise." Carney edited in such a way with his instrument that it turned into a pattern we could read. Then we decided we would study the heat output when we saw this energy was coming out, and the Kirlian photography gave us a general idea of whether the coronas improved or not. Basically whether or not the patient gets better.

Dennis: Very fascinating. One thing that I noticed was that for non-practitioners or lay people to work on one another, you have something called Share Care Workshops. Those are conducted not just at the Institute in Florida, but around the country by different practitioners?

Dr. John: Yes, around the U.S. and Europe, Australia and New Zealand and Japan, too.

Dennis: So that's available for people who want to learn the basics. If they are interested in becoming certified with you, then they come to Florida?

Dr. John: All classes except for our advanced level are taught all over the country, in Europe, Australia, New Zealand and Japan. Our classes up to five levels are taught around the country; sixth level I still hang onto myself and I do teach them.

Dennis: What do you think will happen with the next century of bodywork?

Dr. John: I think that bodywork is going to really thrive and the reason for that is because conventional healthcare is going more and more high tech and more impersonal. I had a patient just the other day that had a virus infection that invaded his brain and they had him in the hospital for four days and nobody came closer than six feet to him. Everything was done by MRI's and all that kind of stuff. No doctor came in and really touched this guy. I think that the human

situation is such that we crave communication with someone on a touching level. When someone is a bodyworker, if all they are is well intentioned, and sensitive to the needs of the person they are working on, they can impart a level of self-healing that can't be done with a machine. What I really see happening is a big polarization.

There are some people that are really hooked on machines and high tech stuff, and there are other people migrating towards bodywork because it involves person-to-person contact. Not only because of that, but that's the thing that they really crave. Bodywork will become more educated also. The more you understand the body and the more you work with it, the more you find out that you can facilitate bodily self-healing. There's a lot of people getting damn tired of paying big bucks for all those pills, you know?

Dennis: Bodywork is a good compliment to the existing systems, but I don't think we can throw away the baby with the bath water and get rid of all Western medicine.

Dr. John: No I don't want to do that. I practiced in the days when we did cardiograms and the like, but I went in there and listened to the patients chest with my stethoscope, and at the same time I had my hand on them. Doctors don't often do that anymore, so that's why people are coming to bodyworkers. Bodywork is the vision of health care that gets more and more popular, simply because of the interpersonal relationship if nothing else!

Dennis: Because it's what people crave.

Dr. John: Well, you are born with a necessity of having your mother bond with you and that doesn't stop. When you are 40 you still need somebody to bond with, and if you go to a doctor and you don't even see the guy except through a screen or he sits on the other side of a big desk where he writes prescriptions, that doesn't fulfill your need! If you go to a

massage therapist and get a massage or go to the spa plus the massage—then you feel better. What I'd like to see happening is that doctor behind the desk would learn how to touch again like we did thirty years ago.

Αντενδείξεις της Κρανιοϊερής Θεραπείας

Understanding the Contraindications



John Upledger, DO, OMM, is President and Medical Director of The Upledger Institute (www.upledger.com) in Palm Beach Gardens

As you've probably read many times over the years, the CranioSacral Therapy (CST) evaluation generally involves no more than five grams of pressure – roughly the weight of a nickel. This gentle touch is one of the primary reasons CST is such a viable health care option for people of all ages and conditions.

That being said, there are a few contraindications for CranioSacral Therapy. Specifically, they are acute intracranial hemorrhage, intracranial aneurysm, recent skull fracture, and herniation of the medulla oblongata – in essence, any physiological condition in which slight changes in intracranial pressure could negatively affect your client.

How do you know when this is the case? If you're not sure, my best advice is to ask. Is there something in your client's history, or even from your own intuition, that is troubling you? If so, I recommend holding off on therapy and consulting with your client's physician. Ask if there is any concern about slight changes in intracranial pressure affecting your mutual client.

