

CranioSacral Therapy vs. Cranial Osteopathy: Differences

Divide

By John Upledger, DO, OMM

CranioSacral Therapy, which I developed in the 1970s, is compared frequently to cranial osteopathy, developed by Dr. William Sutherland. Although Dr. Sutherland's discovery regarding the flexibility of skull sutures led to the early research behind CranioSacral Therapy - and both approaches affect the cranium, sacrum and coccyx - the similarities end there.

What was to become cranial osteopathy began as the idea of an osteopathic student in Kirksville, Missouri, in the early 1900s.

Dr. William Sutherland saw that the bones of the skull were designed to allow for movement in relationship to one another. It was a radical idea that flew in the face of American and British anatomy textbooks, which taught that skull bones fuse together before adulthood.

To test his theory, Dr. Sutherland filled a skull with dry beans and added water. This caused the skull bones to move along the suture lines, and ultimately to disarticulate. He also performed makeshift experiments on himself with helmet-like devices that imposed variable controlled and sustained pressures on different parts of his head. His wife recorded personality changes, head pain and coordination problems he displayed in response to different pressure applications.

Based on his experiments, Dr. Sutherland developed a system of examination and treatment for the bones of the skull that became known as cranial osteopathy. Because so little was known about how it worked - and patient results seemed miraculous at times - Sutherland's system acquired an esoteric reputation.

Conversely, the origin of CranioSacral Therapy can be traced to the accidental discovery of the craniosacral system during a seemingly routine surgery in 1970. At the time, I had a unique view of the dura mater, the

outer layer of the meningeal membrane in the neck. Ordinarily compromised as part of surgical procedure, the dura mater was deliberately left intact during this surgery to prevent any risk of meningeal infection.

My task as a surgical assistant was to hold the dura mater still while the surgeon scraped a calcium plaque off its surface. No matter how I tried, I was unable to do it. The membrane continued to move rhythmically at a rate of about 10 cycles per minute. Neither my colleagues nor any medical text I consulted could explain this phenomenon.

Still curious about what I had seen, I enrolled two years later in a seminar that explained Dr. Sutherland's ideas and taught some of his evaluation and treatment techniques. Coupling my scientific background with tactile sensitivity, I surmised that the rhythmical motion I had seen during surgery could have been caused by a hydraulic-type system functioning inside a membranous sac encased within the skull and canal of the spinal column. After further study and research, I refined Dr. Sutherland's techniques and successfully incorporated them into my private medical practice.

In 1975, I was invited by Michigan State University to lead the world's first task force to study and verify the mobility of cranial sutures and bones. For the next five years, I led a team of anatomists, physiologists, biophysicists and bioengineers, and together we researched the basics and potential for performing therapy on the craniosacral system.

Through an extensive series of studies and experiments, we demonstrated how the craniosacral system could be used to assess and improve numerous health problems involving the brain and spinal cord. Yet this was a very different approach than that used in cranial osteopathy. Here we were focusing not on the bones of the skull, but on the membranes and cerebrospinal fluid surrounding the brain and spinal cord.

We verified that the craniosacral system does indeed operate like a semi-closed hydraulic system. Pressures build as the amount of cerebrospinal fluid increases in the system, forcing the fluid to move up and down the spinal cord. When the fluid moves, the membranes containing it also move, normally at a rate of 6-12 cycles per minute.

CranioSacral Therapy practitioners are trained to gently monitor this rhythm to detect and release imbalances and restrictions in the membranes that could potentially cause sensory, motor or neurological dysfunctions. As such, CranioSacral Therapy is never intended to cure disease, but simply to facilitate the body's ability to self-correct. It offers a comprehensive, whole-body structural and functional evaluation

protocol.

Even today, the focus of cranial osteopathy remains on manipulating the sutures of the skull. With CranioSacral Therapy, the bones of the skull are involved in that they serve as "handles" for the practitioner to use to access and affect the membrane system that attaches to those bones.

Another major difference between the two approaches is in the quality of touch. In general, the manipulations used in cranial osteopathy are often heavy and directive. Practitioners of CranioSacral Therapy usually use a light touch, scientifically measured to be between 5 and 10 grams. That's about the weight of a U.S. nickel resting in the palm of your hand. This gentle quality often belies the effectiveness of the therapy. Most patients report feeling nothing more than subtle sensations during a typical session.

Yes, CranioSacral Therapy and cranial osteopathy are quite different. Yet they remain linked in history by two osteopaths who trusted their observations and continued undaunted in their quests to prove their theories.

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