

Applications of CranioSacral Therapy in Newborns and Infants, Part II

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Editor's Note: Part one of this two-part series appeared in the May 2003 issue.

Forceps and Vacuum Extraction

Once an infant's head is delivered and free from the pressure of the birth canal, we can focus on what occurs as the rest of the child's body is delivered.

The trip through the birth canal involves a brilliantly orchestrated series of twists and turns for the child's torso and pelvis, which essentially mobilizes each joint in the spine and pelvis and stretches all the related musculature and soft tissue. Nature intended this to be a process that relies more on pushing from uterine contraction than pulling from externally applied forces.

When those assisting the delivery process apply excessive traction to the child's head to "assist" the body through the birth canal, significant strains of muscles, ligaments, fasciae and joints may occur. The body's response to a strain is tissue contracture. There also may be small amounts of blood extravasated, which act as irritating stimuli that may later induce fibrotic changes in soft tissues. These phenomena may occur within the craniosacral system and in the paraspinal and pelvic tissues.

Wherever strains and extravasations occur, they can interfere directly or indirectly with proper functioning of the craniosacral system. Strains should be released; contracted tissues should be relaxed; fluid exchanges in tissues where extravasated blood has spilled should be encouraged; and all joints should be mobilized as soon as possible after delivery.

If these issues are not addressed, they can cause a wide variety of craniosacral system problems, spinal problems (that I believe can manifest as scoliosis in later life) and pelvic imbalances (that could easily interfere with the proper functioning of pelvic organs). It is easy to correct the majority of these problems immediately following delivery, and it is essentially risk-free when the work is done by a competent CranioSacral therapist. It requires only minutes to carry out the evaluation and treatment early in the child's life; it seems a shame not to do so as soon as possible.

Other causes of craniosacral system dysfunction that relate to delivery include abnormal presentations, such as either the face, arm, leg and breech. Each of these presents abnormal stresses, strains and pressures upon the child's body, which may manifest as unique craniosacral system problems. The system must be evaluated to determine the dysfunction, and the natural self-corrective mechanisms must be supported to attain full function and efficient craniosacral system function.

Forceps and vacuum-assisted deliveries often impose the excessive "pulling" forces that induce strain patterns in body tissues. Forceps, which are applied asymmetrically, often result in a misshapen head that is beyond the child's self-corrective abilities. These problems can be resolved by a skilled CranioSacral therapist as soon as possible after delivery.

My own experience with children delivered by vacuum extraction has firmly molded my opinion in opposition to this practice. The vacuum or suction on the child's head creates a negative force inside the head that can result in the suction of abnormal quantities of intracranial fluids into the top of the skull vault. This "edema" may result in long-lasting craniosacral system dysfunctions relating to loss of flexibility of the meningeal membranes, and probably some fibrous changes in tissues that are meant to be pliable and compliant.

The "vacuum-extracted" children we have worked on at our clinic require a great deal of CranioSacral Therapy (CST), even when therapy begins during the first year of life. The problems are correctable, but if another choice of delivery is available, it would be better to avoid the risk imposed by applying such strong vacuum forces to the top of the delicate fetal head.

Cesarean Section

I was surprised during my early work to see the strong positive correlation between the presence of significant craniosacral system dysfunctions and delivery by Cesarean section. It was quite puzzling, until I

remembered occasions during C-sections when I saw amniotic fluid spout up into the air a few inches as the incision was made into the uterus. This suggests the sudden reduction of pressure inside the uterus where the child has been living for the past nine months. Fetal physiology could be severely challenged by this sudden change in pressure. It seems comparable to a scuba diver surfacing too rapidly and suffering the "bends."

From a craniosacral point of view, this sudden reduction in external pressure might result in a rapid expansion of the fetal head. This, in turn, could easily result in intracranial membranous strain; micro tears in the meningeal membranes; and tiny capillary bleeds. As these extravasated red blood cells degrade, they undergo biochemical changes in which they become bile salts, which are irritants to brain tissue and membranes. This tissue irritation results in fibrous change in the form of gliosis in the brain loss of compliance in membranes; and small but significant intermembranous adhesions. These conditions may cause craniosacral system dysfunctions that could require extensive therapy.

Postpartum Events That May Relate to Craniosacral System Dysfunction

The most common postpartum event we have seen relating causally to dysfunctions of the craniosacral system is the suctioning of the mouth and nose. The newborn's hard and soft palate, and nasal structures are extremely delicate at the time of birth. The suction bulb or tube easily insults the soft tissues, causing them to contract. When it persists, this contracture compromises hard-palate and nasal-bone mobility that, in turn, causes craniosacral system dysfunction.

Hard palate problems usually result in sphenoid and/or temporal-bone dysfunction. These problems can easily lead to eye-motor system dysfunction and severe irritability of the child. Other symptoms are often sensory and very difficult to evaluate since a newborn cannot provide verbal reports of sensation. Therefore, it is up to the astute CranioSacral therapist to locate the system dysfunctions without much feedback besides crying and other signs of discomfort. Occasionally, the suctioning is done rather roughly, and actual bony dysfunction of the hard palate, zygomata and/or mandible can occur. These problems are more flagrant, and therefore more easily discovered during the evaluative process. What is discovered must then be addressed.

Other postpartum craniosacral problems are usually seen as they relate to injuries, like dropping the newborn. These are all individual and unique problems for which each child must be evaluated. The CranioSacral therapist must address what he or she finds.

Craniosacral System Evaluation and Protocol

I have spoken a lot about CST and its uses in the delivery room and during the early stages of the newborn child's life. In closing, I would like to describe the initial evaluation and protocol as I do it in the delivery room or the nursery.

First, I simply hold the skull vault of the child's head in one hand and evaluate for tightness and/or asymmetry over the whole skull-vault surface. Then I insert one finger of the other hand into the child's mouth and try to induce the sucking response. If it occurs, I enhance it in synchrony with the child's own rhythm. This enhancement is done in the form of gentle finger pressure on the roof of the mouth with each suck. If no sucking occurs, I will gently and rhythmically press on the roof of the mouth. As this rhythmical hard-palate pressure is continued, I can feel the skull vault expanding slowly. In this way, and by gently sculpting with the skull-vault hand, skull asymmetries and overriding can usually be corrected.

Next, I release the occipital base by laying one or two fingers under the back of the neck. These fingers support the upper cervical vertebrae in an anterior position while, with the other hand, I very gently urge the occiput to "back off" of the atlas. Once this is accomplished - and it seldom takes a full minute - I keep my occiput hand where it is. I move the other hand down to the pelvis and gently traction between the occiput and pelvis. This technique is used to release strains induced by "pulling" the newborn through the birth canal.

Frequently, I feel a sort of unraveling process along the spine as I do this technique. I believe many cases of scoliosis are headed off right here, just as many cases of hyperactivity and learning disabilities are avoided by the occipital-base release and the skull-vault molding.

I move both hands to the pelvis and, holding one half of the pelvis in each hand, I release and balance this region. I release the shoulders and rib cage by holding one half of the upper torso in each hand and releasing and balancing, just as I did with the pelvis. This total evaluation and protocol should not take more than five to 10 minutes. If specific problem areas do not resolve, the child should be seen again for re-evaluation and therapy within 24 hours.

This rather innocuous session with a newborn may head off problems later in life. It is a worthwhile, minimal-risk investment in a child's future.

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