There also are some specific situations in which you might want to refer your client to a more experienced CranioSacral Therapist who has gone through advanced training (The Upledger Institute's Advanced I CranioSacral Therapy workshop or higher):

- **Recent brain hemorrhage or stroke.** Refer to an advanced therapist, or proceed after the client's physician verifies there is no more bleeding and gives you the go-ahead.
- **Recent spinal tap or puncture in the Craniosacral system.** Refer to an advanced therapist, or proceed after the client's physician verifies there is no more leaking of spinal fluid and gives you the go-ahead.
- **Arnold Chiari Malformation.** This is an incomplete foramen magnum in which the inferior poles of the cerebellar hemispheres and the medulla protrude and may herniate through the foramen magnum. Refer to an advanced therapist, or proceed after the client's physician gives the go-ahead. If you do proceed, do so with the lightest pressure possible. If you do any dural tube work, set the intention to work in a way that causes no inferior strain. In other words, don't do anything that places more strain – or shifts the fluid pressure to place more strain – on the foramen magnum, brainstem and dural tube. You might even choose to avoid certain techniques altogether that directly engage the area of the malformation, such as occipital cranial base techniques.

- **Recent fracture of skull bones, vertebral column or ribs.** Just proceed cautiously and refer to an advanced therapist if you have any concern.

Remember, CranioSacral Therapy relies on a blend of training, technique, intent, intuition and good old-fashioned common sense. Call on all of these qualities when you work, and you'll know precisely how to proceed.

To easily locate an advanced CranioSacral Therapy practitioner, visit www.iahp.com and look under "Search Practitioners" using three or all five digits of your zip code. Search for therapists with five to six CranioSacral Therapy class bullets filled in, which indicates an advanced level of training.

Craniosacral Therapy

Craniosacral therapy is a gentle, hands-on treatment method that focuses on alleviating restrictions to physiological motion of all the bones of the skull, including the face and mouth, as well as the vertebral column, sacrum, coccyx, and pelvis. Concurrently, the craniosacral therapist focuses as well on normalizing abnormal tensions and stresses in the meningeal membrane, with special attention to the outermost membrane, the dura mater, and its fascial connections. Attention is also paid to alleviating any obstacles to free movement by the cerebrospinal fluid within its membrane compartment and to normalizing and balancing perceived related energy fields. This approach is derived from experiments of John Upledger, an osteopathic physician and researcher (for example, see Upledger, 1977a and 1977b, which are discussed below).

As usually practiced, this therapy is a noninvasive treatment process that requires an uninterrupted treatment session of at least 30 minutes; often the session is extended beyond an hour. Practitioners indicate that successful treatment relies largely on the therapist's ability to facilitate the patient's own self-corrective processes within the craniosacral system. Postgraduate training in craniosacral therapy has been undertaken by a wide variety of physicians, dentists, and therapists. In the United States during 1993, 2,738 health care professionals completed the Upledger Institute's introductory-level workshop and seminar; 1,827 received training at the intermediate level, and 80 completed the advanced level. Training outside this country is available through the Upledger Institute Europe in the Netherlands and on a smaller scale in Japan, New Zealand, France, and Norway by American Upledger Institute teachers.

The most powerful effects of craniosacral therapy are considered to be on the function of the central nervous system, the immune system, the endocrine system, and the visceral organs via the autonomic nervous system. This therapy has been used with reported success in many cases of brain and spinal cord dysfunction. Although these successes have not been documented in formal studies, they have been observed subjectively or anecdotally by both patients and therapists. Most prominent among these success reports are cases of brain injury resulting in symptoms of spastic paralysis and seizure. Other areas of claimed success include cerebral palsy, learning disabilities, seizure disorders, depressive reactions, menstrual dysfunction, motor dysfunction, strabismus (a vision disorder), temporomandibular joint problems, various headaches, chronic pain problems, and chronic fatigue syndrome.

Research on tissues has documented the potential for movement between skull bones in adult humans, and pilot work with live primates has shown rhythmical movement of their skull bones.

Interrater reliability studies, which look for correlations in the observations of two or more independent raters (see the "Osteopathic Medicine" section), have shown agreement between "blinded" therapists evaluating preschool-aged children ("blinding" means that the therapists making the observations did not know which children had received craniosacral therapy, nor did they know the history or problems of the children) (Upledger, 1977a). Controlled studies have shown high correlation between schoolchildren with various brain dysfunctions and specific dysfunctions of the craniosacral system; that is, the craniosacral exam scores correlated with recorded school teacher and psychologist opinions of "not normal," behavioral problems, motor coordination problems, learning disabilities, and obstetrical complications (Upledger, 1977b). Moreover, Upledger reports that a few pilot studies by dentists have demonstrated significant changes in the transverse dimension of the hard palate as well as in occlusion in response to craniosacral therapy.

