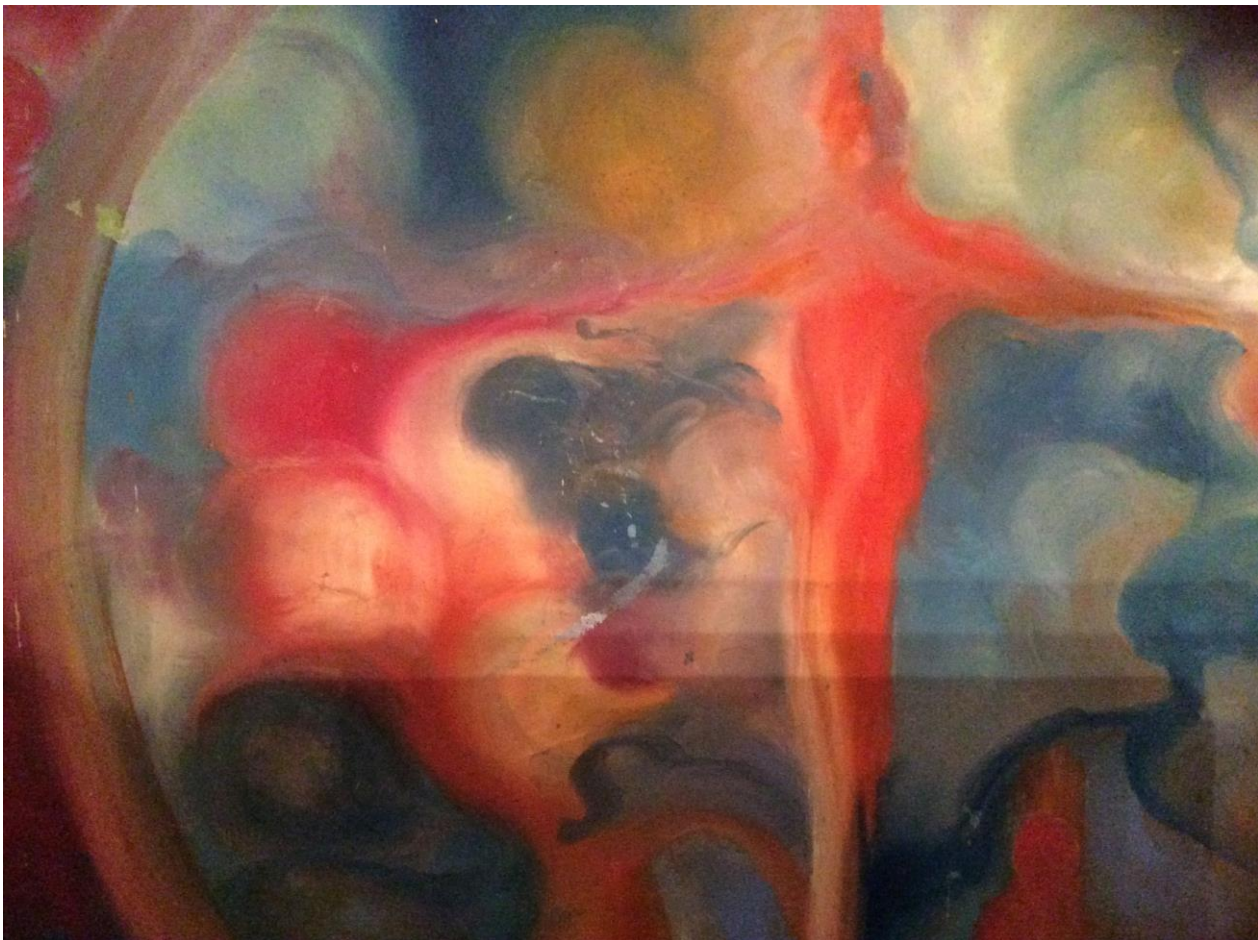


# *International Cranial Association*

## *Journal Issue 1*

*'The noblest study of the acutest minds focused for the good'*  
*Dr. Andrew Taylor Still*





Art by Jonathan  
January 2017

# *Happy New Year*

*'I dislike to write and only do so when I think my productions will go in to the hands of kind hearted geniuses who read, not to find a book of quotations, but to go with the soul of the subject that is being explored for its merits- weigh all truths and help bring its uses forward for the good of man'*

*Dr. Andrew Taylor Still*

## Officers of ICrA

**President:** Carole Smith

**Vice President:** Rosemary Allen

**Treasurer:** Desmond Henley

**Journal Production/Secretary:** Maureen Mulligan

**Committee Members:** Paul Ashburner, Lin Bridgeford, Charles Bruford, Desmond Henley, Brian Isbell

**Administrators:** Kingsley Smith

**Study Day Article:** Bill Ferguson with input from Pat Mc Carthy

## Profiles



### Carol Smith President

I graduated from the college of osteopaths in 1979 and have always had a passion for cranio sacral work and completed the training courses ICra provided in the 1980's and 90's with Joseph Goodman and Bill Wright. I attended all the study days. In 2008, Janine leach asked if I would help her reestablish the association and we have been meeting with amazing speakers ever since  
I am proud to be involved.

### Rosemary Allen Vice-President

Structural & Cranial Treatments for Adults, Children & Babies

### Photo



### Lin Bridgeford – Membership

Lin has a lifetime interest in Healing and Dance which translated well into working as an Osteopath (1986), Kinesiologist (1982) and a Yoga Teacher (1998) and Yoga Teacher Trainer (2015). Lin studied Craniosacral Therapy and Visceral Manipulation with the Upledger Institute (1998) and Cranial Osteopathy with ICrA (2000) and followed the Sutherland Cranial College pathway (2002) to become a Fellow. This was part of a MSc based in Osteopathy, with focus on Sports, Obstetrics and Gynaecology from an Osteopathic viewpoint. MSc research was on the effect of



Osteopathic treatment on the ability to perform yoga postures. Lin is passionate about finding the root cause of issues to help people and has studied Western Medical Acupuncture, Functional Biochemistry/Nutrition, Sound and Colour Therapy, Hypnosis and Neuro Linguistic Programming (NLP).

