

CranioStructural Integration

Author's Foreword

For years I practiced chiropractic using Applied Kinesiology (AK), Sacro Occipital Technique (SOT) and Diversified techniques. My AK and SOT cranial experience was supplemented by Stober's Endonasal Technique. The greatest challenge I encountered was getting the pelvis to stay in position after it was realigned, particularly in SOT Category II patients. Attempts to restrict the activities of athletes for any period of time, or to restrict the type and amount of recreational or work-related activities of others, met with immediate resistance. Some people would simply opt to live with their discomfort. Most employees not on Workers' Compensation or Disability had to continue making a living performing their same activities.

My years of clinical experience using manual muscle testing, postural evaluation, and various reflex procedures in the evaluation and treatment of patients had enabled me to identify and demonstrate the presence of multiple 'common patterns' of musculoskeletal compensation. Some of these patterns could be temporarily eliminated by the treatment techniques I used, but would return when the patient walked around the table or just stood up (i.e., became weight-bearing).

Based on my evaluations of patients in standing positions, one of the major patterns appeared to be an unlevel pelvis, with the sacrum tipped laterally to the right and rotated. The innominate bones appeared to be counter-rotated relative to each other. In the prone position, the right leg was generally functionally shorter, and had greater Achilles tendon tension than the left. The right Gluteus Maximus muscle tested weak while the left tested strong.

In the supine position the left shoulder and hip flexor groups tested weak when the straight arm and straight leg were flexed 30 degrees and pressed toward the table; the right shoulder and hip flexor groups tested strong. Using procedures from Applied Kinesiology, it was also observed that any strong muscle (used as an 'indicator muscle') would weaken when the patients opened their mouth wide, turned their head or eyes to the right, or shifted their jaw to the right.

The supine findings disappeared temporarily when these patients were treated in the supine position as a SOT right Category II (with a horizontal wedge placed under the right iliac crest and an oblique wedge placed under the left acetabulum). However, the symptoms would return on weight-bearing, or if the patient just performed a 'bicycling' movement of their legs while still in the supine position.

According to traditional osteopathic cranial concepts, the right lateral tippage and rotation of the sacrum could be associated with a tipped occiput, as found in sphenobasilar right torsion. The existence of a relationship between dysfunctions of the cranial components and spinal scoliosis (compensation) was succinctly described and emphasized (*italics are his*) by Magoun (1976, p. 73), "Spinal scoliosis and cranial scoliosis are inseparable. What is not generally realized is that *the cranial abnormality precedes and dictates the spinal pattern in a good proportion of the cases*, rather than the reverse."

To understand these osteopathic cranial concepts more fully, I attended several courses on craniosacral technique at the Upledger Institute to acquire craniosacral knowledge and develop

treatment skills in this area. Unfortunately, traditional craniosacral treatment procedures, performed by myself and others using a vault handhold with light force, did not release the cranial right torsion or the associated compensatory musculoskeletal symptoms described above.

However, convinced that Magoun was correct and that the cranial pattern was the key to correcting the spinal and pelvic patterns, I adopted a more assertive treatment approach. By using a modified fronto-occipital hold, direct technique with an adequate amount of force (several pounds), and innovative treatment procedures, I was able to correct the chronic cranial right torsion and release the musculoskeletal dysfunctions previously noted.

Release of the chronic cranial right torsion resulted in immediate reductions in the tippage of the pelvis and sacrum. Most of the other symptoms previously observed in the prone and supine positions were also resolved. This cranial treatment approach was so effective that after the first treatment patients could jog around the room without the symptoms returning. Based on the fact that the corrections would continue to hold on subsequent visits, the improvements appeared to be long-term corrections. This cranial treatment approach and the lasting results have been repeatedly confirmed over the years.

Manual muscle testing and other evaluation procedures soon revealed the presence of a second major chronic pattern: a left lateral strain. This pattern accompanies the chronic right torsion pattern. It is characterized by a bilateral, horizontal shift of the cranial components, anteriorly on the left and posteriorly on the right. A similar shifting appears to occur at the SI joints. The left lateral strain also produces a series of alternating counter-rotations of the spinal vertebrae and segments of the extremities. The left middle and lower Trapezius muscles and the left Gracilis muscle are weak in this pattern. An interesting musculoskeletal effect of the chronic left lateral strain is that its presence prevents the left Psoas, right Tensor Fascia Latae, and other muscles associated with the chronic right torsion, from strengthening after the right torsion release has been performed. As with the torsion pattern, the above symptoms associated with the left lateral strain clear when the chronic left lateral strain is resolved. The chronic right torsion and left lateral strain patterns have been named Primary Cranial Patterns in order to emphasize that the associated neuromusculoskeletal patterns occur secondary to, and in compensation for, the cranial patterns.

An explanation for the failure of the traditional light-force approach to correct the right torsion pattern may have to do with both the extent of the cranial distortion and the chronicity of the pattern. Both the chronic right torsion and the chronic left lateral strain appear early in life. They are long-standing structural shifts of osseous cranial components and are maintained by changes in their soft-tissue holding elements. Physiological motions and the 10 typical compensatory sphenobasilar patterns, which occur in coordination with the spine and pelvis in compensation for our activities of daily living, still occur without altering the chronic right torsion or the left lateral strain patterns. Although light-force can be used to release these transient patterns, it appears to have little effect on chronic patterns.

Chiropractors and osteopaths use a large variety of treatment modalities to treat cranial and musculoskeletal dysfunctions. However, manual muscle testing and other evaluation procedures from Applied Kinesiology demonstrate that the chronic patterns of right torsion and left lateral strain are almost always still present in the cranium and musculoskeletal system, in both general

and clinical populations. These findings indicate that the treatment procedures currently in general use are not effective in eliminating these patterns. However, these chronic patterns can be easily, and permanently, corrected by applying the concepts and procedures presented in this CranioStructural Integration workshop manual.

This shortened edition of my CranioStructural Integration manual has proven to be equally effective as the original longer edition.

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