

Do Cranial Bones Move?

(Ask the Italians)

by **Tedd Koren, D.C.**



WE WERE TAUGHT IN SCHOOL THAT THE cranial bones are fused and do not move after infancy. That's because we weren't taught in Italian. What does language have to do with it? Read on.

Cranial motion was introduced to the osteopathic profession by William G. Sutherland, DO, in the 1920's. Sutherland was inspired by the 18th century philosopher and scientist Emmanuel Swedenborg, who described a rhythmic expansion and contraction of the brain.¹ Using, first, self-experimentation and, later, working on others, Sutherland discovered and described, in great detail, the rhythmic movement of the individual cranial bones and the skull, as a whole. He is considered the father of cranial osteopathy.²

A number of others have continued work in this field. Among them are:

- Nephthi Cottam, DC: discovered and developed cranial adjusting even before Sutherland published his findings. He called his work craniopathy.³
- Major B. DeJarnette, DO, DC: studied with Sutherland and later developed Sacro-Occipital Technique which incorporated many unique cranial/meningeal insights.⁴
- Richard Van Rumpft, DC: developed Directional Non-Force Technique (DNFT). As research director of the Sacro-Occipital Research Society, he taught cranial analysis and adjusting as part of his system from 1940 to 1985.⁵
- Carl A. Ferreri, DC: developed a cranial adjusting procedure known as Neural Organizational Technique (NOT). Using NOT, Ferreri reported success with dyslexia, learning disabilities, bedwetting, nightmares, scoliosis, Down's syndrome, cerebral palsy, color blindness and various other conditions.

Ferreri observed that dyslexia is caused by faulty motion of the sphenoid bone and at least one temporal bone. Learning dis-

abilities involve two sphenoid motions and no temporal bone faults; and misalignment of the skull bones can also result in "ocular lock," making reading difficult.⁶

CranioSacral Therapy (CST)

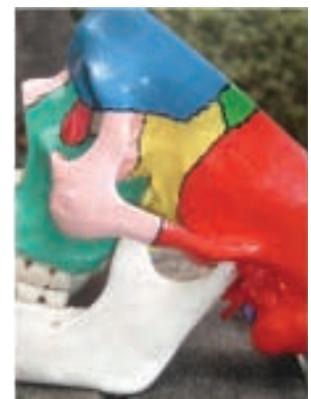
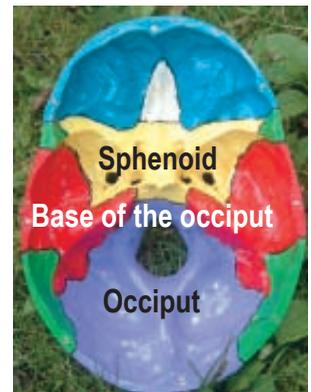
One of today's leading researchers and teachers of cranial movement is John Upledger, DO, developer of CranioSacral therapy (CST). Building upon Sutherland's work, CST uses (primarily) the cranial bones and sacrum as levers to release meningeal tension. Upledger reaffirmed Sutherland's observations that it was possible to feel the rhythmic movements of the human skull.

The human skull can be felt to subtly expand and contract at 6 to 12 cycles per minute, independent of the respiratory and cardiac rhythms. Many conditions could be diagnosed based on the strength and frequency of the skull movements.

The CST practitioner works to release adverse mechanical tension in the meninges and connective tissue to restore natural rhythm and flow of cerebrospinal fluid and energy throughout the body.⁷

Why are we taught cranial bones don't move?

Dr. Upledger was lecturing and demonstrating CST to a medical audience in Israel when he noticed that his statement on cranial bone movement didn't get the dramatic (skeptical) response he'd received from American medical audiences. He mentioned this to his host, who brought him to the hospital library and showed him an Italian anatomy book. His host translated: "Italian anatomists, in the early 1900's, taught that cranial suture ossification was pathological in the mature human adult. These teachings, therefore, contradict the British anatomists, who taught the doctrine of sutural ossification and cranial immobility as a normal condition."⁸



The human skull can be felt to subtly expand and contract at 6 to 12 cycles per minute, independent of the respiratory and cardiac rhythms

“You Americans learned your anatomy from English and German texts which state the skull bones don’t move. The Italian anatomists did not hold to that doctrine,” stated his host.

