

Cranial Technique in the Older Child - Video Two

Vault Hold: Technique 1

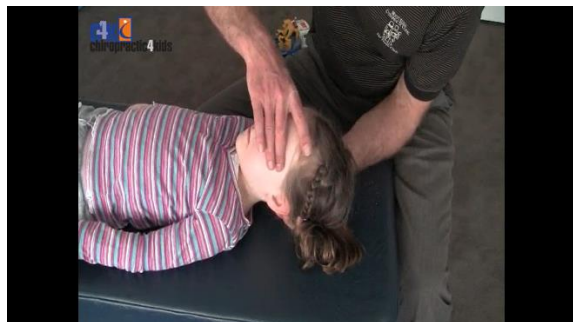


The vault hold is used to evaluate and where necessary correct cranial base motion. The technique as described here can be modified for practitioner and patient comfort taking into account both the size of the patient's head, as well as the size of the examiner's hand. The technique can then be altered or improvised individually for each patient.

With the child supine, the first vault hold involves your index fingers gently contacting the areas overlying the external surfaces of the greater wings of the sphenoid bilaterally. Your fifth fingers rest bilaterally in contact with the occipital squama approximately two centimetres medial to the occipitomastoid suture and slightly above the superior nuchal line. The middle and ring fingers are not in direct contact with the head and do not participate in gathering information during the examination.

As I have said some slight variations in the placement of the fingers may inevitably occur, depending upon the size of the therapists hands and/or the size of the child's head.

Vault Hold: Technique 2



The second vault hold involves supporting the child's occiput with one hand, while the other hand is placed so that the thumb overlies the area of one greater wing of the sphenoid and the fifth finger overlies the opposite sphenoid.

With both of these techniques, it is essential that, prior to contacting this area, you observe for a slight depression or lack of fullness over one or both sphenoids. This may indicate a sphenoid which is locked in extension, and is a common finding in young children.

The motions which you will test using the vault hold, and attributed to movement at the sphenobasilar joint include: flexion/extension, side bending or laterality to the left or to the right, or torsion with the greater wing of the sphenoid high on the left or the right.

In the perfectly functioning craniosacral system, flexion and extension are the only spheno-basilar joint movements which are occurring while the patient is in a relaxed position. However the spheno-basilar joint/cranial base will also allow for torsion and side bending movements.

Your experience and training will potentially determine how you record cranial subluxations. Personally when the spheno-basilar joint moves more readily into flexion and is more resistant into extension I record this as a spheno-basilar flexion subluxation. When the spheno-basilar joint moves further into left lateral strain than into right lateral strain I record this as a spheno-basilar left lateral strain subluxation. In other words the subluxation is named according to the direction towards which the cranial base moves with the greatest ease.

Using either of the vault holds detailed previously, exert a gentle force over the occipital squama and greater wings of the sphenoid concurrently. This force is directed towards the patient's feet. The third and fourth fingers are not in use and the thumbs are in contact with each other. Once you feel that the cranial bones have responded to your initiating force, you then become passive and simply follow the cranial motion to its restricted end point. Flexion at the spheno-basilar joint is the motion being tested with this technique. In other words the angle formed by the occiput and the sphenoid body becomes more acute. Once you have reached the end point of the flexion movement, then passively follow the sphenoid wings and occipital squama back to a position of neutral balanced ease. You then apply a similar bilaterally and equal force in a cephalad direction, towards yourself. Again once the motion is initiated, your force is terminated and the motion is passively followed to its restricted end point. This movement into extension lessens the acuteness of the angle at the spheno-basilar union. This may be repeated several times until you are satisfied that the restriction has been freed.

A variation to this technique, which can be implemented in the older child who can follow instructions, or perhaps for the practitioner who is new to craniosacral therapy and is having difficulty palpating the flexion/extension craniosacral rhythm, is to perform the same technique with prolonged inhalation and prolonged expiration. As we have discussed, this has the effect of inducing flexion and extension movement at the sphenobasilar junction. As you exert a gentle force over the occipital squama and greater wings of the sphenoid towards the patient's feet, you advise the child to take a long, slow, deep inhalation. Following this you then apply a similar force in a cephalad direction towards yourself, and the child is directed to slowly exhale fully through the movement.