IN Health

Lin Bridgeford

07710 227 038

01273 309 557

Clinics in Saltdean, Brighton and Horam. Yoga in Saltdean, Brighton, Crowborough and Horam



## Desmond Henley – Treasurer

Acupuncturist, Craniosacral Therapist, Naturopathy, Osteopath

I have been practicing Osteopathy since 1994 after graduating from the College of Osteopaths. Prior to this I worked in the NHS as a diagnostic radiographer for 22 years. I am very passionate about my work and believe in the principles and practice of osteopathy.



## Paul Ashburner D.O.

With nearly 30 years of clinical practice Paul has accumulated a vast experience in treating a wide range of conditions. Patients range from the new born to those over ninety years old with treatment approaches adapted to suit the individual.



## Charles Bruford

PRINCIPAL, CLINIC TUTOR

Charles Bruford is proud to be a graduate of the European School of Osteopathy. He is a Fellow of the Higher Education Academy and holds a PGCert in Higher Education. He is a fully registered member of the General Osteopathic Council, a member of the British Osteopathic Association and is on the committee of the International Cranial Association.



## ***Dr. Brian Isbell***

BSc, PGCE, PhD, DO, MBiol, completed a BSc in Chemistry and a PhD in Biophysics. Brian taught in a medical school in West Africa for four years before returning to the UK to lecture in biomedical sciences. In 1993 he completed his training in osteopathy and naturopathy at the College of Osteopaths. For 30 years Brian was a Head of a Department at the University of Westminster, where for 15 years he managed a large scheme of degrees in Complementary Medicine as well as lecturing on health sciences, complementary medicine and research. Brian has carried out clinical research and published over 30 papers on topics including the evaluation of effectiveness of complementary therapies and developing educational provision in complementary medicine. For the past 20 years, he has practiced as an osteopath, craniosacral therapist and naturopath in the NHS, private practice and a university teaching clinic.



## **Maureen Mulligan - Secretary**

Fellow ICNM \* CEO Sphenoid Ireland \* CEO CMS Ireland Practitioner courses in suicide prevention.

Working on a research submission.

As CEO CMSP UK led research in the management of violence and suicide prevention with a Cranial based regime within HM Prisons undertaken by the Centre of Crime and Justice Studies, Kings College Hospital in 1998.

Provides a health and well-being programme for battered abused women, men, mothers in cultural poverty deprived communities with highest suicide and crime in Ireland.

Presentation to Oireachtas Justice Committee June 2014 re rights for prisons to recovery option programmes.



## NEWS ITEMS

*Richard Cook is retiring from the Committee. Thank you to Richard Cook for all his dedication and commitment to the ICRA, we wish him the very best for the future.*

***Members Services:*** *if you would like members to know about a service you provide, send details to Head Office.*

*Article contributions for the next journal can be sent to the secretary [maureenmulligan@sphenoidireland.ie](mailto:maureenmulligan@sphenoidireland.ie)*

## Membership News

*Membership year is due from 1st February 2017.*

*New membership fees:*

*£55.00 full membership*

*£35.00 1st year graduate*

*£30.00 Students*

*£50.00 Associate members*

**Professional Development**  
**Spring 2017 International**  
**Cranial Association Study Day**  
**Workshop**

**March 25th 2017**

**Averille Morgan**

**Presents**

**"Exploring osteopathic  
approaches with  
such concepts as Ignition and  
Transition in case studies related  
to Conception and Dying"**

Registration 09:30 for 10.00 to  
17.00

venue is BCOM, London NW3  
5HR,

6 hrs CPD Certificated, open to all  
practitioners

**LUNCH PROVIDED**  
**ON LINE BOOKING NOW**  
**AVAILABLE!!**



**Bookings** [www.icra-uk.org](http://www.icra-uk.org)

**email enquiries@icra-uk.org**

**Course fee: £80 for ICRA**

**members, £55 students; £105 for**

**non-**

*International Cranial Association Seminar November 2016  
Foetal Positioning presentation by Renzo Molinari*

*Report by Bill Ferguson with input from Pat mc Carthy*

## How foetal positioning can lead to foetal dysfunctions in babies and affect mothers postpartum

The presentation began with some slides and case histories, illustrating some of the principles of osteopathic thinking in obstetrics.

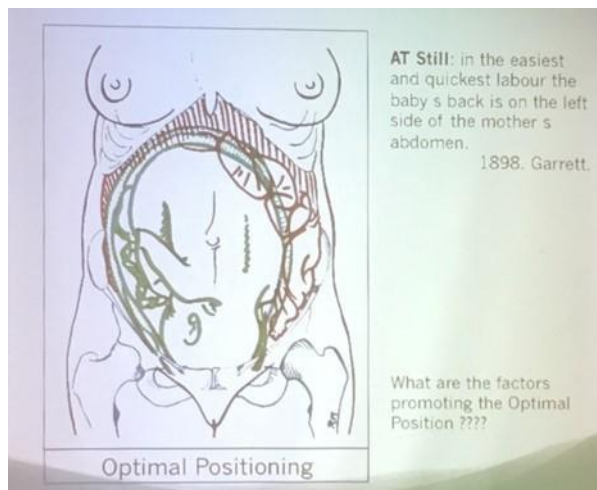
### **Case History 1**

The baby was in a good position and all seemed well. On examination of the mother there was a restriction at the lumbosacral junction. This restriction subsequently prevented engagement of the baby and the emergency medical intervention left the mother badly injured internally, and the baby with cranial vault distortion and neck strain.