At present, work is under way that appears to demonstrate fluctuations in what are called energy measurements in circuits between craniosacral therapists and patients. The circuits are established by attaching electrodes to the patient and the therapist with an ohmmeter and a voltmeter interposed in the circuits. In observations with 22 patients, measurements have ranged from more than 30 million ohms at the start of a treatment session to 448 ohms with a brain-injured child; voltages have fluctuated between 10 and 254 millivolts. Upledger's interpretation is that the elevation in resistances read with the ohmmeter correlate with the palpable resistances that craniosacral therapists feel with their hands and that the energy put into overcoming these resistances is reflected by elevations in the millivolt readings. On the basis of these preliminary studies, plans are under way to explore further whether the energetic changes measured in the circuits accompany specific landmarks in treatment processes.

E Lederman 2000 Facilitated segment: a critical review.
British Osteopathic Journal 22:7-10

The concept of spinal facilitated segments has dominated osteopathic neurophysiology for over half the last century. This concept has been at the heart of osteopathic teachings and is often used both in clinical diagnosis and as part of the rationale of treating different musculo-skeletal and visceral conditions. Surprisingly, such an important subject has never been criticised: the existence of facilitated segments and their relevance to manual therapy or osteopathic medicine has never been questioned. This article re-examines the original studies of Korr, Denslow and their co-workers, aiming to identify what has been demonstrated in these studies and to reinterpret their findings in the light of current knowledge of neurophysiology.

Releasing the Energy Cyst

Have you ever had a client whose injury seemed to cause problems long after the site had healed? That is not as unusual as one might think. Research I conducted in the late 1970s with a biophysicist named Dr. Zvi Karni led us to discover that the body can retain the imprints of physical trauma in the tissues. These imprints, which can also include intense feelings that occurred at the time of injury, actually leave a residue embedded in the body. I call these areas of restricted or disorganized energy “energy cysts.”



The idea behind this is: When an accident occurs, the energy of the accident enters the body. This fits with the laws of thermodynamics, which tell us that energy cannot be created or destroyed. They also tell us that the natural tendency of atoms, molecules and energy is toward disorganization. When this external, disorganized energy – the “energy of injury” – is forced into the body, it penetrates into the tissues to a depth determined by the amount of force versus the density of the tissues. This force is countered only by the density of the tissues it is trying to penetrate.

A blow to the foot or ankle might penetrate through the leg all the way to the pelvis. Once it reaches its depth of maximum penetration, it stops and forms a localized “ball” of energy that doesn’t belong there. If your body is vital and able, the “energy of injury” can dissipate and normal healing can occur, but if your body is unable to dissipate this energy, it is compacted into a smaller and smaller ball in order to minimize the area of disruption to tissue function. As it becomes more compressed and localized, the disorganization within this compressed energy increases until it becomes an “energy cyst.”

A person can adapt to energy cysts; however, over time, the body needs extra energy to continue performing its day-to-day functions. As years pass and the body becomes more stressed, it can lose its ability to adapt. This is when symptoms and dysfunctions begin to appear and become difficult to suppress or ignore. Fortunately, a technique called “Energy Cyst Release” can help the skilled therapist deal with these particular challenges. It is an effective way of encouraging your client’s body to release those areas of blocked energy and accelerate a full recovery.

Energy Cyst Release is a component of CranioSacral Therapy,

which addresses restrictions in the craniosacral system that surrounds the brain and spinal cord. Using a light touch, the practitioner monitors the rhythm of the fluid coursing through the craniosacral system to detect potential restrictions and imbalances. Delicate techniques help release those problem areas and relieve undue pressure on the brain and spinal cord.

As part of that process, the body will sometimes spontaneously return to the same position it was in when the injury was first sustained. As this occurs, the therapist can feel the tissues of the body relax as the energy cyst is expelled. Then the body is free to fully return to its optimal levels of functioning.

