

CranioSomatic Therapy for Applied Kinesiology

CranioSomatic Therapy is a cranial approach to treating musculoskeletal dysfunctions. It integrates traditional osteopathic cranial concepts and procedures with new, more current concepts and treatment procedures. Emphasis is placed on the following three topics: sphenobasilar (SB) patterns and related patterns of muscle function; sutural restrictions and related muscle function; and the Universal Right Torsion and Left Lateral Strain patterns.

Osteopathic literature describes ten SB patterns. Each of these, according to Quadrant Analysis, produces a unique internal and external alignment of the cranial bones. Manual muscle testing (MMT) demonstrates that each SB pattern also results in a unique somatic pattern of facilitated (strong) and inhibited (weak) muscles which can be used to identify the SB pattern. With the exceptions of the ‘universal’ Right Torsion and Left Lateral Strain patterns, treatment of the SB patterns can be accomplished by either pelvic blocking procedures or traditional osteopathic cranial procedures.

Each SB pattern also results in a unique pattern of sutural restrictions. Each restricted suture, or portion thereof, results in the inhibition (weakening) of one or more muscles. Although correction of an SB pattern by the procedures noted above should release the sutures, CranioSomatic Therapy provides a sutural clearing protocol – The 13-Step Clearing Protocol – to clear any sutural restrictions which might remain at the end of any treatment session. However, the clearing protocol can be used anytime; it can even be used as a ‘Self Treatment’ procedure.

The Right Torsion and Left Lateral Strain patterns appear to be universally present. These patterns produce a slight four-opposed rotatory scoliosis which results in a global imbalance of paired muscles, with one facilitated (strong) and the other inhibited (weak). In the supine position, the shoulder flexor group and hip flexor group are strong on the right, but weak on the left. In the prone position, the shoulder extensor group and Gluteus Maximus are strong on the left, but weak on the right. The Right Torsion and Left Lateral Strain patterns are present when the head is in a neutral position or turned to the left, but when the head is turned to the right the above muscle test findings are reversed. This reversal may be associated with the Asymmetric Tonic Neck Reflex, a primitive reflex that is present at birth.¹

The universal cranial Right Torsion and Left Lateral Strain patterns are referred to as Primary Cranial Patterns² to emphasize that the associated neuromusculoskeletal patterns occur secondary to, and in compensation for, the cranial patterns. This designation also differentiates these chronic cranial patterns from functional, easily-corrected sphenobasilar cranial patterns that may occur in coordination with the spine and pelvis as compensations for activities of daily living. (*See: The CranioSomatic Syndrome: A New Paradigm*)

Chiropractors, osteopaths, physical therapists, and others use a wide variety of modalities to treat cranial, spinal, pelvic, and other compensatory neuromusculoskeletal dysfunctions. However, manual muscle testing and other evaluation procedures from Applied Kinesiology demonstrate that the universal Right Torsion and Left Lateral Strain patterns, as well as their compensatory neuromusculoskeletal patterns, are almost always still present in both the general and clinical populations. These findings indicate that the treatment procedures currently in use are not

effective in releasing these chronic cranial patterns. Note that if the cranial patterns cannot be released, neither can the internal and external cranial faults they produce.

An explanation for the failure of traditional approaches to correct these two universal patterns may have to do with both the extent of the cranial distortions and their chronicity. These cranial patterns can be considered ‘pseudo-structural’ in the sense that the position and function of the cranial components, and the resulting chronic patterns of musculoskeletal compensation, are both long-standing. Both the cranial and musculoskeletal patterns can be identified in infants.

The resolution of these cranial patterns requires the application of new concepts and special treatment procedures. These include adequate force (a pound or more for some releases), and a handhold capable applying and maintaining the forces needed to release the cranial soft-tissue holding elements and mobilize the osseous cranial structures. The cranial concepts and procedures presented in CranioStructural Integration (CSI), the third workshop in our CranioSomatic Therapy series, quickly and permanently release both the chronic cranial patterns and their associated compensatory musculoskeletal patterns. These treatment procedures can be performed in one or two sessions and do not need to be repeated.

Correction of the universal Right Torsion and Left Lateral Strain patterns, and the elimination of their related neuromusculoskeletal compensations noted above, may be the key to the successful resolution of several difficult-to-resolve conditions or syndromes. These two chronic cranial patterns may be the underlying etiology of De Jarnette’s chronic SOT Category 1 (pelvic torsion), Category 2 (weight-bearing sacroiliac dysfunction), and Category 3 (Psoas and Piriformis dysfunctions) described in Sacro Occipital literature.^{3,4} A functional short right leg with heel tension and a flaccid right gluteal region (Category 1 indicators) are generally found in the prone position; and positive Arm Fossa tests (Category 2 indicators) are generally found in the supine position. These chronic Category 1 and Category 2 indicators are cleared by the CSI procedures.

The universal Right Torsion and Left Lateral Strain patterns may also be the underlying etiology of the Common Compensatory Pattern (CCP) described by Zink and Lawson⁵ in osteopathic literature. The CCP appears to involve both of these chronic patterns. The CCP is described as having a lateral tipping of the sacrum to the right in the coronal plane and a compensatory spinal scoliosis with four opposing curves. The lumbar curve is convex to the right with a right rotation of the lumbar vertebrae. These symptoms are also cleared by the CSI procedures.

Finally, the universal Right Torsion and Left Lateral Strain patterns, and their resulting compensatory neuromusculoskeletal patterns, could explain Willard Carver’s concept of ‘The Typical’. This pattern is described by Beatty⁶ and others^{7,8} in chiropractic literature as a right sacroiliac dysfunction with the sacrum tipped and rotated to the right and a four-opposed compensatory rotational scoliosis with the lumbar convexity to the right. The cited authors considered the Typical to be universally present and uncorrectable; Beatty referred to it as the hereditary norm of mankind. The above symptoms are also cleared by the CSI procedures.

See *Workshops & Notable Features* for descriptions of these workshops and others.

References:

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5. Zink, JG & Lawson, WB. An osteopathic structural evaluation and functional interpretation of the soma. *Osteopathic Annals*. 1979;7(12)
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