### **Case History 2**

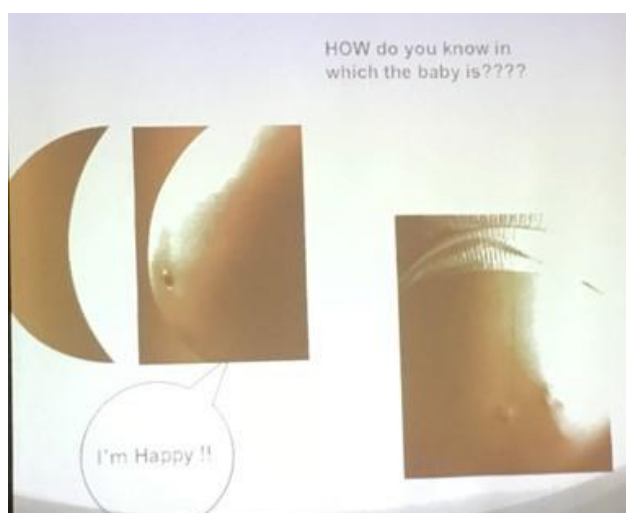
The baby was born with holes in the heart. In this case, it was enough to ensure a good blood supply to the heart and the holes closed on their own.

Renzo advised against a symptom-led approach to treatment, rather use an osteopathic assessment THEN see if the symptoms are explainable in the context of your assessment. There are some exceptions to this guideline: if the mother complains she is “itchy all over”, there could be a liver problem and if there is elevated blood pressure it is wise to refer her to a specialist.



This image shows the optimal position of the baby for easiest delivery. The baby's back is on the left and the chin is tucked in to reduce the A-P dimension of the head.

In late pregnancy, if the head is engaged, exaggerated



rotation of the mother's pelvis is contraindicated. How can we tell the position of the baby (without ultrasound)?

Look at the curve of the belly. A single curve is good; two curves suggests a reversed presentation.

Ask the mother where she felt the kicks to work out the presentation: everywhere – suggests breech, liver – suggests left side, stomach suggests right side. The position becomes fixed at 32 – 34 weeks when the baby weighs about 2.5kg

Palpation: use flat fingers, be sensitive to kicks at your hand. If this happens back off, wait a moment then gently return your hand. If the baby is comfortable with your contact, it may move towards it.

## C-section

80 years ago, 9 out of 10 C-sections were fatal to the mother. Usually because of blood loss.

Caesarean sections are becoming increasingly popular in many societies (London Lindo Wing 82%), USA average 60+%. Unfortunately, the baby misses out on the moulding and massaging effect of a normal delivery and misses out on the opportunity to share the mother's microbiome.

There is increasing concern that lack of microbiome inoculation is connected with the rise in childhood autism, asthma and food intolerance. To minimise this deficit, the mother should be encouraged to breast feed (milk contains >600 families of bacteria) and have direct skin to skin contact with the baby.

Perversely an emergency C-section may be better for the baby as it is the baby who triggers the labour process and not the calendar.

## Fertility

Over the last few generations fertility rates have fallen in both men and women. Some reasons could be antibiotics in the food chain, chemicals from plastic bottles. Sperm counts have dropped by 50% in one generation. The angle of the female pelvis has changed over the last 80 years

What should the birth process look like?



Physiological Birth video clip

<https://www.youtube.com/watch?v=Xath6kOf0NE>

Some recommended reading Michel Odent: Do We Need Midwives, and also his contribution to another book, Mama: Love, Motherhood and Revolution, by Antonella GambottoBurke.



Some interesting thoughts from Dr. Michel Odent

## *Fathers should be banned from birth as they stop the woman relaxing*

A woman in labour needs to be protected against all possible stimulation of her thinking brain, because giving birth is the business of the primitive brain structures. 'The neocortex is useful for daily life, but in some situations – like sex and childbirth – we must stop thinking.'

If a woman could turn off her 'thinking', her neocortical activity, a phenomenon known as the 'foetus ejection reflex' can occur, he said. This is where the baby slips out with no conscious effort, he said. Here, the body does all the work and the woman simply lies back while it happens. He explained: 'If nobody is interfering there will be a short series of irresistible contractions, no voluntary movements at all.'

Even the setup of delivery room stops the natural birth process, as light in hospital lamps is in the blue part of the spectrum. This inhibits the release of melatonin, the 'darkness hormone' which is one of the main birth hormones. Melatonin works alongside oxytocin, the 'cuddle hormone', which plays a role in inducing contractions.

Dr Odent also warned that the increasing tendency towards women having their labours induced could impair their ability to breastfeed.

In a stark warning, he said that if current trends continue, the 'future of the human capacity to give birth is at risk'.

He believes that women are becoming increasingly dependent on other interventions such as forceps, epidural pain-relieving injections and other drugs. He also warned against women routinely being given the drug oxytocin to induce labour or speed the process up.

He urged midwives to become the 'protectors of the evolutionary process' and to protect women from those doctors who are keen to intervene.

And he suggested they sit quietly in the corner of a darkened labour room knitting, which would calm the mother to be and enable her to produce the natural hormones needed for birth.

