

Craniosacral Therapy and Attention Deficit Disorder

By John Upledger, DO, OMM

Craniosacral therapy is a gentle, hands-on therapeutic modality that may have a profoundly positive effect upon brain and spinal cord function. Application of this modality can also positively influence the endocrine and immune systems.

It seems especially effective at relieving excess tension patterns and restricted motion in both osseous and membranous anatomical regions and relationships. By relieving excess tension in the meningeal membranes, the impairment of related nervous tissue function is often restored.

By restoring bone mobility in the skull, spinal column, rib cage and pelvis, abnormal restrictive anchorings of these meningeal membranes are removed. This restoration of natural mobility of the individual bones of the skull also allows the sutural junctures (joints) between these bones to resume their normal pumping and accommodative activities.

The net result of all this is to enhance the movement of fluids throughout the central nervous system and its related structures and systems. Physiological fluid movement is essential to the healthy function of any tissue and organ, whether it be brain, bone, muscle, etc. Fluid is the vehicle used by the body's physiological mechanisms to remove metabolic and toxic wastes from within cells and from intracellular spaces. Fluid is also the vehicle the body uses to deliver nutrients and antibodies, and to carry messenger substances such as hormones, neuropeptides and the electrically charged ions and particles that are so important to physiological function.

Craniosacral therapy has been used quite successfully in the treatment of attention deficit disorder (ADD) and hyperkinesis since 1975. Our clinical experience suggests that, in a significant number of ADD and hyperkinesis cases, a structural problem may be a primary contributing factor to the symptom complex. When this structural problem is present and corrected, the symptoms of ADD and/or hyperkinesis disappear

very quickly, quite often in minutes to hours. If the structural correction holds the treatment, the effects can be permanent.

Sometimes the structural problem requires multiple corrections. However, with each therapeutic treatment, the corrective process becomes easier and the symptomatic improvement lasts longer until, ultimately, neither the structural problem nor the ADD and/or hyperkinesis symptoms reoccur.

The structural problem that often seems to be causally related to ADD and/or hyperkinesis is one that may frequently occur during obstetrical delivery. It happens when there is an excessive back-bending (hyperextension) of the occipital base of the skull upon the first cervical vertebra (atlas). The joint surfaces between this occipital bone and the atlas form a horizontally oriented V-shape, with the point of the "V" facing forward. The most common delivery position for the newborn is facing toward the back of the mother's body. Therefore, the back of the newborn's head comes under the mother's pubic bone complex. In so doing, the head may be severely angulated upon the neck.

This position represents a very threatening situation to the newborn's nervous system. (The neck could be broken if angulation goes much further.) An obvious response to this kind of threat is to splint or contract the tissues (muscles, etc.) to prevent life-threatening damage. When the delivery is over, the splinted tissues may or may not relax.

If they do not relax, the occiput remains in a locked forward (hyperextended) position on the atlas. If the soft tissues do relax, the bony surfaces may or may not release from each other. If the head-neck situation does not naturally self-correct, or if there is not a craniosacrally oriented practitioner available to facilitate the normalization of the head-neck relationship, the persistence of this restrictive situation results in abnormally increased tone of the muscles at the head-neck juncture.

Other soft tissues may also fibrose and hypertrophy. One result of these misguided, but well-intentioned tissue responses, is to increase back pressure to the outflow of blood through the jugular foramina, located in the midst of these overreactive, protective tissues on either side. The jugular veins pass out of the skulls through these foramina, as do the glossopharyngeal, vagus and spinal accessory (cranial) nerves. The increased tissue responses, by heightening venous outflow resistance, must reduce the degree of physiological fluid circulation within and around the brain. These fluids include cerebrospinal fluid, intracellular fluid, interstitial fluid, lymph and blood. The reduction in removal of waste products, secondary to the reduced efficiency of these fluid systems, results in an abnormal accumulation of these products that,

in turn, contribute to an irritable brain.

When fluid motion is restored, the symptoms of ADD and hyperkinesis often disappear. In addition, the impingement upon the major cranial nerves as they exit through the jugular foramina may result in colic, gastric upset, and/or difficulty in swallowing, depending upon the degree of effect upon the glossopharyngeal and vagus nerves. The spinal accessory nerve, when irritated, may cause excessive tone in the major neck muscles.

Craniosacral therapy is ideally suited for resolving the aforementioned structural problems. Although it is common for the head-neck structural problem to occur during obstetrical delivery, it can also be the result of any kind of accident or trauma that "whips" the head backward on the neck. Fortunately, the problem can be corrected with competent craniosacral work at any time, even as early as an hour after birth.

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