This is what happened after a woman named Rebecca* was involved in a severe automobile accident. She visited a CranioSacral Therapist to help relieve the constant pain she had experienced for eight months. Though her fractures had healed, she was left with severe headaches that occurred almost daily, and her neck and lower back hurt constantly. The therapist first tried to find a structural reason that would account for the severity of the pain. Restrictions were cleared in her craniosacral system, which helped with her head and neck, yet her back continued to hurt.

During the tenth session, Rebecca was seated on a treatment table with her back to the therapist. He had one hand on her back and the other on her head as he tested the spine for subtle movements. Suddenly, Rebecca began to push hard against the hand on her back. After a few minutes she slumped forward. Rebecca reported that she had suddenly remembered an incident several years earlier when she was hit by a fist in the middle of her back. The resistance she felt from the therapist's fist enabled her to release the energy of the blow and of the accident injury spontaneously. Her life turned around after that session. Within a month, her pain was minimal.

This is a case in which the tissues had been released, but the

energy cyst still resided within them. By returning her body to the precise position it was in at the time of injury, the mass of disorganized energy that had been forced into the tissues from the original trauma was suddenly given an escape route, which was also the same route of its entry into the body. It is possible, after you've become experienced practicing these techniques, to release energy cysts without using the client's body position as the facilitating factor, but that approach requires a lot more work on your part, and it is much less natural. It is always better to work with the client's body, than against it.

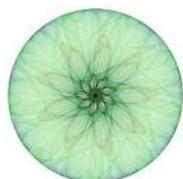
*Name changed to protect confidentiality.

John Upledger, DO, OMM
Palm Beach Gardens, Florida

Πληροφορίες για τη Κρανιοϊερή Θεραπεία

ΠΩΣ ΓΙΝΕΤΑΙ ΜΙΑ ΤΥΠΙΚΗ ΣΥΝΕΔΡΙΑ ΚΡΑΝΙΟΪΕΡΗΣ ΘΕΡΑΠΕΙΑΣ;

Η εφαρμογή της Κρανιοϊερής Θεραπείας γίνεται σε έναν ήσυχο χώρο, με χαμηλωμένο φωτισμό...



Η εφαρμογή της Κρανιοϊερής Θεραπείας γίνεται σε έναν ήσυχο χώρο,

με χαμηλωμένο φωτισμό. Ο ασθενής είναι ξαπλωμένος σ'Α ένα εξεταστικό κρεβάτι, έχοντας βγάλει τα παπούτσια του, φορώντας χαλαρά και άνετα ρούχα. Ο θεραπευτής μπορεί κατά διαστήματα να κάθεται ή να βρίσκεται όρθιος κοντά στο κεφάλι, στον κορμό ή τα πόδια του ασθενή. Οι εμπειρίες κατά την διάρκεια της συνεδρίας είναι τόσο μοναδικές, όσο μοναδικός είναι ο κάθε ασθενής αλλά και ο κάθε θεραπευτής. Μπορεί επίσης να διαφέρουν από συνεδρία σε συνεδρία. Κάποιες φορές ο ασθενής μπορεί απλά να χαλαρώσει ή ακόμα να αποκοιμηθεί, άλλες φορές μπορεί να αρχίσει να μιλάει υπερβολικά, ανακαλώντας κρυμμένες μνήμες ή απελευθερώνοντας κρυμμένα συναισθήματα. Άλλοι παραμένουν σιωπηλοί καθ' όλη τη διάρκεια της συνεδρίας, παρατηρώντας τη διαδικασία της αξιολόγησης ή την ίδια τη θεραπεία, ενώ άλλοι βιώνουν αισθήματα ή αισθήσεις στο σώμα τους.

ΤΙ ΑΚΡΙΒΩΣ ΘΕΡΑΠΕΥΕΙ;

Η μεγάλη πλειοψηφία των ασθενών που ανταποκρίνονται θετικά σε αυτή τη θεραπεία...