Read the full article here [http://www.dailymail.co.uk/health/article-3147111/The-secret-quickpainless-](http://www.dailymail.co.uk/health/article-3147111/The-secret-quickpainless-childbirth-Just-don-t-think-ban-partner-room-leading-doctor-claims.html)

[childbirth-Just-don-t-think-ban-partner-room-leading-doctor-claims.html](http://www.dailymail.co.uk/health/article-3147111/The-secret-quickpainless-childbirth-Just-don-t-think-ban-partner-room-leading-doctor-claims.html)

Treatment modalities:

OSD: muscular and local decompression

FSD: unwinding and de-programming

OSD+FSD is possible and complex to treat

Vagus injuries:

Left vagus lesion expect upper stomach irritation, reflux

Right vagus expect pyloric irritation, vomiting

Different dysfunctional patterns

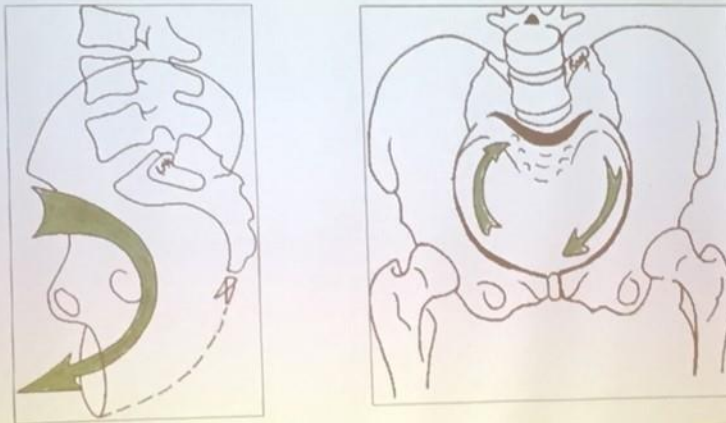
**Obstetrical Osteopathic somatic Dysfunctions.**  
mainly compressive problems and their reactions.

**Foetal Osteopathic Somatic Dysfunctions**  
mainly postural positioning, deviation, sleep positioning

TTT modalities :  
OSD : M , Local decompression....  
FSD : unwinding , deprogrammation...

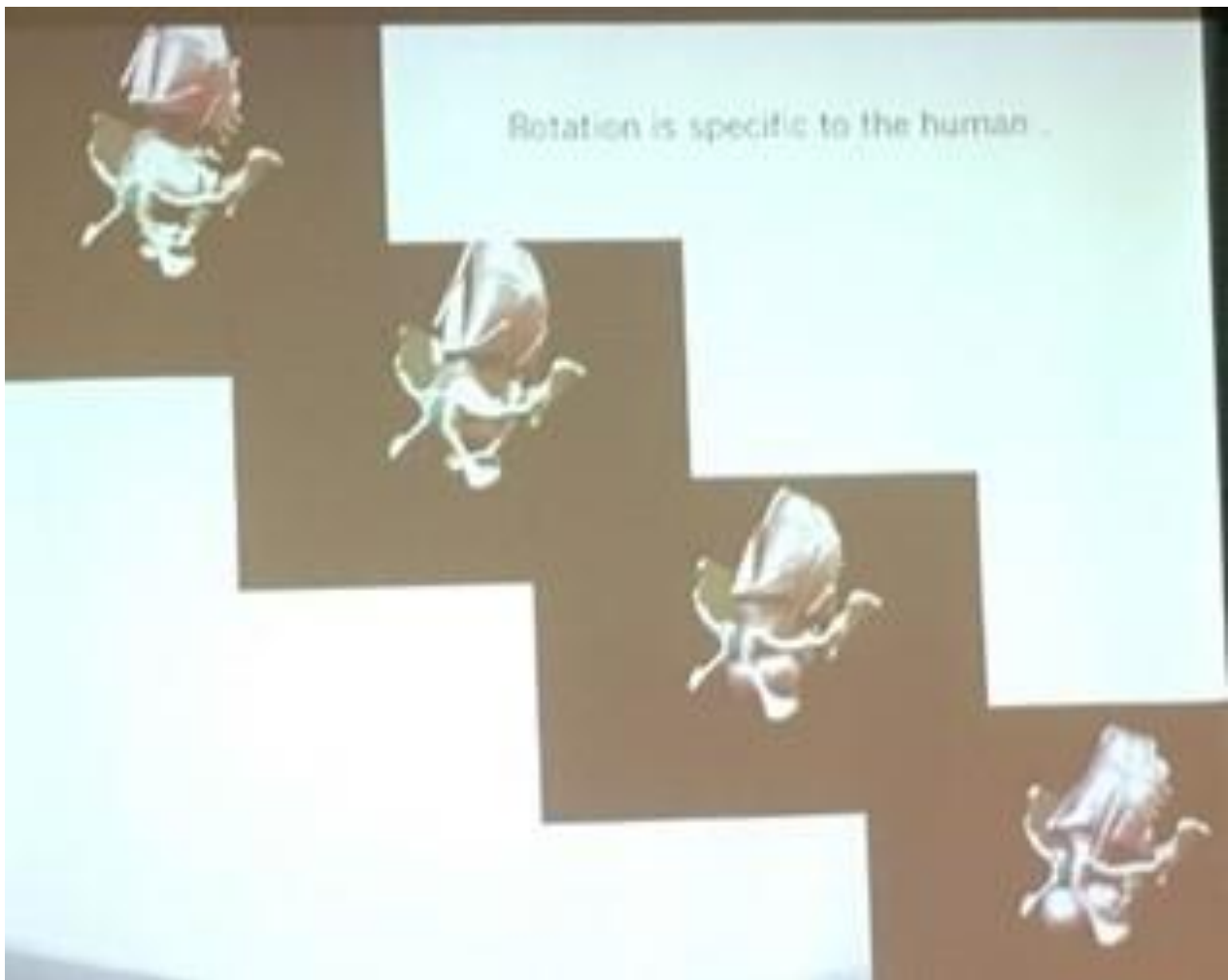
OSD + FSD are possible and complex.

Double Rotation (in sagittal and horizontal planes) = Spiral



The mechanical impetus for this clockwise rotation comes from the uterus. During a uterine contraction the baby is pushed in a spiral direction.

The uterus is held in position by ligaments. Ligaments can fibrose or atrophy when they are subject to trauma or restricted blood supply. This can affect both the position of the uterus and its ability to function normally. For example, a restriction in the broad ligament may also reduce the blood flow in the uterine artery. The hypogastric plexus has a relation to the broad ligament and is vulnerable.



Rotation is a necessary part of birth in humans, other animals have an easier process and have straight birth canals. The sacral promontory forces the shift to an oblique axis. Overall the process is a clockwise spiral.

