Cranial Technique in the Older Child - Video One

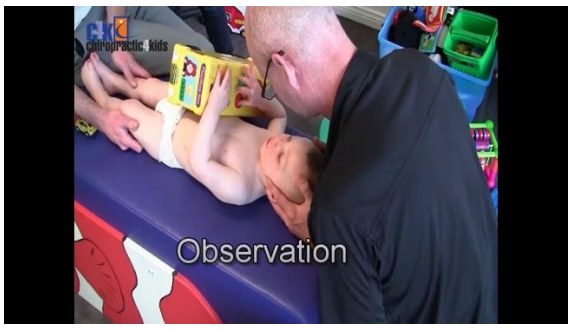
Just like newborns and infants, toddlers and older children also present their own special and unique challenges to the private practitioner in the assessment and treatment of the craniosacral system.

As the baby grows and develops, the character of the cartilage, membrane and bone which comprise the cranial vault undergoes considerable modification. As the child matures, the ratio of flexible membranous cranial vault, to more rigid osseous cranial vault, decreases. This naturally affects how the paediatric practitioner may influence the craniosacral system.

As we have previously discussed, in my experience the most frequent, clinically significant cause of craniosacral system dysfunction is abnormal tension in the dural membrane system. For the purposes of craniosacral diagnosis and treatment, and to help you begin to appreciate the function of the dural membrane system when assessing and treating the toddler and older child, I would urge you to visualise the bones of the cranial vault as well as the sacrum, as the 'solid areas' within the dural membrane. Once you accept the idea that the cranial vault bones and sacrum are simply a part of the dural membrane, and therefore simple levers which can be used to evaluate and treat the dural membrane, the techniques of diagnosis and treatment of abnormal dural tensions in the toddler and older child, become more achievable for the private practitioner.

As we have discussed, in the older child, inhalation and exhalation may be used to not only aid in the assessment of cranial dysfunction, but also may be incorporated as an integral component of a number of cranial treatment techniques.

Observation



The first step in cranial assessment of the toddler and older child, as it is for the infant, involves simple observation. Once again you should observe the child for evidence of facial structure and/or skull asymmetry. In this age group you should pay particular attention to the depression of the greater wing of the sphenoid. As we have discussed, when the sphenoid bone is locked in extension there is often a slight indentation over one or both sphenoids.

You should observe for symmetry of the nasolabial folds, the size and shape of the child's eyes, the level of the ears and mastoid processes, as well as the symmetry of the child's mouth when smiling. Often an obvious asymmetry will not tell you specifically what is wrong, it will simply alert you to the fact that something is wrong with the cranial function of that child. Any asymmetries should therefore be noted and correlated with your other clinical findings.

Initial Palpation

Following observation, you should gently lay your hands on the head of the child , and depending upon the age of the child, palpate the anterior fontanelle, which may have fused to become the bregma, and then palpate the lambda posteriorly. The anterior fontanelle will normally close between 9 and 24 months. (90% are closed by 18 months).

From these landmarks, you should then perform a quick screening palpation of the cranial sutures to give you a general idea of their condition. As with the infant, your screening palpation of the sutures should involve palpating for symmetry and tension. You should also look for ridging or areas of depression.

While palpating the sutures you should at the same time be getting a general feeling for the symmetry of the cranial vault.

As with the infant, the assessment and correction of craniosacral system dysfunction in the toddler and older child, may result in dramatic changes in the child's health and general state of well-being. For this reason, I believe it is essential that any practitioner who treats children of this age, should incorporate this powerful technique into their paediatric management protocol.

Cranial Protocol

As with infants, my examination and treatment of toddlers and older children follows a specific routine. A routine which has been gradually modified over the years. This routine I believe can be easily adopted by even the most inexperienced practitioner, as an effective and powerful adjunct to their current paediatric management protocol. This routine involves the following:

- CV4 (Occipital Pump) Technique

- Cranial base mobility
- Occipital condyle balancing
- Sutural release
- Sacral base release (floating the sacrum)
- Spinal assessment

CV4 (Occipital Pump) Technique

CV4 refers to compression of the fourth ventricle. The CV4 technique promotes fluid movement within the intracranial system, and it is a powerful technique you can use to access and directly alter the cranial rhythm. The primary function of this technique is to correct imbalances in the flexion/extension cycle and functionally reset the cranial system (assuming no major restrictions exist).

Under normal circumstances the occiput provides an accommodation to changing intracranial fluid pressures. The CV4 technique significantly reduces the ability of the occiput to allow for these pressure changes. The intracranial hydraulic fluid pressure is therefore increased and redirected along all other available pathways when the motion of the occiput is restricted. The CV4 technique is, quite simply, an excellent ‘shot gun’ technique for a multitude of problems in that it enhances tissue and fluid motion and helps to restore normal cranial function.

To perform the technique, cup your hands so that the thumbs make a ‘V’. Your thenar eminences should be approximately two centimetres apart. Place them beneath the child’s occiput being sure to totally avoid the occipitomastoid sutures.

There are two CV4 techniques you may wish to use depending upon the age of the child, as well as your proficiency with tuning in to the craniosacral rhythm.

In the younger child, as the child’s occiput narrows in the extension phase of the craniosacral cycle, this movement is followed by your thenar eminences. As the child’s occiput attempts to widen during the flexion phase of the cranial cycle, you should resist this widening. Please note that your hands become immovable, but you do not squeeze your thenar eminences together. Hold this position until you feel a build up of local pressure which at a critical point will push past your resistance and resume flexion and extension. This may be repeated several times and can take several minutes to ‘cycle through’ each time.

In the older child who can follow instructions well, or if you are new to craniosacral therapy and are having difficulty palpating the craniosacral rhythm in a child, then you can use a procedure which utilises the breathing of the child, as well as gentle pressure, to initiate a response. This procedure involves the practitioner with the same hand positions and contact points exerting gentle pressure on the lateral aspects of the occiput. The child is instructed to breathe deeply and then hold the breath out as long as possible, to the point where an involuntary inhalation is taken by the child. The

hand compression is maintained throughout the entire procedure. This process of prolonged exhalation, with an involuntary inhalation may need to be repeated several times to achieve the necessary response. The goal with this technique is to perceive a ‘softening’ of the area between the thenar eminences, with perhaps also a perception of added warmth in the area.

Regardless of whether you consciously feel these changes at the occiput, this technique can be a very effective ‘general cranial’ technique, which I have used with great success many times in my management of paediatric patients.