Ancient cranial adjusting

Cranial adjusting has been around for a long time. It was practiced in India for centuries and was also practiced by the ancient Egyptians and members of the Paracus culture in Peru (2000 BC to 200 AD).⁹

Goethe, also influenced by Swedenborg, considered the cranial bones structurally and physiologically similar to spinal structure: “The idea that the bones of the cranium were metamorphosed vertebrae dates back to an insight by Goethe, the German poet and polymath, in 1790.... The sphenoid and occipital bone are closely linked to each other in the base of the skull. Taken together, they exhibit all the formal elements of a vertebra.... The occipital bone is the equivalent of the body of the vertebra.... Rohen sees the basilar bone (occipital bone and sphenoid) as representing not simply the vertebra but the vertebral column of the skull....”¹⁰

Recently, original research on live monkeys and sections of human skull (containing sutures) demonstrated objectively that the cranium moves in a rhythmical manner. Additionally, the sutures, when viewed under high powered microscopes, rather than being fused and filled with calcified tissue are patent or open and contain connective tissue, nerve tissue and blood vessels.¹¹

Cranial adjusting and the cervical spine

Richard Van Rump, DC, taught that, unless the cranials are

properly moving and aligned, the cervical spine will re-subluxate, no matter how often it is adjusted. While it is undoubtedly the case that upper cervical specific care may positively affect the cranial bones (probably via meningeal release), it is also found that, if cranial subluxations are the “major” or primary dysfunction, cervical care will have limited success.

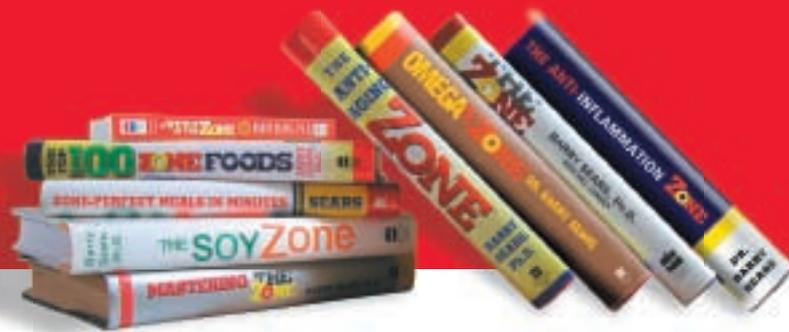
What can cranial subluxations cause?

Subluxations of the cranial bones can cause a multiplicity of problems throughout the body/mind, affecting the proper functioning of the brain, specific brain centers, the brain stem, cranial nerves, cervical ganglia, venous and arterial blood flow, cerebrospinal fluid (CSF) flow and other aspects of our physiology.

A partial list of problems caused by cranial subluxations includes:

- Occipital subluxation: headache and functional disturbances of the brain, stenosis of vertebral artery, disturbance of salivary glands and eyes, disturbance of vagus, glosso-pharyngeal and hypoglossal nerves, instability of cervical spine.
- Sphenoid subluxation: migraines, headaches, depression, vision problems, “brain fog,” grinding of teeth, dental malocclusion, eye pain, deviation of the eyeball, endocrine disturbances, instability of cervical spine.
- Temporal subluxation: dizziness, hearing problems, ringing in the ears, deafness.
- Parietal subluxation: evidence of head trauma.
- Nasal subluxation: disturbance of nasal secretion and nasal breathing; lacrimation.

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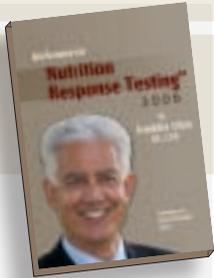


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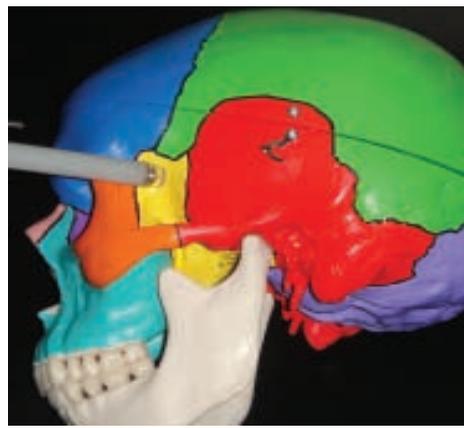
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Koren Specific Technique (KST)

Koren Specific Technique is a quick, easy, gentle technique used to locate and correct subluxations anywhere in the body, including (and especially) the cranium. KST is built (in part) upon the work of Van Rumpft, Sutherland, Upledger and Lowell Ward, DC (developer of Spinal Column Stressology).

With KST, the practitioner is able to check and correct (adjust) the entire structural system, including the cranial bones, quickly and easily.

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See references on pg. 63

*Koren Specific Technique, developed by Tedd Koren, DC, is a quick, easy way of locating and correcting subluxations anywhere in the body. Patients hold their adjustments longer and, because it is a gentle, low-force technique, it's easy on the doctor too. An additional (and very important) bonus for KST practitioners is the ability to specifically analyze and adjust themselves. For seminar information, go to www.tedd-korenseminars.com or call 1-800-537-3001. For information on the ArthroStim™ adjusting instrument, go to www.impactinc.net. Write to Dr. Koren at koren@korenpublications.com. **TAC***



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