

CranioSacral Therapy: Who Shall Do It?

By John Upledger, DO, OMM

In 1977, while I was preparing to conduct a research project involving the use of CranioSacral Therapy (CST) with learning-disabled children, a superintendent of special education suggested that one in 20 children (5 percent) in the Michigan public school system suffered from some form of brain dysfunction. I found this statement utterly astonishing, and very sobering.

This educator was only guessing, but he had been in the school system for over 25 years, so his "guess" carried a lot of observation, experience and wisdom. Even if he was more than 100 percent pessimistic in his estimate, how would we ever be able to offer quality CST to even one in every 100 (1 percent) of the millions of public-school children in Michigan and the rest of the country?

My initial hypothesis suggested that about 50 percent of brain-dysfunctional children could receive significant benefits from CST. (By "brain dysfunction" I mean a wide spectrum of problems, ranging from attention deficit disorder and hyperkinesis to debilitating seizure disorders and cerebral palsy, as well as dyslexia, dyscalcula, speech and motor function disorders, autism and childhood schizophrenia.) However, the children would all have to be CranioSacrally evaluated to determine who would benefit from a full course of treatment.

In Michigan in 1977, there were fewer than 10 osteopathic physicians who were functionally familiar with cranial osteopathy. There were only three or four who were familiar with our brand of CST, which is quite different from the osteopathic and chiropractic versions of cranial manipulation. CST focuses on the membrane as the most common source of craniosacral system dysfunction, and hydraulics (dictating the flow of cerebrospinal fluid through the system) as the means of evaluation and treatment.

A few months earlier, I had presented the second of a series of five-day CST seminars to a group of clinical staff members at the Menninger Foundation in Topeka, Kan. My purpose had been to introduce the pediatric

group to CST as an expansion of its program for the treatment of dysfunctional children. It was during this second seminar that I devised the "10-Step Protocol," which could be used by nonphysician clinical staff members. This protocol was essentially a "cookbook" method that, if carried out by a therapist on a patient, would serve several purposes:

- It would effectively address a majority (probably about 90 percent) of the dysfunctions of the craniosacral system.
- It would be essentially void of potential harm to a patient if carried out as directed.
- Its use would help the therapist develop the manual and perceptual skills necessary for more advanced CST work.
- This protocol does not require the therapist to have in-depth comprehension of underlying anatomical or physiological principles. It only requires knowledge of hand placement, direction of induced forces, a sense of the amount of force used (usually about 5 grams - roughly the weight of a nickel), and a sense of the patient's body response to the therapist's actions.

The rest was taken care of in the design of the 10-Step Protocol. We introduced the underlying anatomy and physiology during the CST seminars we presented at Menninger, but it was not necessary to have extensive knowledge of these principles in order to practice the protocol on a patient. This practice is safe and beneficial to the patient, and instructional to the student therapist.

I also developed the 10-Step Protocol because it was clear to me that the psychiatrists and other physicians at the Menninger Foundation would not (and probably could not) take time to do 30 or 40 minutes of concentrated hands-on therapy with a patient one-on-one, in addition to their psychotherapeutic talk sessions and psychopharmacologic-management responsibilities. Also, some expressed the opinion that "touching the patient" in the way we prescribed in CST would interfere with their objectivity as attending psychiatrists.

My second Menninger seminar was, therefore, largely attended by nonphysician therapists whom would do the hands-on work with pediatric patients. It was my first attempt to teach CST techniques to nurses, physical therapists and psychologists; it seemed successful. The interest was high and the work they were doing in the seminar was of good quality. During the following weeks, I received several telephone calls from nonphysician therapists who reported exciting successes with a variety of patients through the use of CST.

With this recent experience in mind, I saw a possible solution to the problem of how to provide CST evaluation and therapy to such a large number of Michigan public-school children. If the special-education superintendent was correct, we needed to be able to evaluate 5 percent of all public-school children enrolled in Michigan. If I was right, 2.5 percent of those enrolled in public school needed in-depth CST.

I discussed the problem of the lack of CST-qualified physicians with the dean of the College of Osteopathic Medicine at Michigan State University (MSU), where I was then a full-time faculty member. I described my positive experience teaching CST to nonphysician therapists at the Menninger Foundation, and obtained permission to explore the possibility in Michigan. As things have a way of happening, there was a school for multi-disabled children in Lansing, Michigan; CST, and my use of it, had become a major topic of conversation among its staff, because there was 4-year-old boy enrolled there whom I had treated in France earlier that year. During the series of CST sessions in France he had progressed rather dramatically - from hemiplegic to slightly motor impaired. He and his mother followed me back to Michigan for further treatment. By "coincidence," one of the physical therapists at this school had seen this little boy a year earlier at the Bobath Center in England. At that time the child was hemiplegic; now he wasn't.

My reception at the school was warm. The mother and therapist had both described the boy's progress to the staff members, who were waiting with open arms when I came in, and suggested that I teach them CST. We worked through the university. I initially taught the course one night a week for one university quarter. MSU provided the enrollees with postgraduate credit for course completion. Soon, we expanded the CST curriculum to two quarters.

The course enrollment began to include therapists of varied backgrounds from other centers for disabled children around the state, and from Ohio and Indiana nearby. (I discovered news travels very fast on the disabled-child network.) The enrollees were physical therapists, occupational therapists, nurses, special-education teachers, school psychologists and the like. Within a short time, there were a few physicians and chiropractors, as well.

At the same time I was teaching these open-enrollment courses, I was also teaching CST to full-time osteopathic and medical students within their respective colleges. This dual activity offered me an excellent chance to compare progress in the use of CST between the two groups. I taught essentially the same material to both.

In general, I found the nonphysician therapists a little better at learning and applying the evaluation and therapy techniques than the osteopathic and medical students. I think this was largely due to the differences in actual hands-on work experience, and the dedication of practicing therapists that develops as they see disabled children improving under their hands. The osteopathic and medical students did not have these experiences and motivating factors available to them. I also found a higher level of manual sensitivity in the majority of experienced therapists that the student physicians did not possess. This manual sensitivity is extremely necessary for the high-quality practice of CST.

The results obtained with patients (which is what it should be all about) of nonphysician therapists from a wide variety of disciplines were excellent. Since those first experiences, I've gone on to train thousands of massage therapists and other professional health care providers, who have done very well with CST. Now, we often teach the parents of disabled children to do this work on their children. After all, our goal is to help those in need.

So the question remains: Who can do CranioSacral Therapy? The answer is simple. Anyone who is motivated, compassionate, sensitive, and willing to subordinate his or her ego so that the patient is the most important factor.

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