The CranioSomatic Syndrome: A New Paradigm

The typical human body is asymmetrical in both structure and function. Contributing significantly to these asymmetries is the body's pattern of neuromusculoskeletal compensations for the presence of two chronic cranial patterns: a Right Torsion and a Left Lateral Strain. These patterns appear to be universally present and associated with the Asymmetric Tonic Neck Reflex, a primitive reflex (see Asymmetric Tonic Neck Reflexes below).

The postural compensations resulting from these two cranial patterns include both 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. In addition, the Left Lateral Strain produces a shearing of both the cranium and the pelvis in the horizontal plane with the left side moving anteriorly and the right side moving posteriorly. The anterior shearing of the cranium can frequently be observed in in the close-up facial views of TV commentators and their guests. The left eye may appear slightly larger and more forward than the right.

The muscular compensations for the Right Torsion and Left Lateral Strain patterns result in global imbalances in muscle function. Manual muscle testing in the prone and supine positions, generally reveals an imbalance in paired muscles, with one testing strong (facilitated) and the other testing weak (inhibited). For example, the right Anterior Deltoid tests strong and the left tests weak; the right Latissimus Dorsi tests strong and the left tests weak; the right Psoas tests strong and the left tests weak; the left Tensor Fasciae Latae tests strong and the right tests weak; the left Piriformis tests strong and the right tests weak, etc. Other applied kinesiology evaluation procedures (Challenge and Therapy Localization) can be used to demonstrate that muscles of mastication and eye movements are also involved in this global musculoskeletal imbalance.

The right torsion pattern can be confirmed by the following muscle test results. 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 chronic cranial Right Torsion and Left Lateral Strain are referred to as Primary Cranial Patterns by Dr. Hancock[1] to emphasize that the associated neuromusculoskeletal patterns occur secondary to, and in compensation for, the cranial patterns, rather than the reverse. This designation also differentiates these chronic cranial patterns from functional, easily-corrected sphenobasilar cranial patterns which occur in coordination with the spine and pelvis in response to activities of daily living.

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

An explanation for the failure of traditional approaches to correct these two chronic patterns may have to do with both the extent of the cranial distortions and their chronicity. These chronic 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 and require changes to the cranial soft tissue holding elements to release them. Both the cranial and musculoskeletal patterns can be identified in infants.[1]

The resolution of these 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 the chronic cranial patterns. The treatment procedures can be performed in one or two sessions and do not need to be repeated.[1]

Correction of the 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.[2, 3] 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 Category 1 and Category 2 indicators are cleared by the CSI procedures.

The chronic Right Torsion and Left Lateral Strain patterns may also be the underlying etiology of the Common Compensatory Pattern (CCP) described by Zink and Lawson[4] 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 chronic 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 Beatty[5] and others[6, 7] in chiropractic literature as a right sacroiliac dysfunction with a sacrum tipped and rotated to the right and a four-opposed compensatory rotational scoliosis with the lumbar convexity to the right. These symptoms are also cleared by the CSI procedures. The cited authors considered the Typical to be universally present and uncorrectable; Beatty referred to it as the hereditary norm of mankind.

Asymmetric Tonic Neck Reflex (ATNR)

The ATNR is a primitive reflex that is present at birth. When the head is turned to either side, the tone of the flexor and extensor muscles is altered. On the side which the head is turned towards, the extensor muscles are facilitated and the flexor muscles are inhibited. On the side which the head is turned away from, the flexor muscles are facilitated and the extensor muscles are

inhibited. Obviously, the tone of the supporting adductor and abductor muscles, and the internal and external rotator muscles, changes to be consistent with the flexors and extensors

When the chronic Right Torsion and Left Lateral Strain patterns are present, the following results are expected. When the head is turned to the left, or remains in the neutral position, the resulting muscular pattern will resemble a right torsion. On the right side the flexor muscles will be facilitated and the extensor muscles will be inhibited. On the left side the extensor muscles will be facilitated and the flexor muscles will be inhibited. When the head is turned to the right, the resulting muscular pattern will resemble a left torsion. On the right side the extensor muscles will be facilitated and the flexor muscles will be inhibited. On the left side the flexor muscles will be facilitated and the extensor muscles will be inhibited.

When the chronic Right Torsion and Left Lateral Strain patterns have been removed by the treatment techniques in CSI, and the cranium is not in a functional SB torsion pattern, turning the head right or left appears to produce no change to the tone of flexor or extensor muscles. The ATNR appears to function only in the presence of a torsion pattern. Eliminating the effect of the ATNR may have important therapeutic benefits when treating some neurological pathologies.

See *Workshops & Notable Features* for descriptions of this workshop and others.

References

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