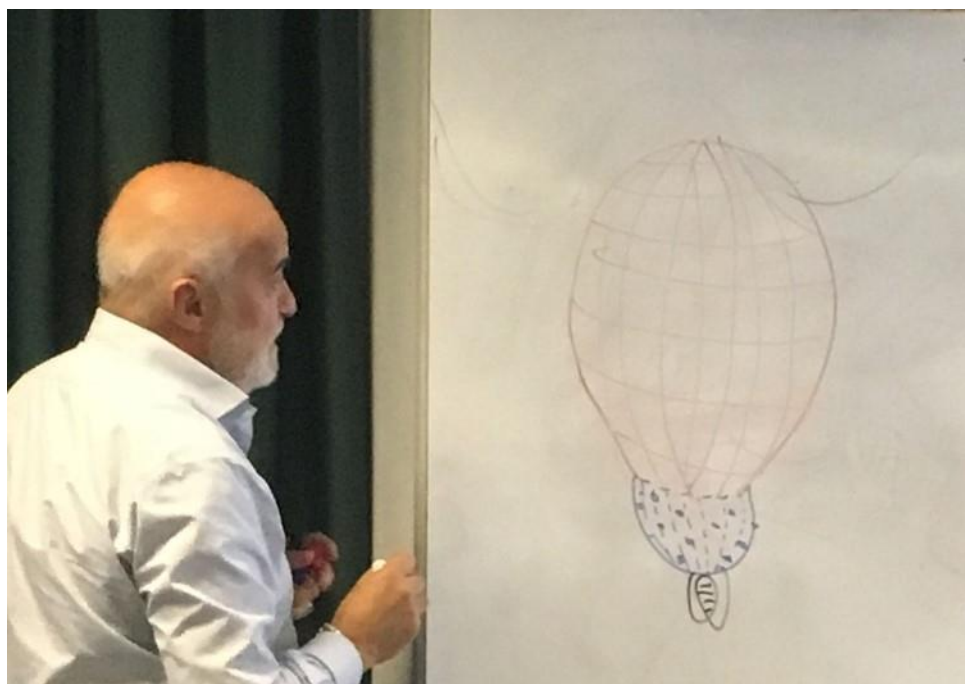
The first rotation is in sagittal plane around the axis of the pubis. If the baby has his back on the left he will engage with occiput anterior. If his back is on the right he will engage with occiput posterior. The second rotation (in 94% of cases) is in a horizontal plane with occiput anterior or posterior.



*The hypogastric plexus controls the opening of the cervix at ovulation time. Important for fertility.*

*“80% of problems are due to poor blood supply or poor drainage.”*

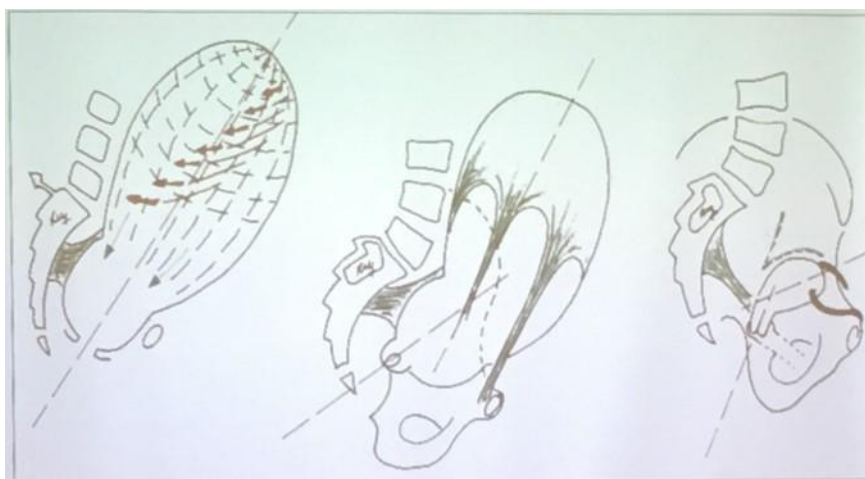
*A T Still*



The pregnant uterus: upper part with fibres running vertical, horizontal and oblique, inferior segment with intramural receptors and the cervix with mucus tap.

Generation of a clockwise and inferior rotational force during uterine contraction.

*The broad ligament contains vestigial muscle fibres*



If the uterus is side bent left and rotated left (36% of women) it will start contracting from the left side. The baby is then pushed clockwise as it comes down.

If it starts with a contraction on the right, that will go backwards through the oblique fibres and the uterus will rotate right.

6% of women have uterus side bent and rotated in opposite directions. In such cases the baby will have difficulty engaging; it will be squeezed but not guided.

## Where do I put my head?

ROP = right occiput posterior. Long birth 24h,

painful to mother as baby rotates, but once in position and engaged it will be okay. Some babies persist until they reach the left engagement (24 h or more).

The face will be forced against the pubis and might be neurologically damaged. Symptoms: hyperactivity, crying all the time. Later at around 18 months glue ear, sinus problems as matures.