Η μεγάλη πλειοψηφία των ασθενών που ανταποκρίνονται θετικά σε αυτή τη θεραπεία

είναι αυτοί των οποίων τα συμπτώματα δεν έχουν αντιμετωπισθεί ικανοποιητικά από άλλες θεραπευτικές προσεγγίσεις. Με την Κρανιοϊερή θεραπεία δεν αντιμετωπίζουμε παθήσεις, αλλά βελτιώνοντας την λειτουργικότητα του νευρικού συστήματος, ενισχύουμε τον φυσικό αμυντικό μηχανισμό του οργανισμού, έτσι ώστε να του δώσουμε την δυνατότητα να αυτοδιορθωθεί. Μέσω αυτή της προσέγγισης συμπτώματα που επιμένουν, όπως για παράδειγμα είναι οι ημικρανίες, ο πονοκέφαλος, ο χρόνιος πόνος, οι αϋπνίες, οι αισθητικές διαταραχές, προβλήματα κροταφογναθικής άρθρωσης, ινομυαλγία, σπαστικό ραιβόκρανο, ορμονικές

διαταραχές, κατάθλιψη, συναισθηματικές διαταραχές και άλλα που σχετίζονται με την δυσλειτουργία του νευρικού συστήματος, μπορούν να αντιμετωπισθούν με αποτελεσματικότητα.

ΤΙ ΜΠΟΡΕΙ ΝΑ ΠΕΡΙΜΕΝΕΙ Ο ΑΣΘΕΝΗΣ ΜΕΤΑ ΑΠΟ ΜΙΑ ΣΥΝΕΔΡΙΑ ΚΡΑΝΙΟΪΕΡΗΣ ΘΕΡΑΠΕΙΑΣ;

Όπως το κάθε άτομο βιώνει τη κάθε συνεδρία της Κρανιοϊερής Θεραπείας με ένα μοναδικό τρόπο, έτσι τα άμεσα αποτελέσματα μπορούν επίσης να διαφέρουν.



Ο ασθενής μπορεί να χαλαρώσει τόσο ώστε να κοιμάται αρκετές ώρες μετά το τέλος της θεραπείας

Σε άλλους αυξάνεται η ενεργητικότητα τους. Ελάττωση του πόνου ή αύξηση της λειτουργικότητας μπορεί να προκληθεί αμέσως μετά τη θεραπεία ή μπορεί να επιτευχθεί σταδιακά τις αμέσως επόμενες ημέρες. Καθώς η Κρανιοϊερή Θεραπεία ενισχύει το φυσικό αμυντικό μηχανισμό του οργανισμού δεν είναι καθόλου αφύσικο η βελτίωση να συνεχιστεί εβδομάδες μετά τη θεραπεία.

ΕΧΕΙ ΠΑΡΕΝΕΡΓΕΙΕΣ;

Δεν έχει παρενέργειες.



Κάποιες φορές στη διάρκεια της θεραπείας, ο θεραπευτής θα υποστηρίξει περιοχές του σώματος του ασθενή, διευκολύνοντας την απελευθέρωση της συσσωρευμένης έντασης.

Αυτή η διαδικασία ονομάζεται «Απελευθέρωση Κύστης Ενέργειας» ή “Απελευθέρωση των ιστών της περιοχής”. Στη διάρκεια αυτής της

απελευθέρωσης ο ασθενής μπορεί να ανακαλέσει στη μνήμη του περιστατικά που αφορούν ένα προηγούμενο shock, τραύμα σωματικό ή ψυχικό / συναισθηματικό. Ανακαλώντας και βιώνοντας ξανά, σε περιορισμένη ένταση και διάρκεια, προηγούμενες τραυματικές εμπειρίες βοηθιέται το σώμα να αναστρέψει την δυσλειτουργία, αποκαθιστώντας την προηγούμενη “αρμονία”. Για κάποιους υπάρχει η φάση της αναδιοργάνωσης καθώς το σώμα προσαρμόζεται στις αλλαγές που γίνονται στο Νευρικό σύστημα, διορθώνοντας αφ’εαυτού προηγούμενες δυσλειτουργίες.

ΕΠΙΒΑΛΛΕΙ ΣΥΓΚΕΚΡΙΜΕΝΟ ΤΡΟΠΟ ΖΩΗΣ;

Όχι



Όχι ο ασθενής συνεχίζει την ζωή του κανονικά χωρίς περιορισμούς.

Τελικά αυτό που μας ενδιαφέρει είναι να προσφέρουμε στον ασθενή λειτουργικότητα απαλλαγμένη από συμπτώματα.