Spheno-basilar junction flexion.



Another technique which can be used to create flexion at the spheno-basilar junction involves placing gentle pressure through the hard palate. This can be a quite challenging technique when applied to a toddler who is not of the age where they will necessarily respond to instructions. The danger is that the child will clamp down on your finger resulting in a painful bite! It is important therefore to modify your technique to minimise the chance of this happening.

There are a number of options available to you which should allow you to satisfactorily perform this procedure without injury. One option is to have the parent gently but firmly hold the child's mouth open, or to perhaps gently push the child's cheek from the side so that the child cannot close the mouth. You may wish to use a device such as a cork wedged between the child's back teeth. For younger children who have only their front teeth you can perform this technique by coming in from the side of the mouth.

These are all techniques you may wish to experiment with in order to find that procedure which best works for you. Personally I have found that all children are different and therefore you need to be flexible with your approach with this technique.

Using a glove or finger cot, apply gentle pressure to the midline of the hard palate just posterior to the cruciate suture, on the palatine bones. The direction of pressure is towards the anterior fontanelle or bregma. As we have discussed earlier, by inducing pressure into the palatine bones, movement is created in the vomer which then influences the movement of the sphenoid.

While applying this pressure your other hand contacts the occiput with gentle pressure below the external occipital protuberance, to direct the occiput into flexion. Combining the two movements together will allow you to follow the cranial bone movement into flexion to its restricted end point.

You may need to perform this technique a number of times to effect maximum change in the cranial function of the child.

Once again a variation to this technique, which can be implemented in the older child who can follow instructions, or perhaps for the practitioner who is new to craniosacral therapy, is to perform the same technique with prolonged inhalation. As we have discussed, this has the effect of inducing flexion at the sphenobasilar junction. As you exert a gentle force into the hard palate, you advise the child to take a long, slow, deep inhalation. As with the original technique, while applying this pressure your other hand contacts the occiput with gentle pressure below the external occipital protuberance. As the child exhales you release the pressure at both contacts, and then resume the pressure again on inspiration. This should be performed a number of times.

This technique in children can be very powerful and in many cases is the key to the entire cranial system.

Spheno-basilar junction lateral flexion



As with the infant, side bending or lateral distortions of cranial base motion should also be assessed for in the toddler and older child.

To assess for lateral distortions at the spheno-basilar junction, sit to the side of the patient and place the palm of your inferior hand under the occiput with your fingers perpendicular to the spine. Then

gently contact the greater wings of the sphenoid with the thumb and middle finger of your other hand (being careful not to contact the frontal bone).

Under normal circumstances, during the flexion phase the occiput and the greater wings of the sphenoid will move closer as the angle of the inferior sphenobasilar surface slightly decreases.

To begin the technique, at the beginning of the flexion phase of the craniosacral motion, gently approximate your fingers on one side. You should note the extent of the perceived movement, and then passively monitor the movement back to neutral, then through the extension phase, and back to neutral again. As the next flexion phase begins, repeat the test on the opposite side. The amount of approximation on each side is then compared.

Please note that the force applied by you during this technique is very small. Once the lateral movement has begun into flexion in response to your induced force, you should simply become a passive monitor observing how far the movement will go.

For the practitioner new to cranial work, this technique can be quite challenging. If you are having trouble perceiving movement at the sphenoid, it can help to ask yourself, "Do I feel a sense of opening and closing as I move my fingers together?" Most importantly do not expect to feel more, by pushing more firmly. Your contact should always be very light because the movement is very subtle.

Once again there is a variation to this technique. With the same contacts just described, as you approximate your fingers on one side, you advise the child to take a long, slow, deep inhalation. Then maintaining the contact you follow the movement back through prolonged exhalation. The amount of movement is then compared.

Spheno-basilar junction torque



Following testing for lateral distortions, you should then proceed to the assessment of torsional distortions of cranial base motion.

To assess for torsional distortions at the spheno-basilar junction, you should maintain the same contacts and gently induce torque by rotating your superior and inferior hands in opposite directions. If the perceived movement is not equal and symmetrical, gently work the restricted side by torquing the sphenoid and occiput in opposite directions while holding the occiput into flexion. I find that this technique works best when the child is directed to take a prolonged, deep inhalation as you gently induce torque with your contacts.