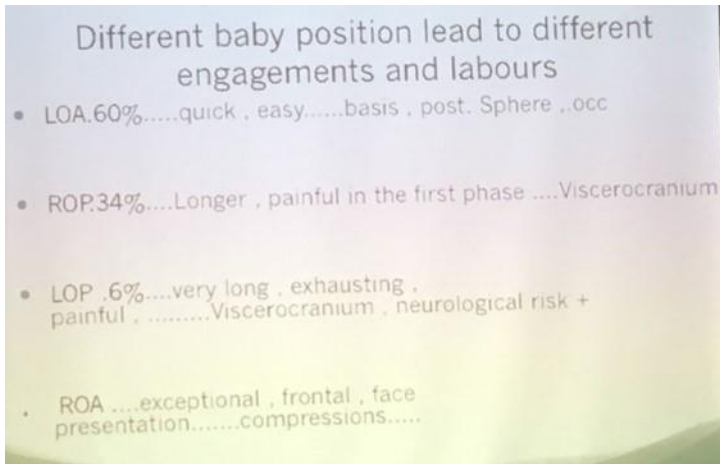
Vagus injuries:

Left vagus lesion expect upper stomach irritation, reflux

LOP = left occiput posterior. Long (15-20 hours), exhausting, painful labour and risk of neurological injury to baby

ROA = right occiput anterior

Unpredictable, a lot of potential for injury. Expect impaction and compression injuries. Often ends



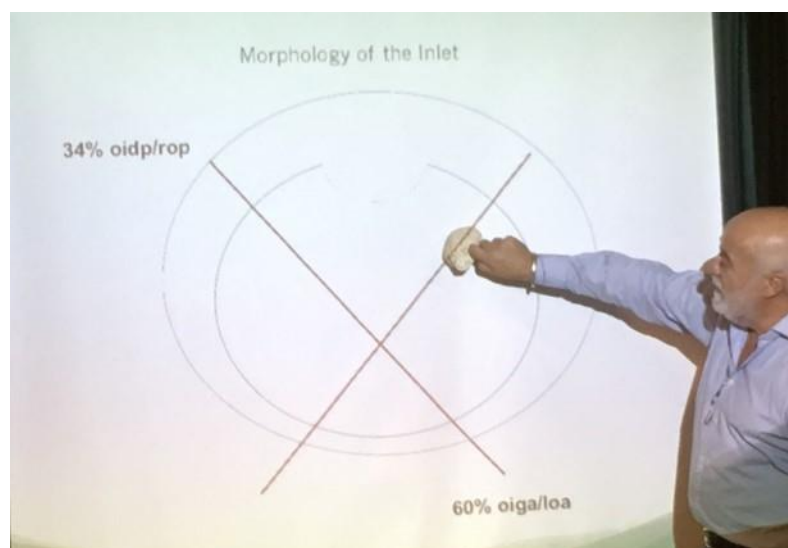
LOA = left occiput anterior. The best one 6-9 hours. During birth the baby rotates clockwise around the neurological axis, (they never rotate anticlockwise) from this position only 30° rotation is needed to engage. Common

risk, compression on left squamous occiput and occipito mastoid process – some digestive upset, reflux, nothing serious in an emergency C-section.

Right vagus expect pyloric irritation, vomiting

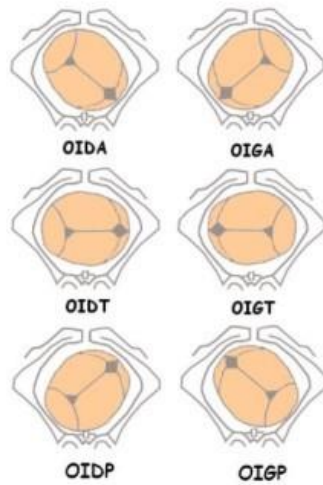
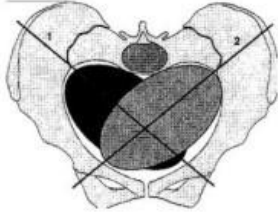
*Small babies are not a good option. Small babies (<2.7kg) often have difficult births. They tend to go transverse or they lock in the pelvis. Between 3-3.7kg they rotate easily.*

Distribution of engagement positions = right occiput posterior 34% loa = occiput anterior 60% oidp and oiga abbreviations (in French) for common cranial presentations.



rop  
left  
are

## Variétés de présentations



To get into a good position the baby has to negotiate the sacral promontory as it turns.

**It's getting harder!**

There are an increasing number of back to back presentations and more babies rotating backwards. It seems that the nature of the female pelvis is changing over generations. We can speculate that this may be due to reduced muscle tone and less physical activity, more hours sitting perhaps?

Men are changing too!

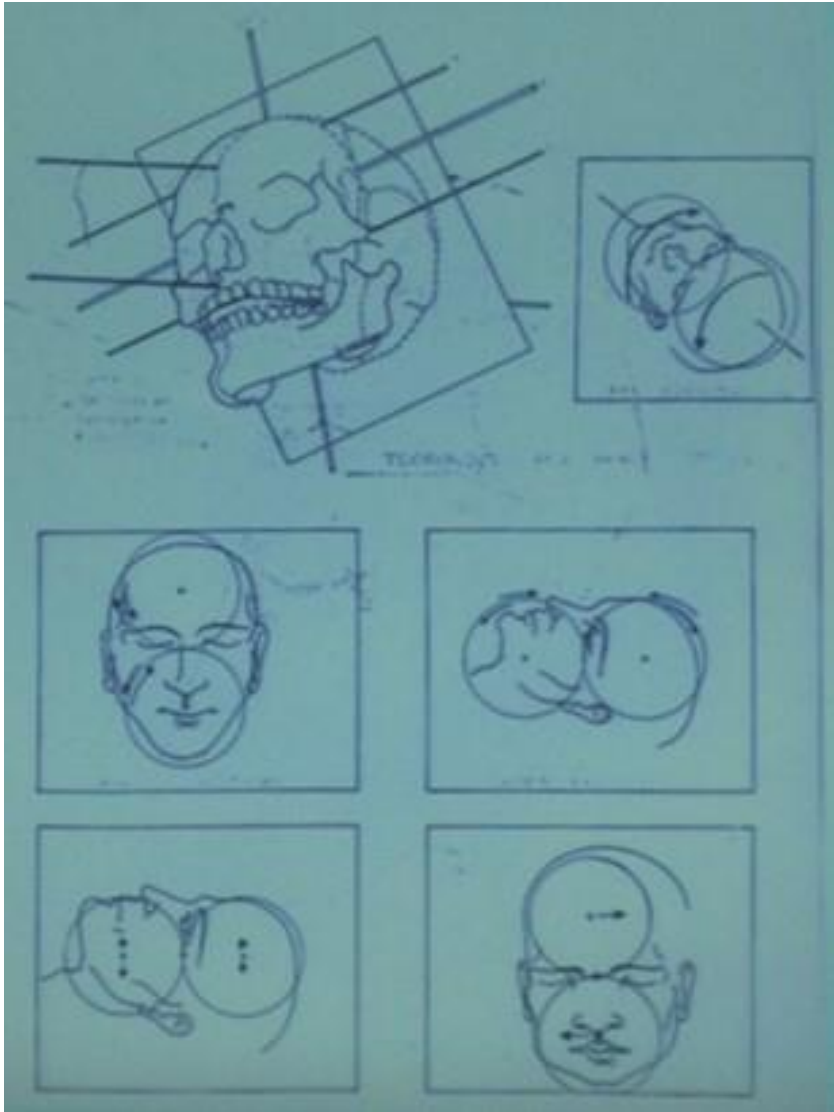
Over the last 40 years' sperm counts have almost halved in European men.