ΣΥΝΔΥΑΖΕΤΑΙ ΜΕ ΚΛΑΣΣΙΚΕΣ ΘΕΡΑΠΕΙΕΣ;

Φυσικά.



Φυσικά συνδυάζεται με άλλες μορφές θεραπείας.

Ενισχύοντας τον φυσικό αμυντικό μηχανισμό του οργανισμού, διευκολύνουμε την αποτελεσματικότητα άλλων θεραπευτικών προσεγγίσεων.

ΠΟΥ ΜΠΟΡΩ ΝΑ ΚΑΝΩ ΘΕΡΑΠΕΙΑ; ΜΕ ΠΟΙΑ ΣΥΧΝΟΤΗΤΑ;



Η θεραπεία αυτή εφαρμόζεται αποκλειστικά από θεραπευτές εκπαιδευμένους από το Ινστιτούτο Upledger, που ίδρυσε ο εμπνευστής αυτής της θεραπευτικής προσέγγισης Dr. John Upledger.

Η συχνότητα καθορίζεται από τον θεραπευτή ανάλογα με τις ανάγκες του ασθενή. Συνήθως πραγματοποιούνται 3 συνεδρίες την πρώτη εβδομάδα, 2 τη δεύτερη και 1 συνεδρία την τρίτη εβδομάδα. Μετά από 15 μέρες, γίνεται άλλη μία συνεδρία και στη συνέχεια μία φορά το μήνα για 6 μήνες. Η κάθε συνεδρία διαρκεί περίπου μία ώρα.

Απελευθερώστε το Νευρικό σας Σύστημα!!!

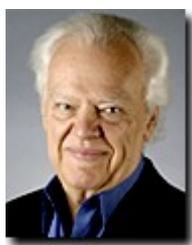


Ο Εγκέφαλος και ο **Νωτιαίος Μυελός** – οι δυο βασικές συνιστώσες του Κεντρικού Νευρικού Συστήματος (ΚΝΣ) – απαιτούν ένα ισορροπημένο φυσιολογικό περιβάλλον, ώστε να λειτουργήσουν

αποτελεσματικά. Η διαταραχή αυτής της ισορροπίας μπορεί να προκαλέσει αισθητικές, κινητικές και νευρολογικές διαταραχές στον άνθρωπο. Η Κρανιοϊερή Θεραπεία είναι **μια μέθοδος, με ήπιους χειρισμούς, που εφαρμόζεται από κατάλληλα εκπαιδευμένο θεραπευτή, σε διάφορα σημεία του σώματος – κυρίως στα οστά του κρανίου, του προσώπου, στη σπονδυλική στήλη και στο ιερό οστού**

– με σκοπό να εκτιμήσει αλλά και να αποκαταστήσει τη λειτουργικότητα του περιβάλλοντος, μέσα στο οποίο λειτουργούν ο Εγκέφαλος και ο Νωτιαίος Μυελός.

Με τον τρόπο αυτό συμβάλλει στη βελτίωση της λειτουργίας του νευρικού συστήματος, ιδιαίτερα του Εγκέφαλου, με αποτέλεσμα να ενισχύεται ο φυσικός αμυντικός μηχανισμός του οργανισμού και να καταπολεμώνται τα συμπτώματα ασθενειών, μερικά εκ των οποίων είναι χρόνια, όπως για παράδειγμα ο πονοκέφαλος, η ημικρανία, ο χρόνιος πόνος, το άγχος, αλλά και διαταραχές του ύπνου και της πέψης.



Lighten your touch, listen with an intention to serve, and trust what you feel. If you can do that, then you've got what it takes to be a good craniosacral therapist. Chances are, you've had it all along"

Εμπνευστής αυτής της θεραπευτικής προσέγγισης είναι ο Αμερικανός Οστεοπαθητικός ιατρός Dr. John Upledger, ο οποίος από το 1975 έως το 1983, που ήταν κλινικός ερευνητής και καθηγητής στο Michigan State University, μαζί με την επιστημονική του ομάδα, έβαλε τις βάσεις της Κρανιοϊερής Θεραπείας, και στη συνέχεια μέσω του Ινστιτούτου Upledger την διδάσκει σε θεραπευτές από όλο τον κόσμο.