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CRANIOSACRAL THERAPY;WHO SHALL DO IT?

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In 1977, while preparing to conduct a research project involving the use of CranioSacral Therapy with learning disabled children, it was suggested to me by a superintendent of special education that one in twenty (5%) children in the Michigan public school system suffered from some form of brain dysfunction. I found this statement to be 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 with it a lot of observation, experience and wisdom. Even if he was over 100% pessimistic in his estimate how would we ever be able to offer quality CranioSacral Therapy to even one in every one hundred (1%) of the millions of public school children in Michigan and the country. My initial hypothesis suggested that about 50% of brain dysfunctioning children could receive significant benefit from CranioSacral Therapy. However they would all have to be CranioSacrally evaluated in order to decide which of them would benefit from a full course of treatment. By brain dysfunction I mean a wide spectrum of problems which ranges from attention disorder and hyperkinesis on the one hand to debilitating seizure disorders and cerebral palsy on the other. It includes dyslexia, dyscalcula, speech and motor function disorders and extends all the way to autism and childhood schizophrenia.

In the state of Michigan in 1977 there were fewer than 10 Osteopathic physicians who were functionally familiar with Cranial Osteopathy There were only 3 or 4 who were familiar with our brand of CranioSacral Therapy which was and is quite different from the Osteopathic and the Chiropractic versions of cranial manipulation in that it focuses on membranes as the most common source of CranioSacral dysfunction and hydraulics as the means of evaluation and treatment.

A few months earlier I had presented the second of a series of 5 day seminars on CranioSacral Therapy and its uses to a group of clinical staff at the Menninger Foundation in Topeka, Kansas. My purpose had been to introduce the pediatric group to CranioSacral Therapy as an expansion in their program for the treatment of dysfunctional children.

During this second seminar I devised a "10 Step Protocol" which could be used by non-physician clinical staff. This "10 Step Protocol" was designed to be a "cook book" method which if carried out by the therapist on a patient, would serve several purposes. First, it would effectively treat a great majority (probably about 90%) of the dysfunctions of the CranioSacral system as well as the osseous sutural problems upon which Cranial Osteopathy places its focus. Second, it would be essentially void of the potential for harm to the patient if carried out as directed. Third, its use by the therapist would develop the manual and perceptual skills necessary for more advanced CranioSacral Therapy work. Fourth, the use of this "10 Step Protocol" does not require comprehension of underlying anatomical or physiological principles by the therapist. It only requires knowledge of hand placement, direction of induced forces, a sense of the amount of force used (usually about 5 grams), and a sense of the patient's body response to the therapist's actions. All the rest was taken care of in the design of this protocol. We did indeed present the underlying anatomy and physiology during the seminar, but it was not necessary to have extensive knowledge of these principles in order to practice this "10 Step Protocol" on a patient. This practice is safe and beneficial to the patient as well as instructional to the student therapist.

I developed this "10 Step Protocol" because it was clear to me that the psychiatrists and other physicians at the Menninger organization would not and probably could not take the 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 of them expressed the opinion that "touching the patient" in the way which we prescribed in CranioSacral Therapy would interfere with their objectivity as attending psychiatrists. My second

Menninger seminar was therefore largely attended by non-physician therapists who would do the hands-on work with the pediatric patients. It was a first, this attempt on my part to teach the techniques of CranioSacral Therapy 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 non-physician therapists who reported exciting successes with a variety of patients with the use of CranioSacral Therapy.

With this recent experience in my mind I saw a possible solution to the problem of "how to provide CranioSacral 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% of all the public school children enrolled in Michigan. If I was right, 2.5% of the total public school enrollment needed reasonably indepth CranioSacral Therapy.

I discussed the problem of lack of CranioSacrally qualified physicians with the dean of the College of Osteopathic Medicine of Michigan State University where I was then full time faculty. I described my positive experience in the teaching of CranioSacral Therapy to non-physician therapists at the Menninger Foundation in Kansas and I obtained permission to explore the possibility in Michigan.

As things have a way of happening there was a school for multiply handicapped children in Lansing, Michigan. CranioSacral Therapy and my use of it had become a major topic of conversation amongst their staff because a 4 year boy was enrolled who I had treated in France earlier that year. During his treatment series in France he had progressed from hemiplegic rather dramatically to slightly motor impaired. His mother and her son followed me back to Michigan for further treatment. By "coincidence" one of the physical therapists at this school had seen this boy a year earlier at the Bobath Center in England. At that time the child was hemiplegic and now he wasn't.

My reception at this school for multiple handicapped children was very warm. The mother and the therapist had both described the boy's progress to the staff and so the staff was waiting with open arms when I came in and suggested that I teach CranioSacral Therapy to them. We worked through the University. The courses I taught were initially one night a week and lasted one university

quarter. Michigan State University provided the enrollees with post graduate credit for course completion. Soon we expanded the CranioSacral Therapy curriculum to two quarters.

The course enrollment began to include therapists of varied backgrounds from other centers for handicapped children around the state and from the nearby states of Ohio and Indiana. I was shown that news travels very fast on the handicapped child network.

The enrolles in the postgraduate university sponsored courses 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 taking the classes. At the same time that I was teaching these open enrollment CranioSacral Therapy courses, I was also teaching CranioSacral Therapy 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 CranioSacral Therapy as I taught essentially the same material to both groups. In general, I found the non physician 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 the practicing therapists which develops as they see a disabled child improve under their hands. The Osteopathic and Medical students do 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 which the student physicians did not yet possess. This manual sensitivity is extremely necessary for the high quality practice of CranioSacral Therapy.

The results obtained with patients, which is what it should really be all about, have been and continue to be excellent by well trained non-physician therapists from a wide variety of disciplines. Since those first experiences I have also trained a large number of massage therapists and dentists. Both professions have done very well with CranioSacral Therapy.

Now we often teach the parents of disabled children to do CranioSacral Therapy on their children. After all our goal is to help those who need.

Who can do CranioSacral Therapy? Anyone who is motivated, kind, compassionate, sensitive and willing to subordinate his/her ego so that the patient is the most important factor.