Spermatozoa are created in subcutaneous fatty cells in areas where we have undifferentiated fascia such as the omentum. Such cells are susceptible to environmental chemicals from plastics and have been found

on biopsy to contain a range of exogenous chemical residues. This has an inhibiting effect on spermatogenesis.

## Practical Session

An overview of some useful techniques for treating commonly seen mechanical injuries to the face and head.



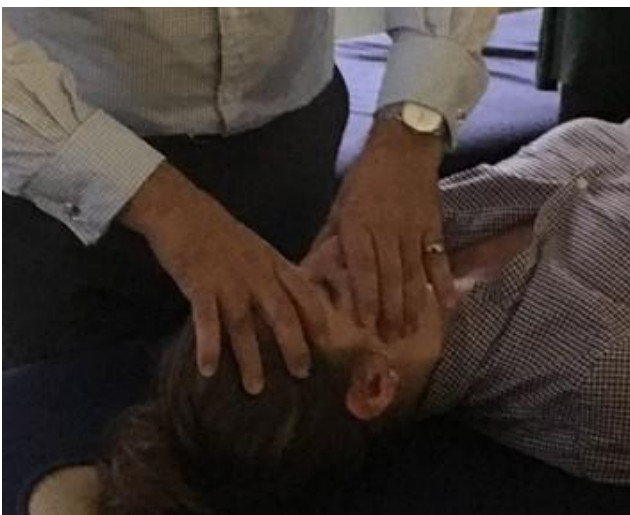
Consider the neurocranium and viscerocranium as two spheres.

1. Imagine the eyes as the axis.

Contact the upper sphere on frontal or sphenoid, the lower sphere on the maxillae and test flexion/extension by rolling the spheres inwards and outwards.

2. test side bending with the nasofrontal sagittal line as the axis
3. test torsion with the vertical axis
4. test lateral shear
5. test A-P shear

6. test approximation/distraction along the vertical axis



A good technique is to stack all of the above, following into the direction of ease sequentially to make an indirect technique.

Showing hand position for spheres technique





Showing hand position for babies with frontal compression. Contact zygomae with one hand, root of nose and frontal with other. Mobilise “hinge” along line of eyes

*Thanks to Pat MacCarthy for sharing her notes from the final hour of the seminar*

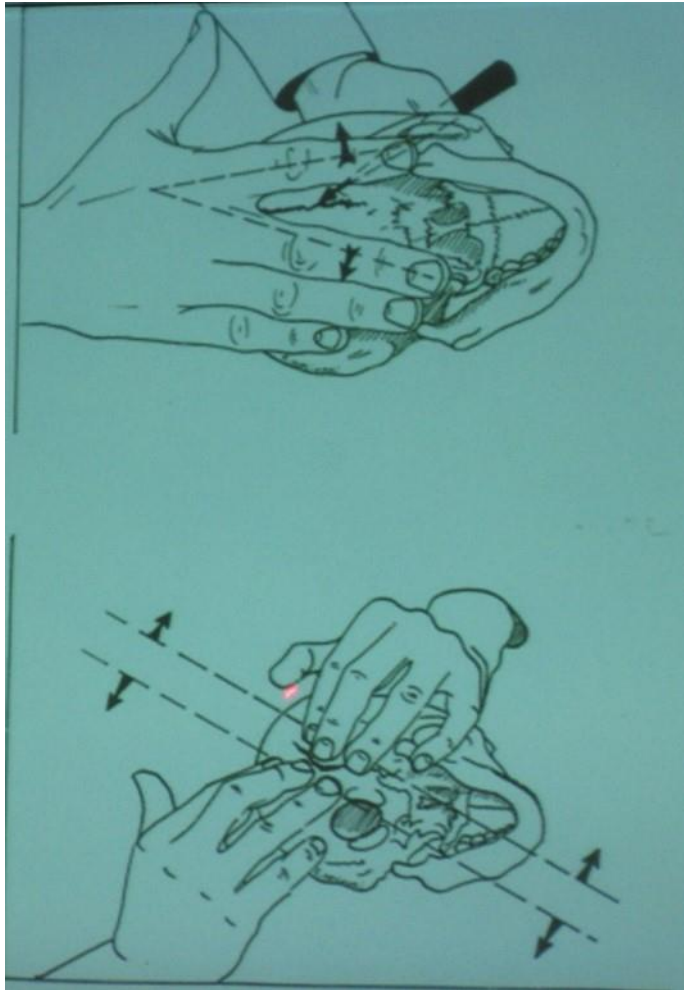
### ***FACIAL ASYMMETRY RELEASE***

Renzo showed a series of 4 photos of the same baby who had evident facial asymmetry initially and then was beautifully balanced by the fourth image. He said this kind of asymmetry was typical of compressions and distortions around the central part of the cranial base. His mode of treatment he described as going to the motion barrier and disengaging with the tension between your hands (as we’d just practised) to release the impaction from labour.

### ***OM SUTURE RELEASE***

The next practical session relates to problems at the Occipito-Mastoid suture. Important elements pass through the OM area and “you need to open the suture for the future”.

V-spread technique on the OM demonstrated a plus a straightforward two-handed spreading technique for the same area. The idea is to open the system, disengage the compaction and wait for the release, it is a DIRECT release as taught by Viola Frymann. These techniques should follow SUBOCCIPITAL INHIBITION.



**Upper:** Occipitomastoid suture viewed from base of skull “Vspread on OM joint”

**Lower:** shows finger placement on OM “Direct OM separation”

### V-SPREAD TECHNIQUE

Advice on finding the right degree of pressure for a V-spread. Its “like stepping carefully into a boat on the water” not jumping in with both feet but stepping carefully first with one foot then gently following with the other keeping a sense of balance all the time.

The placement of the other hand, to direct fluid to the technique from the opposite side of the skull, requires you to imagine the head is “full of olive oil” use the point of the index finger, with the forearm in line initially, to pass a pulse across this “bowl of thick liquid”. Ensure the pressure is accurately reaching the area between the V-spread fingers of the other hand before relaxing and dropping the “pointing” forearm.

V-spread techniques are also good for TEMPORO-PARIETAL IMPACTIONS which are important in babies.

### CAUTION

Renzo recalled an experienced cranial osteopath examining a very big baby in Russia in St Petersburg. The osteopath described “a beautiful boy who was very healthy and with good energy” only to be interrupted by the local Head of Neurology who said they couldn’t be more wrong. The baby was going to be seriously disabled because his temporo-parietal suture had been so compressed during a difficult birth that he would never walk or talk because of the brain damage this had caused. Apparently there was a visible step between the two bones above the ear and very slight fasciculation on his arm, but his point was that until babies start to express motor and other skills through development you have to be very aware and look for subtle signs to make a careful and sound assessment. He said we need a lot more medical knowledge as a baby who looks really well can be disabled. He described seeing babies with Downs syndrome where in their first few days and weeks it may not always be apparent.

### ABDOMINO-PELVIC TREATMENT & the VAGUS

He then moved on to talk about treating problems with the VAGUS nerve not just at the cranium but in the abdomen and pelvis and the need to balance “both ends”. Gynaecologists in the 1900s had to rely on manual techniques to stem haemorrhages because at that time it was all they could do but they lost those skills as surgical, chemical and instrumental techniques advanced. There were around 5000 gynaecologists in Germany at that time working exclusively with manual techniques.

Byron Robinson in 1907 who wrote a paper called “The Intestinal Brain” was rejected by his scientific peers, but his thinking is now more widely accepted.

“DYNAMOGENIC REFLEX” Thure Brand DO observed that women who had a complete cord section still had peristalsis around their ovaries and fallopian tubes independent of stimulation from CNS.

Manual treatment of the lower abdomen/pelvis is probably needed more than ever nowadays not just because of static work and leisure postures but because women are often on the hormonal contraceptive pill for 10-15 years and end up with a lot of fibrosis in the abdomen and there are increasing concerns about infertility.

The technique is akin to a V-spread on a larger scale. Using the little-finger border of both hands, start with a gentle but firm placement widely to either side of the abdomen at umbilical level. With a wavelike “wiggling” cupping motion the two hands are drawn down the sides of the abdomen meeting in a V shape at the pubis, this is repeated, then the weight is shifted more to the fingertips so that the same gentle cupping and dragging route is followed but with more of a vibrating action.

Case history: a woman with infertility problems and signs of vagal irritation (abdominal symptoms, dizziness, auditory issues, heart palpitations) was angry and frustrated at her route, seeing various consultants to no avail. Renzo used this technique in conjunction with others and she felt calmer at the end of the session as well as having good results with other symptoms. Releasing visceral tissues helps associated neurological vascular and lymphatic tissues.

### ***PSOAS & THORACIC DIAPHRAGM***

If there is undue tension between these areas in a pregnant woman in particular she may even find it hard to lie flat and may feel dizziness, faintness and nausea.

He demonstrated on a class member who had restriction in one of her diaphragmatic crura (tested sitting by following movement of lower ribs with breath). He then treated that side with her lying supine, by reaching across and lifting that side of her lower ribs up and holding this till he felt a release.

His point was that in a pregnant woman, imbalances between her psoas, crurae and diaphragm may lead to a difficult foetal position and that relaxation around the uterus (which lies along the psoas like a pair of guide-rails) will encourage more comfortable options for the baby’s lie.

### ***PIRIFORMIS, OBTURATOR INTERNUS & LEVATOR ANI***

Also important to treat for similar reasons are the piriformis muscles and the obturator interni and also the levator ani as these muscles help to trigger rotation of the baby during the birth process. Anything touching a baby can change its position. Checking and treating these muscles is important to allow the uterus to be balanced.

Report of Renzo Molinari’s talk by Bill Ferguson

Osteopath in Tenterden [www.billferguson.co.uk](http://www.billferguson.co.uk)

November 2016

(with input from Pat MacCarthy)



## Research Update

### Promoting a programme for prisoners and deprived communities in the treatment of violence, self-harm & suicide prevention.

The Sphenoid Ireland seminar “Promoting health and well-being in the young” which was held on 08<sup>th</sup> April in the European Commission Office Dublin 2016 following the European seminar in 2015 in The European Parliament Brussels aimed to build a consortium for a research call in 'Promoting health and well-being in the young' and for the needs of young prisoners with histories of family, religious and institutional abuse. We have provided a submission and are in a consortium. We have a request

for a research submission and we welcome interested individuals and organisations.

[info@sphenoidireland.ie](mailto:info@sphenoidireland.ie)